Referral Form

Fax: (602) 506-2495
Email: pf@mail.maricopa.gov

Mail: Public Fiduciary
222 N Central Avenue, Suite 4100
Phoenix, Arizona 85004

Proposed Ward Information

Name:____________________

Address:____________________

City:__________ State:__________ Zip:__________

Phone Number:__________ Year of Birth:__________

Marital Status:__________ Name of Spouse:__________ Legal Status:__________

Referral Source:

Name:____________________

Relationship:____________________

Address:____________________

City:__________ State:__________ Zip:__________

Phone Number:__________ Fax:__________ Email:__________

Are you making this referral on behalf of an Agency: ☐Yes (complete below) ☐No

Agency Name:____________________

Contact:__________ Phone Number:__________

Address:____________________

City:__________ State:__________ Zip:__________

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Is this referral being made due to medical discharge issues? ☐Yes ☐No

If "yes", please give a detailed description of all facilities where referrals for placement were made, attempts to coordinate discharge with family and include any bioethics consultations.

Purpose of Guardianship: How will a guardian benefit the proposed ward? Describe what unmet need exists that cannot be addressed by another agency, service or alternate to guardianship:

Situation: Briefly describe the chronology of recent events leading up to this referral:

Please explain why the proposed Ward is unable to care for their Activities of Daily Living (bathing, dressing, grooming, toileting, walking, eating):

Alternatives to Guardianship: Guardianship is a serious step and should only be sought as a last resort. Please check below the alternatives to guardianship that may benefit the proposed Ward:

- Assistance from family and/or friends
- Case Management Services
- Clinical and Mental Health Support Services
- Day Treatment Activities
- Home and Community Based Support Services
- Homemaker Services
- Meals on Wheels
- Representative Payee Services for SSA or VA
- Senior Center Activities

Please state below in specific detail why this individual will never be able to understand and provide informed consent in the nature of any illness, disorder, or medical need they may develop?

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Are there any known directives:

Do Not Resuscitate (DNR)	☐Yes	☐No	☐Unknown	Any Known Instructions	☐Yes	☐No	☐Unknown
Power of Attorney (POA) - Medical	☐Yes	☐No	☐Unknown	Wills	☐Yes	☐No	☐Unknown
Power of Attorney (POA) - Financial	☐Yes	☐No	☐Unknown				

Income Type and Amount

Type	Amount	Type	Amount
SSA		Retirement/Pension	
SSI		Annuity	
VA		Railroad	
Civil Services		Other	

Is there a Payee in place: ☐Yes ☐No Payee Name:____

Please list any bank accounts, trusts, annuities, life insurance, or retirement accounts:

Name	Account Type	Account Number (last 4 digits only)	Location

Please list any land, house(s), or building(s) this person owns:

Item	Address	City	State	Zip

Mortgage Information: **Homeowners Insurance Co Name:**

Please List any Vehicles

Make	Model	Year	Location

Is there additional information to add regarding the real and personal property?

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Please list any family, partners, and friends of the proposed ward

Name	Address:	Phone Number:	Relationship

Is the proposed Ward a resident of Maricopa County? Yes No

If the proposed Ward is married, please provide the current location of the spouse:

Is the proposed Ward a Veteran? Yes No VA#

Is there a history of, or any recent violent threats or actions known? Yes No

If yes, please describe:

Is the person at risk of loss of money or property? Yes No

Is the person at risk of abuse or currently being harmed? Yes No

Please check all boxes that apply:

	Receiving	Eligible	Pending	Contact Name and Phone Number
ALTCS:	☐	☐	☐	
APS Involvement:	☐	☐	☐	
DDD:	☐	☐	☐	
Food Stamps:	☐	☐	☐	
HCBS:	☐	☐	☐	
HUD:	☐	☐	☐	
Meals on Wheels:	☐	☐	☐	
NT19 Supports:	☐	☐	☐	
SAIL:	☐	☐	☐	
T19 Supports:	☐	☐	☐	

Benefit Information:

	Receiving	Eligible	Pending	Provider Name/Insurance Agency
AHCCCS:	☐	☐	☐	
ALTCS:	☐	☐	☐	
Medicare:	☐	☐	☐	
Private Insurance	☐	☐	☐	

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Please list all known doctors and clinics:

Name	Phone Number	Specialty

Please include or attach any additional information that will assist in the investigation:

☐ I affirm that the information provided in this referral application is true and accurate and that I have made every effort to obtain ALL requested information, and I am prepared to testify to these statements and information in a Court of Law.

*Note: The Public Fiduciary may require additional information be submitted as a supplement to this referral application. A public fiduciary community referral is not a guarantee that Guardianship and/or Conservatorship will be sought after, and the Maricopa County Public Fiduciary will base its recommendation on least restrictive measures and alternative appointments