REQUEST FOR GUARDIAN SERVICES

Empowering individuals with disabilities to live their fullest life. John 10:10

Please attach a recent copy of the Expert Evaluation for this Resident/Patient.

Date: _______________

General

Resident/Patient Name: ____

Address: ____ Phone: ____________________

Previous Address: ____

Date of Birth: ___________ Place of Birth: _____________________ Gender: ☐ Female ☐ Male

Social Security number: ____________________________

Medical Insurance: ____

Insurance number: _______________________________

Payee: ____

Medical diagnosis: ____

____

DNR Code status: ____

Referring person/agency: _______________________________ Phone: ____________________

Is this a request for an Emergency Guardianship? ☐ Yes ☐ No

If Yes, reason for Emergency: ____

____

Is this a request for a change of Guardian/POA? ☐ Yes ☐ No

If Yes, reason for Change: ____

____

Reason for Guardianship Request: ____

____

Does the Resident/Patient have a Durable Power of Attorney? ☐ Yes ☐ No

The Full Life Center, Inc.
349 E. High Ave., New Philadelphia, Ohio 44663
Phone: (330) 343-0008 Fax: (330) 602-2822 Email: office@TheFullLifeCenter.org
www.thefulllifecenter.org

If Yes, who is the Durable Power of Attorney: ______________________

What does the Durable Power of Attorney cover: ☐ Medical Care ☐ Finances ☐ Both

(Please attach a copy of an existing POA)

Describe Resident/Patient's level of functioning: ______________________

____

Is Resident/Patient agreeable to Guardian care? ☐ Yes ☐ No

Family

Spouse:______________________

If spouse is deceased, date of death: ______________

Date of Marriage: ______________

Children and Grandchildren:______________________

____

____

Siblings: ______________________

____

Parents: ______________________

Describe the level of the family's involvement: ______________________

____

____

____

Are there any concerns about the family? ☐ Yes ☐ No

If Yes, what concerns are there about the family? ______________________

____

Name, address, phone number of next of kin involved with the Patient/Resident: ______________

____

Assets and Income

Source of Income: ☐ SSI ☐ SSDI ☐ Pension ☐ Other; please list: ______________

Investments: ☐ Yes ☐ No If Yes, describe: ______________________

Real Property and Location: ☐ Yes ☐ No If Yes, describe: ______________________________

Other Assets: ____

____

Funeral/Death Certificate information:

Does the Resident/Patient have a Pre-Arranged funeral? ☐ Yes ☐ No

If Yes, with which Funeral Home? ____

Location of Burial Plot: ____

Religious Affiliation: ____

Work Experience: ____

____

Other Affiliations: ____

____

Veteran: ☐ Yes ☐ No If Yes, branch and years of service: _______________________________

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