Guardianship Alliance of Colorado
Guardianship Referral Form

Proposed Client Name:	Proposed Client Date of Birth:	Date of Referral:
Referring Party Name:	Referring Party Phone:	Relationship to Proposed Client:

General Information

Proposed Client Home Address:		
Status of Home (Circle One): Own Rent Other	Living Alone: Yes No	Marital Status:
Nursing Facility:	Date of Admission:	
Place of Birth:	Social Security Number:	Medicare Number:
Medicaid ID Number:	Other Insurance Name:	Other Insurance ID Number:

Medical Information

Physician Name and Phone Number:	Psychiatrist Name and Phone Number:
Dentist Name and Phone Number:	Optometrist Name and Phone Number:
Current Diagnoses:	
Advance Directives(Circle all that apply): Full Code No Code Living Will Power of Attorney	
Immediate Health Care Concerns:	

Personal Contacts

Family

Please list ALL living family members.

Name:	Relationship:	Address:
Phone:	Level of Involvement:	
Name:	Relationship:	Address:
Phone:	Level of Involvement:	
Name:	Relationship:	Address:
Phone:	Level of Involvement:	
Name:	Relationship:	Address:
Phone:	Level of Involvement:	

Family (Cont'd)		
Name:	Relationship:	Address:
Phone:	Level of Involvement:	
Name:	Relationship:	Address:
Phone:	Level of Involvement:	

Friends (Please list any involved friends)		
Name:	Relationship:	Address:
Phone:	Level of Involvement:	
Name:	Relationship:	Address:
Phone:	Level of Involvement:	
Name:	Relationship:	Address:
Phone:	Level of Involvement:	

Spouse Information

Spouse's Name:	Spouse's Date of Birth	Spouse's SSN
Current Status: Divorced: Date		Deceased: Date
Spouse's Military Service: Branch:	Discharge Date:	Discharge Status:
Former Spouses:		

Legal Information

Other advocates currently involved (Circle all that apply): Power of Attorney Representative Payee Case Manager/Social Worker Mental Health Clinic Attorney Other Personal Representative Other (Please list):	
Does the client have a will? Yes No	If yes, Will Administrator Name and phone number:
Does the client have a trust? Yes No	If yes, Trustee Name and phone number:
Any pending legal action? Yes No	If yes, describe:

Insurance Information

Life Insurance

Life Insurance? Yes No	If yes, Company Name:		
Phone Number:	Policy Number:	Type of Insurance: Whole-Life Term-Life	Paid in full? Yes No
Name of Beneficiary:	Address of Beneficiary	Phone Number of Beneficiary:	

Health Insurance

Medicare: Yes No	Medicare Type (Circle all that apply) Part A Part B Part D	
Medicare Part D Provider (Prescriptions):	Medicare Part D Policy Number:	
Medicare Replacement Insurance: Yes No	Provider:	Policy Number:
Medicaid: Yes No	Medicaid Member ID:	
Other Health Insurance: Yes No	Company Name:	Policy Number:
Phone Number:	Address:	

Financial Information

Income

Source:	Amount:	Frequency:
Source:	Amount:	Frequency:
Source:	Amount:	Frequency:

Bank Accounts

Checking Account: Yes No	Bank Name:	Account Number:	Approx. Balance:	Co-Owner:
Savings Account: Yes No	Bank Name:	Account Number:	Approx. Balance:	Co-Owner:
Other Account:	Bank Name:	Account Number:	Approx. Balance:	Co-Owner:
Other Account:	Bank Name:	Account Number:	Approx. Balance:	Co-Owner:

Expenditures

Rent/Mortgage Paid To:	Average Amount Due:	Due Date:
Electricity/Energy Paid To:	Average Amount Due:	Due Date:
Water Paid To:	Average Amount Due:	Due Date:
Natural Gas/Propane Paid To:	Average Amount Due:	Due Date:

Expenditures (Cont'd)			
Other Paid To:	Average Amount Due:	Due Date:	
Credit Card Paid To:	Current Balance:	Average Amount Due:	Due Date:
Credit Card Paid To:	Current Balance:	Average Amount Due:	Due Date:
Loan Paid To:	Current Balance:	Average Amount Due:	Due Date:

Real Estate			
Address of Property:		Property Type: House Mobile Home Townhouse Other	
Previous Address:			
Mortgage Type:	Balance Owed:	Monthly Payment:	Paid in Full: Yes No
Mortgage Company Name:		Mortgage Company Phone Number:	
Mortgage Company Address:			
Years Owned:	Any Liens? Yes No	Lienholder:	Amount Owed on Lien:
Annual Tax Amount:	Are Taxes Current? Yes No	Back Taxes Owed:	

Funeral/Burial Arrangements		
Funeral Home Name:	Address:	Phone Number:
Pre-paid Plan or Trust? Yes No	Paid in Full? Yes No	Amount Owed:
Company Name:	Policy Number:	
Burial or Cremation?	Cemetery Name:	Cemetery Phone Number:
Own Any of the Following? Plot Vault Headstone Marker	Paid In Full? Yes No	Amount Owed:

Other Information		
Religious Preference:	Church Preference:	Highest Level of Education:
Occupation:	Mother's Name:	Father's Name:

Psychosocial History: (Briefly document family history, educational, occupational, military background, socialization patterns-family, friends, other community supports, etc.)
Psychiatric History: (Briefly document diagnostic history, reason for most recent admission; describe mood, behaviors, substance use history, etc.)
Physical Limitations, if any: (vision, hearing, Dental, speech, nicotine use etc.)
Rationale for why guardianship is necessary for this client: (Briefly document reasons why guardianship is appropriate)