FIFTH CIRCUIT PUBLIC GUARDIAN CORPORATION

Office of the Public Guardian of Marion County, Florida
P.O. Box 4985, Ocala, FL 34478

INTAKE AND REFERRAL PROCESS

Guardianship is a serious step and should only be used as a Last Resort. Guardianship is for persons who are unable to make decisions to manage their property and/or personal lives. Alternatives to guardianship are listed on the Intake and Referral Form and must be considered prior to guardianship.

If individuals and organizations know of someone who may be in need of Fifth Circuit Public Guardian Corporation (FCPGC) services, please complete the Intake and Referral Form. The Case Manager must screen each person referred to the FCPGC to determine if the individual meets the Eligibility Requirements and that no alternative exists that is less restrictive than the type of guardianship sought.

Public Guardianship Eligibility Criteria:

- The person must be ADJUDICATED incapacitated by a court or the Referral Source must be willing to initiate the Incapacity proceedings. The Referring Source must be the Petitioner and willing to testify in court of the need for guardianship.
- The person must have limited financial resources.
- The person must have no family or friends that are willing or qualified to be their guardian. The person's family members and friends **will be** contacted.

Referral Procedure:

- After a Completed Intake and Referral Form is received, FCPGC will determine if the person meets the Eligibility Requirements.
- If the person does not meet the Eligibility Criteria, the FCPGC will notify the Referral Source.
- If the person meets the Eligibility Criteria, the Case Manager will notify the Referral Source that FCPGC is willing to act as Guardian **after** appointment by the Court.
- The FCPGC caseload capacity will affect the processing of the Referral.
- If the FCPGC caseload is at capacity, the Case Manager will place the Referral on the Waiting List using the criteria for prioritization.

  Prioritization Criteria:

  1. Cases where the lack of guardianship is more likely than not to result in the physical harm to an incapacitated person or to others. This includes cases where the abuse and/or neglect have been alleged or proven.
  2. Cases where the incapacitated person needs an advocate to prevent abuse or neglect. This includes cases that require decision-making involving multiple and/or intrusive treatments.
  3. Cases that require a Guardian to approve residential placements.
  4. The needs of the incapacitated person are not being met. This includes individuals who are without family.
  5. Decision making is required in limited situations that do not require ongoing intervention. This includes the need to resolve property issues.

- The Case Manager will notify the Referral Source that the Referral has been placed on the Waiting List.
- If multiple cases on the Waiting List have the same level of priority, Referrals will be processed in the order they are received.
- If there is a change in the status of the person, the Referral may be re-prioritized. The Referral Source is responsible for submitting updated information to the FCPGC.
- FCPGC will notify the Referral Source when a vacancy exists in the FCPGC caseload and the processing of the Referral can commence.
- Upon a vacancy in the FCPGC caseload, the Case Manager will make an initial visit to the person to verify information on the Intake and Referral Form and assess whether the person is still eligible for public guardianship services.
- The FCPGC will prepare the pleadings to initiate the Incapacity Proceeding.
- Three professionals will visit the person and make recommendations to the Court. These professionals are called the “Examining Committee”.
- The Court will set a hearing that permits the Alleged Incapacitated Person the opportunity to present evidence and have an attorney to represent their interests.
- The Referral Source (Petitioner) must be willing to appear and testify under oath in the Court Hearing as to the information provided in the Intake and Referral Form.

The entire process takes on average from 1 to 3 months. However, Emergency Temporary Guardianship can be arranged if needed.

Thank you for requesting the services of the FCPGC. We understand that all of the information on the Intake and Referral Form may not be available at the time of the referral, but complete as much as possible since eligibility and prioritization are determined by the information provided.

Under Florida Law although the FCPGC may be willing to act as Guardian, the FCPGC **may not** serve as Guardian until duly appointed by the Court.

If you have any questions regarding the Fifth Circuit Public Guardianship Program, please feel free to contact Cathy Ackerman at (352) 401-7807.

