Date of Referral _____
Date Action Taken _____
Is this a medical emergency? _____

Board of Community Guardians

Referral for Guardianship/Conservatorship

Individual's Information

_____ _____
Name SSN

_____
Address City Zip

Date of Birth _____ Sex: M F Marital Status _____

Individual is at: Home Hospital Care Facility

Referral Information

_____ _____ _____
Personal Making Referral Phone Number Official Title

_____ _____ _____
Address City State/Zip

Reason for Referral:

_____

_____

_____

_____

_____

_____

_____

Medical Information

Medical Diagnosis and Prognosis of Individual:

_____

_____

Physician's Name	Address	City
State/Zip	Phone Number	

Prescribed Medications: _____

We need an affidavit from a Physician stating why they feel this person is in need of a Guardian. (Attach Letter/Affidavit)

Is a copy of the physician's affidavit attached to this application? Yes No

_____

Personal/Financial Information

Monthly Social Security	Other Income	Person Handling Finances
Checking Accounts	Account Balances	Other Assets
Savings Accounts	Account Balances	
Property Owned	Vehicles Owned	

Next of Kin (Information needed in case of death)

Individual's Place of Birth _____
Mother's name (married and maiden) _____
Mother's place of birth _____
Father's name _____
Father's place of birth _____
Veteran ____ Branch of Service _____Rank & Serial # _____
Highest grade of education completed _____
Have funeral arrangements been made _____
With who _____

_____

For Board Use Only

DO NOT WRITE BELOW THIS LINE

Court Visitor _____

Who is paying fee? _____

Approved by _____

If this is a medical emergency, people contacted:

1. Yes/No
2. Yes/No
3. Yes/No

Sent to Prosecuting Attorney _____ Fax # 736-4157

Volunteer Assigned _____