ATS Guardianship Services, Inc.

Guardianship Referral Form

Thank you for requesting the services ATS Guardianship Services, Inc. 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 out as completely as possible.

Date: _____

CLIENT INFORMATION (AIP Alleged Incapacitated Person)

Client's Name_____Also Known As: _____

Gender: ☐ Male ☐ Female Date of Birth:_____ Age:_____ Race: _____

U.S. Citizen: ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower Name of Spouse: _____

SSN:_____-_____-_____Primary Language:_____County of Residence: _____

Current Location: _____

Current/Previous Occupation _____

If facility, admission date:_____Phone: _____

REFERRAL SOURCE:

FINANCIAL

Monthly Income: SS $_____ SSI $ _____ SSDI $ _____ Pension $_____

Annuities _____ VA $_____ Veterans ID: _____

INSURANCE

Medicare No.: _____ Medicaid No.: _____ Other Insurance: _____

Notes: