Guardianship Referral Form

Date of Referral: _____ Referring Agency: _____

Name of Referral Contact: _____

Referral Contact Phone: _____ Referral Contact Email: _____

Referral Address: _____

Proposed APSI Client Demographics

Full Name: _____
First Middle Last

Preferred Name/Nickname: _____

Social Security Number: _____

Date of Birth: _____ Age: _____

Ethnicity/Race: _____

☐ Male ☐ Female ☐ Transgender-Male ☐ Transgender-Female

Home Address: _____

Move In Date: _____ Proposed APSI Client/Home Phone Number: _____

Proposed APSI Client E-Mail: _____

****Should the proposed APSI client move from the address noted above during the referral process you are *required* to inform APSI of the new address (this includes hospitalization and respite stays)**

Type of Housing/Setting (check all that apply):

☐ Community Waiver Home ☐ ICF ☐ Developmental Center ☐ Family Home ☐ Respite

☐ Independent Living ☐ Nursing/Rehab Facility ☐ Other: _____

Living Arrangements (check all that apply):

☐ With Relative(s) ☐ Independent ☐ With Unrelated Roommate(s) ☐ Residential Provider Present

☐ Remote Supports ☐ Other _____ Number of Unrelated Roommates ____

Residential Provider Name: _____ Provider Contact Name: _____

Provider Business Address: _____

Provider Phone Number: _____ Provider Fax Number: _____

Provider Email Address: _____

Alternative Provider Contact Name: _____

Staffing Level:

☐ No Staff Present ☐ Staff Present 24/7 ☐ Staff Present Less Than 24/7 But Present Daily

☐ Staff Present Less Than 24/7 But Present Weekly ☐ Other _____

Are there any safety concerns in the residence or with the proposed APSI client?

***If yes, please check all that apply and specify if the concern is in the residence or the proposed APSI client*.

☐ Yes ☐ No

☐ Potential for Verbal Aggression ☐ Potential for Physical Aggression ☐ Weapons in the Residence

☐ Drug Activity ☐ Animals in the Residence ☐ Registered Sex Offender

☐ Other _____

Notes Regarding Concerns: _____

_____

Does the proposed APSI Client leave their residence during the day for employment or programing?

☐ Yes ☐ No

If yes, please complete the information below:

☐ Day Program / Workshop

Name of Day Program / Workshop: _____

Address: _____

Contact Name: _____ Contact Number: _____

Day(s) / hours of attendance: _____

☐ Community Employment

Name of Employer: _____

Address: _____

Day(s) / hours of employment: _____

☐ Other

Name: _____

Address: _____

Day(s) / hours: _____

County Board of DD Eligibility

Is the proposed APSI client County Board of DD eligible? ☐ Yes ☐ No
***Please attach a copy of the OEDI, FED Form, or LOC*

County Board: _____

SSA Name: _____ SSA Email: _____

SSA Phone Number: _____

Medical Information

Level of Intellectual Disability: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

Medical Diagnoses: _____
_____
_____

Psychiatric Diagnoses: _____
_____
_____

Allergies/Adverse Medication Reaction(s): _____

Does the proposed APSI client have a living will, Power of Attorney, or existing advance directives (DNR, DNR-CC, Etc..) **If yes, please attach a copy.* ☐ Yes ☐ No ☐ Unknown

Does the proposed APSI client have a pre-existing burial plan? **If yes, please attach a copy.*
☐ Yes ☐ No ☐ Unknown

Communication

Primary Language: _____

Communication Style (check all that apply):

☐ Easily Understood ☐ Difficult to Understand ☐ Uses Sign Language ☐ Nonverbal

☐ Uses Gestures ☐ No Receptive or Expressive Language ☐ Assistive Technology

Hearing (check all that apply):

☐ Deaf ☐ Wears Hearing Aids ☐ Has Cochlear Implants ☐ Other _____

Probate Court Case Information (if applicable)

Is there a Court Appointed Guardian in place? ☐ Yes ☐ No
***If yes, please answer the questions below.*

County of Probate Court: _____

Probate Court Case Number: _____

Guardian's Name: _____ Guardian's E-mail: _____

Guardian's Address: _____

Guardian of Estate Name (GOE): _____ GOE E-mail: _____

GOE Address: _____

Has the Statement of Expert Evaluation (SOEE) been dispensed? ☐ Yes ☐ No ☐ Unknown

