Aging Solutions, Inc.

"Linking Healthcare Options"

Office of Public Guardian for Brevard County
PO Box 561049 Rockledge, FL 32956-1049
Phone: (321) 768-7997 Fax (321) 722-0910

GUARDIANSHIP INTAKE AND REFERRAL FORM

Thank you for requesting the services of this agency. We understand that not all of the information asked for on this form may be available at the time of the referral. Nevertheless, please fill it out as completely as possible since eligibility for the public guardianship program is mandated by Florida Statutes 744.2007 subsection (1) & (3). The information requested assists us in expediently making a determination.

Please note that the acceptance of a potential Ward into the public guardianship program is made by the Office of the Public Guardian.

Who will petition the Court for the Guardianship (be the Petitioner)?

Name: _____

Address: _____

_____

Telephone: _____

E-Mail Address: _____

Who will represent the Petitioner (be the Attorney for Petitioner)?

Name: _____

Address: _____

_____

Telephone: _____

This information is absolutely essential;
without it, acceptance into the program could be delayed.

(Please complete all three if known)

Client's Name: First: _____ Gender: _____ Age: _____ Race: _____

Middle: _____

Last: _____

Also Known As: _____

Current Location: _____

Address: _____

_____

Length of time at this Address: _____

Birth Date:_____

Birthplace: _____

U.S. Citizen?_____

Marital Status: _____

Religious Preference: _____

Telephone: _____ Languages Spoken: _____

Previous
Address:_____

Attending
Physician: _____ Physician Phone: _____

Address: _____

Current/Previous Occupations: _____

Anyone living with the Client? _____ Please specify: _____

Telephone: _____ _____

Family/Significant Others:

Name/Relation: _____ Name/Relation: _____

_____ _____

Address: _____ Address: _____

_____ _____

Telephone: _____ Telephone: _____

Why does this client need a guardian? (Please be specific, thorough, and convincing)

_____

_____

_____

_____

_____

_____

Additional Comments:

_____

_____

_____

_____

_____

_____

_____

Doctor: _____ Dentist: _____

Address: _____ Address: _____

_____ _____

Telephone: _____ Telephone: _____

Diagnosis: _____

_____

_____

Allergies: _____

Medical
History: _____

_____

_____

Mental status/
Level of Functioning: _____
(including ambulation
and ADL's) _____

_____

Social Security #: _____ Monthly Income: SS - $_____ SSI - $_____

Medicare #: _____ OSS - $_____ VA - $_____

Medicaid #: _____ Pension/Annuity $_____

Veterans #: _____ Dividend/Interest $_____

Other Insurance: _____ Other Income - $_____

_____ _____

Rep Payee? Yes _____ No _____ Who? _____

Assets/Property:
Personal (accounts, stocks, furniture, Real (Land, buildings, mobile homes, jewelry, etc.) –

_____ _____

_____ _____

_____ _____

Date: _____ Contact Person: _____

Category (check the appropriate one):

Nursing Home/ACLF _____ Hospital _____ Name of Agency: _____

State Agency _____ County Agency _____ Address: _____

Court _____ Other (Please specify) _____ _____

_____ _____