RI VOLUNTEER GUARDIANSHIP PROGRAM

RI OFFICE OF HEALTHY AGING

REQUEST/ REFERRAL FOR VOLUNTEER GUARDIAN OF THE PERSON

Date of referral: _____ Name of Referred Elder: _____
Person making this Referral: _____
Reason for the Guardianship Request:

_____
Name & Address of Facility/Residence where the Elder resides:

_____
Phone: _____ Fax: _____Email: _____
Admission Date: _____ Admitted From: _____
Age (must be at least 60): _____Date of Birth _____ Male: ___Female: _____
Marital Status: Never Married _____Married ____ Widowed ____ Divorced ___ Unknown ___
Ethnicity/Race: _____ Primary Language: _____
Is the Elder a Foreign National _____ If yes, please identify status_____
Has The Alliance for Better Long Term Care been involved at any time? Yes____ No _____

FINANCIAL and MEDICAL SERVICES INFORMATION
Amount of Elder's *GROSS ANNUAL* Income from all sources: $_____
(Needed to determine eligibility for volunteer guardianship services)

RI Medical Assistance (Medicaid) Approved? _____ Is Approval Pending? _____
If not, what is facility's source of payment?

_____
If Elder receives health insurance services such as Optum, Evercare, or any other such services, name of provider & type of services:

_____

If Elder receives Hospice services, name of provider: _____

Is Elder receiving SSI? _____ If not, why not? _____

Total amount in the Personal Needs Account at this time: $_____

DECISION-MAKING IMPAIRMENT AND OTHER MEDICAL INFORMATION
Please attach diagnoses record and complete the following:
Is Dementia the diagnosed cause of decision-making impairment? yes____ no_____
If yes, what is causing the Dementia: (for example, Alzheimer's, vascular)?

Other reasons for decision-making impairment: _____

_____

Additional Diagnoses: _____

History/diagnosis of psychiatric disorder/ mental illness if any: _____

_____

History/diagnosis of developmental disability if any: _____

Is there a pending physician's recommended treatment needing assisted decision- making?
_____ If yes, what is the recommended treatment: _____

Are there any acute or treatable conditions that effect decision-making ability or pose an imminent health risk? If so, please explain:

_____

_____

Health status:
___ Stable, minimal management _____
___ Stable, extensive management _____
___ Unstable/declining/end of life _____
___ Significant behavioral issues: _____

Please fax or mail a copy of DMAT if available; most recent DMAT date_____
****If no DMAT has been completed, please submit a copy of the most recent record confirming the diagnoses listed above such as Admission record.**
Primary Care Physician or Treating & Examining Physician who completed DMAT:

_____

Elder's Current Code Status: _____

Funeral Arrangements if any: _____

_____

LESSER MEASURES: **Please check if the Elder understands and can sign any of the following:**

___Durable Power of Attorney for Health Care
___Living Will
___Power of Attorney
___Durable Power of Attorney
___Representative Payee
___ DNR/ Other such directives
___Trusts
___Money Management
___Single Court Transactions
___Govt. Benefit/Social Services
___Housing Options
___Joint Property Arrangements

List any of the above items that the Elder now has and provide copies:

_____

FAMILY INFORMATION

All Known Living Family Name(s), Relationship, Addresses, Phone(s):

_____

_____

_____

_____

Family involvement: Minimal/None ____ Involved/Cooperative ___ Hostile or Adversarial ___

Has any family or friends been asked to become guardian? ___ If yes, please provide details (who, when, and what was the response): _____

_____

Additional Information Required: Courts frequently require an Affidavit of the attempts made to locate family members. Please list in detail what efforts were made by the facility to locate and contact family, and what were the results. Include conversations with patient; conversations with a known/possible relative; internet or telephone book searches; examination of medical records, etc., including dates.