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| DHSlogo1113 | Allegheny County Department of Human Services2018 Guardianship Referral Form |

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| **FORM INSTRUCTIONS** |

1. All sections must be completed to assist with the guardianship process, including sections that require current address, telephone, and email contact information.
2. The individual being referred must have a documented mental health diagnosis and/or other documented behavioral health needs.
3. The person completing this referral must be able to establish and verify that a less-restrictive alternative to a guardianship does not exists.
4. A licensed physician must be willing to provide sworn testimony to establish the need for a guardianship and that all other less-restrictive alternatives have been explored.
5. All known family members of the individual who are 18-years-old or older must be documented.
6. Please send all completed referrals to Melissa Medice, Office of Behavioral Health (OBH) via email (Melissa.Medice@alleghenycounty.us) or via fax at (412) 350-4245.
7. If you have any questions about your referral, please call Melissa Medice at (412) 350-3341.

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| **Section A. REFERRAL SOURCE**  |
| Referral Source Contact Person:       | Office Phone:       |
| Referral Source Position & Agency Affiliation:       | Cell Phone:       |
| Referral Source Contact Address:       |
| Referral Source Email:       |
| Has this referral been discussed with all treatment supports? [ ]  YES [ ]  NO |

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| **Section B. IDENTIFYING INFORMATION**  |
| Individual being referred:       |
| Individual’s Current Address:       |
| Individual’s previous addresses throughout the last 6 months:  |
|       |       |
|       |       |
|       |       |
| Current Phone Number:       |
| DOB:       | Race:       | Legal Sex:       |
| SS#:       | Marital Status:       |
| Hgt:       | Wgt:       | Eye Color:       | Hair Color:       |
| **Section B. IDENTIFYING INFORMATION (continued)** |
| Is the individual Transition Age Youth (18-21) [ ]  YES [ ]  NO |
| Education Level:       | Occupation:       |
| Veteran: [ ]  YES [ ]  NO | Branch:       | Discharge Status:       |
| Place of Birth:       | Mother’s Maiden Name:       |
| State Hospital Involvement: [ ]  YES [ ]  NO  | Dates:       |
| Blind: [ ]  YES [ ]  NO | Deaf: [ ]  YES [ ]  NO |
| CSP: [ ]  YES [ ]  NO  | ACSP: [ ]  YES [ ]  NO |

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| **Section C. GUARDIANSHIP**  |
| Type of Guardianship Being Sought: [ ]  PERSON [ ]  ESTATE |
| Describe in detail why the identified individual needs a guardian to make decisions on their behalf:       |
| Describe the nature and timeframe of prior services/supports which were explored before this referral:        |
| Explain why the above services/supports were unsuccessful in supporting this individual:      |
| Was there a previous guardian? [ ]  YES [ ]  NO Dates:       | Reason for Removal:       |
| **Identify the licensed physician that will provide medical testimony regarding the need for guardianship:**  |
| Name:       | Address:       | Phone:       | Email:       |
| Has this referral been discussed with this doctor and are they in agreement? [ ]  YES [ ]  NO |
| Has this doctor confirmed that they will provide sworn medical testimony? [ ]  YES [ ]  NO  |

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| **Section D. PYSCHIATRIC/MEDICAL** |
| Current DSM Diagnosis:       |
| Date of last Psychiatric Evaluation:       | Last Psychiatric Hospitalization:       |
| Most Recent Psychiatric Admission:     Contact Person:       Contact Phone:        | Commitment Status:     Expiration Date:      |
| Medical Conditions (e.g. diabetes, heart disease, etc.):       |

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| **Section D. PYSCHIATRIC/MEDICAL (continued)** |
| Current Medications (attach additional sheets if needed): **Medication** **Dosage** |
|       |       |
|       |       |
|       |       |
| Allergies:       |
| Primary Medical Doctor:      Phone:       Address:       |
| Primary Psychiatric Doctor:     Affiliated Agency:       Phone:       Address:       |
| Other Doctors Involved (include name, address and phone number):        |

