



# Senior Resource ASSOCIATION

## Public Guardian Program Referral and Intake Form

Please complete this document in its entirety. If the field is not applicable, please insert "n/a" or "unknown."

### Referral's Information

*The information in this section pertains to the individual being referred to SRA's Public Guardian Program*

Date of Referral: \_\_\_\_\_ Full Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

How long has the referral lived at the above residence: Years \_\_\_\_\_ Months \_\_\_\_\_

Present location and address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Place of Birth City/State: \_\_\_\_\_

If not a native Floridian, date referral moved to Florida: \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Religion: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Name of spouse: \_\_\_\_\_ Is spouse living: \_\_\_\_\_

If not, date and place of death \_\_\_\_\_

Last occupation: \_\_\_\_\_ Highest level of education: \_\_\_\_\_

Father's Full name: \_\_\_\_\_ Mother's maiden name: \_\_\_\_\_

Does the referral have any of the following:

Health Care Proxy:  Yes  No

Health Care Surrogate:  Yes  No

Does not resuscitate document:  Yes  No

Living Will:  Yes  No

US citizen?:  Yes  No

If not a U.S. citizen: Immigration status: \_\_\_\_\_ Immigration #: \_\_\_\_\_

## Referral Source Information

*The information in this section pertains to the individual/agency making the referral to SRA's Public Guardian Program*

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Agency: \_\_\_\_\_ Title: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Relationship to the referral: \_\_\_\_\_

Name of the person completing the Referral and Intake form: \_\_\_\_\_

## Relative and/or Friends of Referral

*Please provide information regarding the referral's relatives and/or friends below*

NAME	RELATIONSHIP	PHONE NUMBER	HAS THE REALTIVE OR FRIEND BEEN CONTACTED?

## Referral's Mental and Behavioral Status

1. Diagnosis: \_\_\_\_\_
2. Intellectual challenge/developmental disability: \_\_\_\_\_
3. Please check all that apply:
  - a. Does the referral have impaired memory?  Yes  No
  - b. Is referral confused and disoriented to time , place , person ?
4. If the referral is confused and disoriented, please give examples: \_\_\_\_\_
5. Is the referral able to understand simple concepts and ideas?  Yes  No
6. If the referral is not able to understand simple concepts, please give an example: \_\_\_\_\_  
\_\_\_\_\_
7. Is the referral able to:
  - a. Function in his/her environment  Yes  No
  - b. Manage finances  Yes  No
  - c. Exercise judgement  Yes  No
  - d. Problem solves  Yes  No

If the answer to the above a. thru d, questions were no, please give an example: \_\_\_\_\_  
\_\_\_\_\_

8. In your opinion, is the referral above able to:
  - a. Manage his/per property and finances, or make any gift or disposition of his/her property?  
 Yes  No
  - b. Determine his/her residence?  Yes  No
  - c. Consent to medical treatment?  Yes  No
  - d. Make decisions about the social environment or other social aspects of his/her life?  
 Yes  No
9. Please check the appropriate classification for the referral. *More than be many be check if applicable:*
  - a. Elderly
  - b. Mental Illness
  - c. Cognitive Impairment
  - d. Intellectual Challenge/Developmental Disability

## Referral's Financial Status

1. Current Monthly income: \$ \_\_\_\_\_
2. Does the Referral receive any income from the following sources:
  - a. Social Security (SSA)  Yes  No
  - b. Supplemental Security Income (SSI):  Yes  No
  - c. Veterans Affairs benefits (VA)  Yes  No
  - d. Optional State Supplementation (OSS)  Yes  No
3. If the referral has a **Private Pension**, what is the source \_\_\_\_\_
4. **Bank Account(s)**  
Please list all that apply. If not applicable, list "n/a" or "unknown."

BANK NAME AND LOCATION	BANK TYPE/TITLE OF ACCOUNT	PHONE NUMBER	AMOUNT

5. Does the referral have any **certificates of deposit**:  Yes  No  
If yes, please list all that apply: \_\_\_\_\_  
\_\_\_\_\_
6. Does the referral have any **stocks/bonds**:  Yes  No  
If yes, please list all that apply: \_\_\_\_\_  
\_\_\_\_\_
7. Does the referral have a safety **deposit box**:  Yes  No  
If yes, please list all that apply: \_\_\_\_\_  
\_\_\_\_\_

8. **Real Estate**

Please list all that apply. If not applicable, list "n/a" or "unknown."

DESCRIPTION	TITLE	LOCATION	EST. VALUE

9. **Personal Property**

Please list all that apply. If not applicable, list "n/a" or "unknown."

DESCRIPTION	TITLE	LOCATION	EST. VALUE

Referral's end of life arrangements

1. Does the referral have any **burial arrangements**?  Yes  No

If so, please explain: \_\_\_\_\_

2. Does the referral have any **wills**:  Yes  No

If yes, please list all that apply: \_\_\_\_\_

3. Does the referral have any **additional arrangements** to note:  Yes  No

If yes, please list all that apply: \_\_\_\_\_

Please confirm the name of the referral: \_\_\_\_\_

Additional notes/comments: \_\_\_\_\_

Full name of the person completing SRA's Referral and Intake form: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

THIS SECTION IS FOR OFFICE USE ONLY

Review of Referral and Intake by SRA staff: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Referral accepted:  Yes  No

If not accepted, please list detailed reason: \_\_\_\_\_

If referral is accepted, is the referral placed on the waitlist or is there an immediate opening at SRA-PCP:

Waitlist placement:  Yes  No

Initiate process to petition for incapacity:  Yes  No

Has the WellSky been updated accordingly and noted "disposition"?

Yes  No

Has a note been issued in WellSky, and a copy of the Referral and Intake form been uploaded?

Yes  No