



Adult Advocacy & Representation, Inc.

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Brevard County
P.O. Box 560939
Rockledge, FL 32956
321-768-0533
321-722-0910 Fax

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 so that eligibility for the guardianship programs determination can be made.

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

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

Name: _____

Name: _____

Address: _____

Address: _____

Telephone: _____

Telephone: _____

E-Mail Address: _____

E-Mail Address: _____

**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: _____

M. _____

Last: _____

Also Known As: _____

Birth Date: _____

Current Location: _____

Birthplace: _____

Address: _____

U.S. Citizen?

Marital Status: _____

Telephone: _____

Languages Spoken: _____

Current/Previous Occupation: _____

Permanent
Address: _____

Anyone living with the Client? _____

Please specify: _____

Telephone: _____

Family/Significant Others:

Name: _____

Name: _____

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) _____

.....**For Office Use Only.....Please Do Not Write Below This Line.....**

Disposition: Advice Only _____ Brief Service _____ Referral _____ Denied/Accepted _____

Priority Level: _____ Type of Guardianship: _____

Comments: _____

Classification: Elderly _____ Mentally Ill _____ Dually Diagnosed _____ Epilepsy _____

Dev Disabled/Mentally Retarded _____ Cerebral Palsy _____ Autism _____ Spina Bifida _____

Other: _____

ELIGIBILITY CONSIDERATIONS FOR ACCEPTANCE

The following criteria are drawn from Section 744, Florida Statutes, to determine a potential eligibility for Guardianship services:

1. The person alleging incapacity must be the petitioner for such or be willing to testify regarding their knowledge of the alleged incapacitated person by attending the adjudication hearing.
2. Advance Directives have not been located and family or friends, other persons, are either unwilling or unable to assume guardianship, per the assessment of the referral source.
3. Asset and income information provided by the referral source shows the potential Ward means of being able to support fee for service guardianship services.
4. Assessment that no alternative less restrictive than guardianship exists.

PRIORITIZATION OF REFERRALS

As the need for guardianship services are being reviewed the following prioritization of referrals will be adhered to (within categories the case with the earliest referral date will be given preference.):

Highest

1. Cases in which the appointment of a Guardian is necessary to prevent abuse, or exploitation of the potential Ward.
2. Cases in which the appointment of a Guardian is necessary to prevent neglect including self-neglect.
3. Cases in which the potential Ward has previously been adjudicated incapacitated, but no available or appropriate Guardian has been found.
4. Cases in which there is an immediate need for advocacy, e.g., cases requiring multiple and/or intrusive treatment or complex medical decisions.
5. Cases in which special problem situations require resolution, e.g., property issues.
6. Cases in which needs of a functionally incapacitated person are not being met by the existing network of interested person of community resources. This includes person in residential facilities.
7. Cases in which the Ward is placed in a residential setting, but faces discharge due to inability to obtain Medicaid benefits.
8. Cases in which a Guardian would enable the transfer of the potential Ward to a less restrictive setting, e.g., from an acute-care facility to the community.
9. Cases in which a Guardianship already exists and where the Guardian has no compelling reason to relinquish authority.