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| **SECTION E. CURRENT SERVICES** |
| Mental Health Service Provider Name:      Affiliated Agency:       Address:       |
| Office phone:       | Cell Phone:       | Email:       |

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| Does the individual have an Intellectual Disability: [ ]  YES [ ]  NO Current IQ:       |
| ID Support Coordination Unit:ISC’s Name:       Email:       |
| Office phone:       Cell phone:       |

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| Does the individual have any other DHS involvement? (e.g. CYF, Aging, Homeless/Hunger): [ ]  YES [ ]  NO |
| Describe other DHS service involvement:       |
| Contact Person(s) for other DHS service involvement: |
| **Name** | **Email** | **Phone** |
|       |       |       |
|       |       |       |

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| **SECTION F. HEALTH INSURANCE** **(N/A for areas that are not applicable)** |
| Primary BH MCO:       | MA ID #:       |
| Primary PH MCO:       | Policy Number:       |
| Medicare:       | ID #:       |
| Other:       | Policy Number:       |

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| **G. RESIDENTIAL SERVICES (if applicable)** |
| Provider:       | Address:       | Phone:       |
| Provider:       | Address:       | Phone:       |
| **Section H. NATURAL SUPPORTS** \*\*information must be as complete as possible including all possible ADULT family members due to the necessity of sending notification of petition\*\* |
| **Family Member** | **Address** | **Phone** |
| Father:       |       |       |
| Mother:       |       |       |
| Sibling:       |       |       |
| Sibling:       |       |       |
| Sibling:       |       |       |
| Sibling:       |       |       |
| Other:       |       |       |
| Other:       |       |       |
| What is the current level of family involvement?       |
| Who is the primary support for the individual?       |
| Has family been approached to serve as guardian? [ ]  YES [ ]  NODescribe Reason if No:       |
| Is the family in agreement with a professional guardian being appointed? [ ]  YES [ ]  NO |

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| **Section I. FINANCIAL INFORMATION - INCOME** |
| Checking Account: [ ] YES [ ]  NO | Value:       | Institution:       |
| Savings Account: [ ]  YES [ ]  NO | Value:       | Institution:       |
| Employment: [ ]  YES [ ]  NO | Employer:       | Time Employed:       |
| SSI: [ ]  YES [ ]  NO | Amount:       |
| SSD: [ ]  YES [ ]  NO | Amount:       |
| Food Stamps: [ ]  YES [ ]  NO | Amount:       |
| Other:       | Amount:       | Frequency:       |
| Income Producing Assets (including CD’s, Property and Life Insurance): [ ]  YES [ ]  NO |
| Life Insurance: [ ]  YES [ ]  NO | Value:       | Institution:       |
| Certificate of Deposit: [ ]  YES [ ]  NO | Value:       | Institution:       |
| Burial Account: [ ]  YES [ ]  NO | Value:       | Institution:       |
| Other:       | Value:       | Institution:       |
| Does the Individual have a REP PAYEE: [ ]  YES [ ]  NO |
| Name:       | Address:       | Phone:       |

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| **Section J. FINANCIAL INFORMATION – EXPENSES** |
| **Expense** | **Amount** | **Frequency** |
| Rent:       |       | Landlord:       |
| Utilities:       |       |       |
| Utilities:       |       |       |
| Utilities:       |       |       |
| Mortgage: [ ]  YES [ ]  NO |       | Provider:       |
| Medication Costs:       |
| Other Known Expenses (e.g. spending money, bus pass, etc.):      |

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| **Section K. LEGAL** |
| Justice System Involvement: [ ]  YES [ ]  NOPlease Describe:       |
| Last Will & Testament: [ ]  YES [ ]  NO | Date Completed:       |
| Living Will [ ]  YES [ ]  NO | Date Made:       |
| Power of Attorney: [ ]  YES [ ]  NO | Name:      Phone:       | Address:       |
| Mental Health Advanced Directive: [ ]  YES [ ]  NOAgent:       Agent Phone#:       |
| Other Legal Concerns (e.g. criminal charges, civil lawsuits, settlements, etc.):       |

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| **Section L. VERIFICATION**  |
| Print Name:      Signature:  | Date:       |