DALLAS COUNTY PROBATE COURTS
GUARDIANSHIP CASE REFERRAL FORM

Date: _____

Person needing guardian (proposed ward):

Name: _____

(If applicable, please list: Facility Name, the Name of the Facility's Current Administrator, Date of Admission, and Person Who Admitted the Proposed Ward):

_____

_____

Phone #: _____Fax #:_____

DOB: _____

Social Security Number: _____

Referral Source:

Name of Administrator (or person to receive copy of Guardianship Application if filed)

_____

Your name: _____

Your title or relationship to the proposed ward: _____

Address: _____

_____

_____

Phone #: _____ Cell #: _____

Facility Fax #: _____

1. Why do you think this person needs a guardian? Include a description of any incidences you have witnessed and dates on which they occurred. If necessary, please continue on back of this page.

_____
_____
_____
_____

2. Does the proposed ward have a living SPOUSE? ___YES ___NO

   If YES, list name of the proposed ward's spouse along with the address and phone number.

   _____
   _____
   _____
   _____

3. Does the proposed ward have any living SIBLINGS? ___YES ___NO

   List the NAMES and AGES of all known living SIBLINGS of the proposed ward along with the ADDRESSES and PHONE NUMBERS. If necessary, continue on back of page.

   _____
   _____
   _____
   _____
   _____
   _____

4. Does the proposed ward have any living CHILDREN? ___YES ___NO

   List the NAMES and AGES of all known living CHILDREN of the proposed ward along with the ADDRESSES and PHONE NUMBERS. If necessary, continue on back of page.

   _____
   _____
   _____
   _____
   _____
   _____

5. Does the proposed ward have any living PARENTS? ___YES ___NO

   List the NAMES and AGES of all known living PARENTS of the proposed ward along with the ADDRESSES and PHONE NUMBERS. If necessary, continue on back of page.

   _____
   _____
   _____
   _____
   _____
   _____

6. List the NAMES and AGES of all OTHER known FAMILY MEMBERS of the proposed ward along with their ADDRESSES and PHONE NUMBERS.

   _____
   _____
   _____
   _____

6a) When were the family members last contacted?

_____
_____

6b) How were the family members contacted, i.e. by first class mail, certified mail, by telephone, or other methods?

_____
_____

7. List the NAMES of all known close friends and clergy of the proposed ward along with the ADDRESSES and PHONE NUMBERS.

_____
_____
_____
_____
_____
_____

7a) When were the friends and clergy last contacted?

_____
_____

7b) How were the friends and clergy contacted, i.e. by first class mail, certified mail, by telephone, or other methods?

_____
_____

8. Has there been an Adult Protective Services case on this person in the last 6 months? _____

_____
_____
_____
_____
_____
_____

9. Provide any other information that you think may be relevant or helpful to the Court in its investigation of this matter.

_____
_____
_____
_____
_____
_____

Please answer the following to the best of your knowledge:

10. Is there a guardianship pending or in place in any other county or state? If there is, please give details.

    _____
    _____
    _____
    _____
    _____

11. This person ___**is** / ___**is not** a resident of Dallas County.

12. This person ___**has** / ___**has not** executed a power of attorney to the following person (if possible, attach a copy):

    Name: _____

    Address: _____

    _____

    Phone #: _____

13. The nature and degree of the person's incapacity is as follows:

    _____
    _____
    _____
    _____
    _____
    _____

14. Identify any health or medical issues regarding this person:

    _____
    _____
    _____
    _____
    _____
    _____

15. This person has the following assets and income:

    A. real estate:_____

       value:_____

    B. bank accounts:_____

       value: _____

    C. other assets:_____

       value: _____

D. monthly income:_____

source:_____

E. burial policy:_____

value: _____

16. Is this person in **imminent danger** of having his/her **estate** seriously damaged or dissipated unless immediate action is taken? ___YES ___ NO

If yes, explain:

_____
_____
_____
_____
_____
_____

17. Is this person in **imminent danger** of serious impairment to his/her **physical health or safety** unless immediate action is taken? ___No ___Yes
If yes, explain:

_____
_____
_____
_____
_____
_____

18. Has a referral of abuse, neglect, or exploitation been made to the state Adult Protective Services Program (1-800-252-5400)? ___No ___Yes
If so, please provide, if known, the name of the Adult Protective Services Worker and the telephone number:

_____
_____

This information is true and correct to the best of my knowledge.

_____
Signature

_____
Printed Name

FOR OFFICE USE:
Referral received by: _____ Date received: _____
Action taken: _____

Section 670 Worksheet

TO BE COMPLETED BY BUSINESS OFFICE

Proposed Ward's Name._____ Social Security No.:_____

Date of Birth:_____

Medicaid Eligible: ___NO ___YES

FULL VENDOR APPLIED INCOME

List each Applied Income Source and Amount (ie; SSDI, Teacher's Retirement, Gov't Retirement, etc…)

_____

_____

_____

_____

ONLY COMPLETE THE FOLLOWING IF ***MEDICAID ELIGIBLE*** AND THE ***APPLIED INCOME AMOUNT IS GREATER THAN $60 PER MONTH***.

Representative Payee: Individual, or Non-profit agency

Name: _____Phone: _____

Address:_____

City,State,Zip:_____

Representative Payee: if SNF or LTC Facility

Business Manager:_____

Address:_____

City,State,Zip:_____

Phone Number:_____FAX:_____

Medicaid Eligibility Worker

Name:_____

Address:_____

City,State,Zip:_____

Phone Number:_____