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| DHSlogo1113 | Allegheny County  Department of Human Services  2018 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: | | | | | | |
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| 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** | |
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| 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  NO  Describe 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  NO  Please 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  NO  Agent:       Agent Phone#: | | | |
| Other Legal Concerns (e.g. criminal charges, civil lawsuits, settlements, etc.): | | | |

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