Date SOEE Dispensed by Court: _____

Why is the current guardian resigning or being removed by the Court?_____

_____

_____

Financial Information:

*****APSI is required to provide the Court with the proposed APSI client's financial information***

Does the proposed APSI client have a payee? ☐ Yes ☐ No

Payee Agency Name: _____ Contact Name: _____

Payee Agency Address: _____

Contact Phone Number: _____ Contact Fax: _____

Contact Email: _____

Is the proposed APSI client qualified for Medicaid? ☐ Yes ☐ No

Monthly Income *(please check type of income and list amount):*

☐ SSI _____ ☐ SS _____ ☐ SNAP Benefits _____ ☐ VA _____

☐ SSDI _____ ☐ Community Employment _____ ☐ Other _____

Does the proposed APSI client have a**:**

STABLE Account: ☐ Yes, *if yes, amount in account* _____ ☐ No

Trust: ☐ Yes, *if yes, amount in Trust* _____ ☐ No

Bank Account: ☐ Yes, *if yes, amount in Account* _____ ☐ No

Name of Bank: _____ Type of Account: _____

Other: _____

Monthly Expenses *(please check all that apply and include expense amount):*

☐ Rent: _____ ☐ Utilities: _____ ☐ Food: _____

☐ Internet/Cable: _____ ☐ Other: _____ ☐ Vehicle: _____

Presenting Circumstances:

Why is the proposed APSI client being referred for APSI guardianship services?

What alternatives to guardianship services have been tried or considered?

Has guardianship been discussed with the proposed APSI client? Does the individual know a referral for guardianship is being made?

Has guardianship been discussed with family/friends? Is anyone interested in applying for guardianship? Is the family aware a referral is being made to APSI? Why does APSI need to serve as guardian over friends or family?

Family Information (Next of Kin)

****Please note that per Ohio Law, APSI is *required* to notify *all* known next of kin regardless of their relationship/involvement with the proposed APSI client. To include: mother, father, brother, sister, adult children and/or next closest relatives**

Name: _____
First Last

Relationship: _____ Is this person actively involved? ☐ Yes ☐ No

Address: _____
Street City State Zip Code

Phone Number: _____ Email: _____

Deceased? ☐ Yes ☐ No Date of Death (if applicable) _____

Name: _____
First Last

Relationship: _____ Is this person actively involved? ☐ Yes ☐ No

Address: _____
Street City State Zip Code

Phone Number: _____ Email: _____

Deceased? ☐ Yes ☐ No Date of Death (if applicable) _____

Name: ____
First Last

Relationship: ___________________________ Is this person actively involved? ☐ Yes ☐ No

Address: ____
Street City State Zip Code

Phone Number: ____________________________ Email: ____

Deceased? ☐ Yes ☐ No Date of Death (if applicable) ____

Name: ____
First Last

Relationship: ___________________________ Is this person actively involved? ☐ Yes ☐ No

Address: ____
Street City State Zip Code

Phone Number: ____________________________ Email: ____

Deceased? ☐ Yes ☐ No Date of Death (if applicable) ____

Name: ____
First Last

Relationship: ___________________________ Is this person actively involved? ☐ Yes ☐ No

Address: ____
Street City State Zip Code

Phone Number: ____________________________ Email: ____

Deceased? ☐ Yes ☐ No Date of Death (if applicable) ____

Name: ____
First Last

Relationship: ___________________________ Is this person actively involved? ☐ Yes ☐ No

Address: ____
Street City State Zip Code

Phone Number: ____________________________ Email: ____

Deceased? ☐ Yes ☐ No Date of Death (if applicable) ____

******Please attach an additional sheet if necessary**

The following documents MUST be included with the completed APSI Guardianship Referral Form. APSI is unable to process the referral until all necessary documents are received.

- Ohio Eligibility Determination Instrument (OEDI)/FED Form/Level of Care (LOC)
- Birth Certificate
- Social Security Card
- Statement of Expert Evaluation (SOEE)– MUST be completed by/signed by a licensed physician or psychologist. You MUST mail the original copy to APSI (see below). The SOEE must be less than 90 days old at the time of filing.

  Advocacy and Protective Serv ices, Inc.
  Attn. APSI Legal Team
  4110 N. High Street, 2nd Floor
  Columbus, Ohio 43214

- Burial Plan (If applicable)
- Living will, Power of Attorney, or existing advance directives (DNR, DNR-CC, Etc.) (If applicable)