

Aging Solutions, Inc.
"Linking Healthcare Options"

Office of Public Guardian for Pasco County

PO Box 342065, Tampa, FL 33694-2065

Phone: (727) 442-1188 Fax (813) 949-1996

GUARDIANSHIP INTAKE AND REFERRAL FORM

Thank you for requesting the services of this agency. We understand that not all of the information asked for on this form may be available at the time of the referral. Nevertheless, please fill it out as completely as possible since eligibility for the public guardianship program is mandated by Florida Statutes 744.2007 subsection (1) & (3). The information requested assists us in expediently making a determination.

Please note that the acceptance of a potential Ward into the public guardianship program is made by the Office of the Public Guardian.

Who will petition the Court for the Guardianship
(be the Petitioner)?

Name: _____

Address: _____

Telephone: _____

E-Mail Address: _____

Who will represent the Petitioner (be the
Attorney for Petitioner)?

Name: _____

Address: _____

Telephone: _____

**This information is absolutely essential;
without it, acceptance into the program could be delayed.**

(Please complete all three if known)

Client's Name: First: _____ Gender: _____ Age: _____ Race: _____

Middle: _____

Last: _____

Also Known As: _____

Current

Location: _____

Address: _____

Length of time at this Address: _____

Birth Date: _____

Birthplace: _____

U.S. Citizen? _____

Marital Status: _____

Religious Preference: _____

Telephone: _____

Languages Spoken: _____

Previous

Address: _____

Attending

Physician: _____

Physician Phone: _____

Address: _____

Current/Previous Occupations: _____

Anyone living with the Client? _____ Please specify: _____

Telephone: _____

Family/Significant Others:

Name/Relation: _____

Name/Relation: _____

Address: _____

Address: _____

Telephone: _____

Telephone: _____

Why does this client need a guardian? (Please be specific, thorough, and convincing)

Additional Comments:

Doctor: _____ Dentist: _____

Address: _____ Address: _____

Telephone: _____ Telephone: _____

Diagnosis: _____

Allergies: _____

Medical
History: _____

Mental status/
Level of Functioning: _____
(including ambulation
and ADL's) _____

Social Security #: _____ Monthly Income: SS - \$ _____ SSI - \$ _____
Medicare #: _____ OSS - \$ _____ VA - \$ _____
Medicaid #: _____ Pension/Annuity \$ _____
Veterans #: _____ Dividend/Interest \$ _____
Other Insurance: _____ Other Income - \$ _____

Rep Payee? Yes _____ No _____ Who? _____

Assets/Property:

Personal (accounts, stocks, furniture, Real (Land, buildings, mobile homes, jewelry, etc.) –

Date: _____ Contact Person: _____

Category (check the appropriate one):

Nursing Home/ACLF _____ Hospital _____ Name of Agency: _____

State Agency _____ County Agency _____ Address: _____

Court _____ Other (Please specify) _____

