LAW OFFICE OF RACHEL A. BROOKS
Guardianship / Conservatorship Referral Form

WELCOME!

This optional referral form is for facilities or health care providers who have a patient or resident who may need a guardianship or conservatorship. This form is for your convenience. If you prefer, you may call us directly.

If you are a parent or other family member who is interested in guardianship or conservatorship, please skip this form and call us directly.

If you have questions, please call the office directly at 360-699-5801.

Completion of this form does not, in itself, create an attorney-client relationship.

Don't worry if you don't have all the information requested, but please provide as much information as you can.

Thank you!

YOUR INFORMATION

FACILITY NAME: _____

YOUR NAME: _____

YOUR TITLE: _____

YOUR PHONE NUMBER: _____

YOUR EMAIL ADDRESS: _____

PERSON IN NEED OF PROTECTION

FULL NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

PREVIOUS RESIDENCE OR FACILITY: _____

DISCHARGE PLAN, IF ANY: _____

IS THERE A CURRENT POWER OF ATTORNEY? ☐ YES ☐ NO

FINANCIAL AGENT: _____

HEALTH CARE AGENT: _____

FINANCIAL INFORMATION

SOURCE OF INCOME:

☐ SSA ☐ SSDI ☐ SSI ☐ PENSION ☐ UNKNOWN

TOTAL MONTHLY INCOME: $_____

VALUE OF ASSETS (If known): $_____

BANKS / FINANCIAL INSTITUTIONS: _____

IS THERE A BALANCE DUE TO THE FACILITY? ☐ NO ☐ YES ($_____)

ADULT PROTECTIVE SERVICES

IF APS IS INVOLVED WITH YOUR PATIENT, PLEASE PROVIDE THE NAME AND CONTACT INFORMATION FOR THE APS INVESTIGATOR:

_____

FOR MEDICAID LONG-TERM CARE CLIENTS

MEDICAID LONG TERM CARE (ACES) NUMBER: _____

DSHS FINANCIAL & HCS WORKERS: _____

_____

FOR VETERANS

BRANCH OF SERVICE: _____

SERVICE NUMBER: _____

DATE ENTERED: _____

DATE SEPARATED: _____

FAMILY & FRIENDS

SPOUSE OR DOMESTIC PARTNER: _____

SPOUSE PHONE NUMBER: _____

SPOUSE ADDRESS: _____

CHILDREN

CHILD	ADDRESS	PHONE NUMBER

ADULT STEP-CHILDREN

STEP-CHILD	ADDRESS	PHONE NUMBER

AGENTS / LAWYERS / PAYEES / TRUSTEES / CAREGIVERS

NAME	ADDRESS	PHONE NUMBER

OTHER FRIENDS AND FAMILY

NAME	ADDRESS	PHONE NUMBER

CURRENT HEALTH INFORMATION

PRIMARY DIAGNOSES (Check all that apply)

- ☐ Dementia, Alzheimer's Type Dementia, Other
- ☐ Stroke
- ☐ Heart Disease
- ☐ Kidney / UT Disease
- ☐ High Blood Pressure
- ☐ Schizophrenia
- ☐ Diabetes
- ☐ Depression
- ☐ Anxiety

Other: _____

COGNITIVE SCREENING

MOCA SCORE: _____ DATE: _____

SLUMS SCORE: _____ DATE: _____

MMSE SCORE: _____ DATE: _____

BIMS SCORE: _____ DATE: _____

OTHER: _____ DATE: _____

AREAS OF NEEDED ASSISTANCE (Activities of Daily Living)

- ☐ Medication Management
- ☐ Making Medical Appointments
- ☐ Maintaining Nutrition
- ☐ Preparing Meals
- ☐ Transfers or Mobility
- ☐ Transportation
- ☐ Bathing or Showering
- ☐ Other Personal Hygiene
- ☐ Locating Housing
- ☐ Managing Money
- ☐ Applying for Benefits

PROPOSED GUARDIAN OR CONSERVATOR

WHO SHOULD BE THE GUARDIAN (Manage personal decisions?)

_____

This is a ☐ lay person ☐ professional?

WHO SHOULD BE THE CONSERVATOR (Manage financial decisions?)

_____

This is a ☐ lay person ☐ professional?

OTHER INFORMATION

Please provide any additional relevant information.

_____

_____

_____

THANK YOU for the referral.

Please provide the following documents with the referral: facesheet, DSHS or nurse assessment, Power of Attorney documents, relevant case notes, cognitive screening

Please fax or email this form to:
ELECTRONIC FAX: 360-699-5802
HARD FAX: 360-993-0154
ENCRYPTED EMAIL: rachel@guardianship-law.com