 **Advocates for Change LLC
  *...where YOU matter most!***

**Guardianship Application**

Office 919.999.0575 | Fax: 919-803-7465

|  |
| --- |
| Date   |
| cLIENT NAME DATE OF BIRTH |
|  |
| CURRENT ADDRESS |
|  |
| PHONE Ss# |
|  |
| SEX \_\_\_\_ m RACE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  \_\_\_\_ F |
|   |
| marital status \_\_\_\_ sINGLE \_\_\_\_ mARRIED \_\_\_\_ SEPARATED |
|  \_\_\_\_ DIVORCED \_\_\_\_ WIDOWED |
|   |
| SPOUSE NAME (IF APPLICABLE)  |
|   |
| FACILITY \_\_\_\_ YES \_\_\_\_ NO FACILITY NAME |
| FACILITY ADDRESS  |
| ADMISSION DATE PHONE CURRENT EMPLOYMENT/RETIRED FROMEMERGENCY HEALTH NEEDSEVALUATION COMPLETED BYEMERGENCY GUARDIANSHIP NEEDED \_\_\_\_ YES \_\_\_\_ NOIF YES, EXPLAIN WHYREFERRAL SOURCEREFERRED BY PHONE EMAILWHY REFERREDESTATE INFORMATIONOWN PROPERTY \_\_\_\_ YES \_\_\_\_ NO ADDRESSOWN VEHICLE \_\_\_\_ YES \_\_\_\_ NO MAKE MODELLIFE INSURANCE \_\_\_\_ YES \_\_\_\_ NOIF YES, WHERECHECKING OR SAVING ACCOUNT \_\_\_\_ YES \_\_\_\_ NOIF YES, WHERECURRENT PAYEE \_\_\_\_ YES \_\_\_\_ NOIF YES, WHOM BENEFITS/INCOME SOURCE  \_\_SSI \_\_SSDI \_\_SA \_\_MEDICAID \_\_MEDICARE \_\_va \_\_OTHER AMOUNT ($)MEDICAL INSURANCE\* \_\_\_\_\_YES \_\_\_\_\_NOPOLICY NUMBERS:MEDICAID#\* MEDICARE#\* VA SERVICE CONNECTED \_\_\_\_\_ YES \_\_\_\_\_ NO SERVICE #\*PROVIDE COPIES OF INSURANCE CARDSVETERAN BRANCH OF SERVICECURRENT/PREVIOUS GUARDIAN \_\_\_\_ YES \_\_\_\_ NOCOURTNAME RELATIONSHIP PHONESUPPORT SYSTEM (include family, friends, neighbors, other contacts)\* Relationshipsname addressphone relationship to clientname addressphone relationship to clientCHILDREN\* \_\_\_\_ yes \_\_\_\_ no \*if yes, pROVIDE NAME, dob, aDDRESS, pHONEPHYSICIANNAME ADDRESSSPECIALITY PHONEPHYSICIANNAME ADDRESSSPECIALITY PHONESPECIFIC DIAGNOSISCURRENT MEDICATIONSFUNERAL PLANS PREPAID \_\_\_\_ yes \_\_\_\_ no PREPLAN \_\_\_\_ yes \_\_\_\_ noname of cemeteryaddress phonefuneral homeaddress phoneReligion churchliving will \_\_\_\_ YES \_\_\_\_ NO CONTACT PERSONdnr \_\_\_\_ YES \_\_\_\_ NO CONTACT PERSONWHEREdpoa YES NO CONTACT PERSONCURRENT PSYCHOLOGICAL\* \_\_\_\_ YES \_\_\_\_NO  \*if yes, provide a copy |
| client’s ability to perform the following IADL/ADL TASKS |
| 1-nEEDS NO aSSISTANCE 2-NEEDS SOME ASSISTANCE 3-NEEDS FULL ASSISTANCE |

|  |  |  |
| --- | --- | --- |
| TASK | 1, 2, 3 | COMMENTS  |
| AMBULATION |  |  |
| BOWEL/BLADDERCONTROL |  |  |
| DRESSING |  |  |
| BATHING |  |  |
| GROOMING |  |  |
| EATING |  |  |
| TRANSFERS: | \_\_\_\_\_to/from bed \_\_\_\_\_to/from chair \_\_\_\_\_into/out of car  |
| MEAL PREPARATION |  |  |
| MEDICATION INTAKE |  |  |
| HOUSEKEEPING |  |  |
| COMMUNICATION | \_\_\_\_\_SPEAKING \_\_\_\_\_WRITING \_\_\_\_\_SIGNING \_\_\_\_\_GESTURES \_\_\_\_\_COMMUNICATION DEVICES |
| MEAL PREPARATION |  |  |
| MEDICATION INTAKE |  |  |
| MONEY MANAGEMENT |  |  |
| PHONE USE |  |  |
| SHOPPING |  |  |
| READING |  |  |
| HOBBIES |  |  |
| OTHER |  |  |