 **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 FROM  EMERGENCY HEALTH NEEDS  EVALUATION COMPLETED BY  EMERGENCY GUARDIANSHIP NEEDED \_\_\_\_ YES \_\_\_\_ NO  IF YES, EXPLAIN WHY  REFERRAL SOURCE  REFERRED BY  PHONE EMAIL  WHY REFERRED  ESTATE INFORMATION  OWN PROPERTY \_\_\_\_ YES \_\_\_\_ NO ADDRESS  OWN VEHICLE \_\_\_\_ YES \_\_\_\_ NO  MAKE MODEL  LIFE INSURANCE \_\_\_\_ YES \_\_\_\_ NO  IF YES, WHERE  CHECKING OR SAVING ACCOUNT \_\_\_\_ YES \_\_\_\_ NO  IF YES, WHERE  CURRENT PAYEE \_\_\_\_ YES \_\_\_\_ NO  IF YES, WHOM  BENEFITS/INCOME SOURCE  \_\_SSI \_\_SSDI \_\_SA \_\_MEDICAID \_\_MEDICARE \_\_va \_\_OTHER  AMOUNT ($)  MEDICAL INSURANCE\* \_\_\_\_\_YES \_\_\_\_\_NO  POLICY NUMBERS:  MEDICAID#\* MEDICARE#\*  VA SERVICE CONNECTED \_\_\_\_\_ YES \_\_\_\_\_ NO SERVICE #  \*PROVIDE COPIES OF INSURANCE CARDS  VETERAN BRANCH OF SERVICE  CURRENT/PREVIOUS GUARDIAN \_\_\_\_ YES \_\_\_\_ NO  COURT  NAME  RELATIONSHIP PHONE  SUPPORT SYSTEM (include family, friends, neighbors, other contacts)\*  Relationships  name address  phone relationship to client  name address  phone relationship to client  CHILDREN\* \_\_\_\_ yes \_\_\_\_ no \*if yes, pROVIDE NAME, dob, aDDRESS, pHONE  PHYSICIAN  NAME ADDRESS  SPECIALITY PHONE  PHYSICIAN  NAME ADDRESS  SPECIALITY PHONE  SPECIFIC DIAGNOSIS  CURRENT MEDICATIONS  FUNERAL PLANS  PREPAID \_\_\_\_ yes \_\_\_\_ no PREPLAN \_\_\_\_ yes \_\_\_\_ no  name of cemetery  address phone  funeral home  address phone  Religion church  living will \_\_\_\_ YES \_\_\_\_ NO CONTACT PERSON  dnr \_\_\_\_ YES \_\_\_\_ NO CONTACT PERSON  WHERE  dpoa YES NO CONTACT PERSON  CURRENT 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/BLADDER  CONTROL |  |  |
| 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 |  |  |