Area Five Agency on Aging & Community Services:
Adult Guardianship VASIA Program

GUARDIANSHIP INTAKE REFERRAL

COUNTY OF RESIDENCE:_____

CLIENT INFORMATION

_____
First Name Middle Last Name

Date of Birth_____ Age_____ SS#_____

Medicare #_____ Medicaid #_____

Other Insurance_____
Name Policy #

_____
Address

Current Address_____

_____

Home Phone_____ Cell Phone_____

Marital Status_____

Spouse/Partner's Name_____

Spouse/Partner's Address_____

Spouse/Partner Phone_____ Cell Phone_____

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CURRENT SITUATION

Hospital & Room No_____ Physician:_____

Date Admitted_____ SW/Case Mgr_____

Medical Condition(s)_____

_____

_____

Diagnosed Incapacity_____

_____

Date diagnosed_____ By_____

POST HOSPITAL NEEDS

_____.

REASON WHY GUARDIANSHIP IS NEEDED

_____

_____

Name of Person Making Referral_____

Contact Number_____ Date_____

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CONTACT INFORMATION (Blood relatives or friends, please specify)

Name_____

Address_____

Phone_____Relationship to Client_____

Name_____

Address_____

Phone_____ Relationship to Client_____

Name_____

Address_____

Phone_____ Relationship to Client_____

Name_____

Address_____

Phone_____ Relationship to Client_____

Name_____

Address_____

Phone_____ Relationship to Client_____

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Additional Comments_______

_____

_____

_____

Additional Case Information_____

_____

_____

_____

Complete this document with as much detail as possible and mail or email to:

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