Guardianship Services of Southwestern Indiana, Inc.

CASE INTAKE REFERRAL INFORMATION FORM

REFERRAL SOURCE: Referral Date:

Healthcare Facility Street Address City Zip

Social Worker/Case Manager Telephone #

E-mail Address

CLIENT INFORMATION:

First Name Middle Name Last Name

Birth Date: Age: SS#:

Medicare #: Medicaid #:

Current Address:

City State Zip Code

Home Telephone #: Cell Phone #:

Marital Status: Spouse/Partner's Name:

Spouse / Partner's Address:

City State Zip Code

Spouse / Partner's Telephone:

CURRENT SITUATION FACILITY ROOM #:

Physician:

Date Admitted: SW/Case Manager:

Medical Condition(s):

Diagnosed Incapacity:

Date Diagnosed: By:

FAMILY / FRIENDS CONTACT INFORMATION

1. Name

Address

Telephone # Relationship to Client

2. Name

Address

Telephone # Relationship to Client

Comments:

Guardianship Information Sheet*Must be completed

Protected Person Estimated Value $_____

Last:*_____ Suffix:_____ First:*_____
Middle:_____
DOB:*_____ Gender:*_____ Race:*_____ Hispanic?: Yes/No
Eye Color:_____ Hair Color:_____ Height:_____ Weight:_____ lbs
Scars, Marks, and Tattoos:
_____

Own property:
_____vehicle:_____
Banking
info:_____
___
Income/SS/SSDI: $_____
If SS/SSDI have the benefits been frozen? Y/N