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INTAKE & REFERRAL FORM

REFERRAL SOURCE (Petitioner) CONTACT INFORMATION

Name/Title: ____________________

Organization: ____________________

Address: ____________________

Telephone: (____) ____________________ Cell Phone: (____) ____________________

E-Mail: ____________________ Fax: (____) ____________________

Relationship to Referral: ____________________

REFERRAL (Alleged Incapacitated Person) PERSONAL INFORMATION

Referral Name: ____________________

Current Address (Include Facility Name): ____________________

____

Telephone Number: (____) ____________________ Date of Birth: ____________________ Age: __________

Sex: ☐ Male ☐ Female Race: ____________________ Primary Language: ____________________

Marital Status: ☐ Married ☐ Divorced ☐ Widowed Religion: ____________________

Education: ☐ GED ☐ High School ☐ Some College ☐ College ☐ Other____________________

Social Security No.: ____________________ Place of Birth (State/Country): ____________________

Medicare No.: ____________________ Medicaid No.: ____________________

U.S. Citizen: ☐ YES ☐ NO If No, Immigration Number (if applicable): ____________________

Previous Residence: ____________________

Referral's Maiden Name: ____________________ Occupation: ____________________

Mother's Maiden Name: ____________________ Occupation: ____________________

Father's Name: ____________________Occupation: ____________________

ALTERNATIVES TO GUARDIANSHIP

Guardianship is a serious step and should be used as a last resort. **Alternative options should be considered before proceeding with this referral**. Please indicate with an "X" if the person has any of the following:

____ Client Advocate (for recipients of developmental services)
____ Guardian Advocate (for persons with developmental disabilities and/or mental health services)
____ Joint Bank Accounts
____ Direct Deposit/Automatic Bill Pay
____ Power of Attorney
____ Durable Power of Attorney
____ Trust
____ Medical Proxy
____ Health Care Surrogate
____ Advanced Directives
____ Living Will
____ DNR (Do Not Resuscitate Order)
____ Last Will and Testament
____ Final Arrangements If yes, where ____

If the person has any of the above, please explain whether these alternatives have sufficiently met the person's needs. If not, why ____

____

LEGAL

Has the person been previously adjudicated incapacitated? ______ Yes ______ No
If yes, attach a copy of the legal papers including medical assessments.

If yes, list name of current Guardian: ____

County/State of Adjudication: ___________________________ Year Established: ____________________

REASON PERSON REFERRED NEEDS A GUARDIAN

Explain why the person needs a guardian: ____

____

____

____

____

Have you informed the person that you have initiated a Referral for Guardianship? ____ Yes __ No

SOCIAL

Please note that Public Guardianship is **NOT** an alternative if a qualified relative or friend is willing and able to assume guardianship. Before making this referral, you are required to make every effort to contact family members and friends to determine if they are willing to serve as Guardian. The Court will ask this question under oath.

Relatives and Friends:

Name: ____ Relationship: ___________________

Address: ____

Telephone: (____) ______________ Cell: (____) __________________ Willing to be Guardian _____ Yes ____ No

Name: ____ Relationship: ___________________

Address: ____

Telephone: (____) ______________ Cell: (____) __________________ Willing to be Guardian _____ Yes ____ No

Name: ____ Relationship: ___________________

Address: ____

Telephone: (____) ______________ Cell: (____) __________________ Willing to be Guardian _____ Yes ____ No

Name: ____ Relationship: ___________________

Address: ____

Telephone: (____) ______________ Cell: (____) __________________ Willing to be Guardian _____ Yes ____ No

Name: ____ Relationship: ___________________

Address: ____

Telephone: (____) ______________ Cell: (____) __________________ Willing to be Guardian _____ Yes ____ No

Summary of your contact with the person's family during the period you have been involved:

____

____

____

____

____

____

List the name, address, and phone number of persons who have personal knowledge of this individuals disabilities and need for guardianship:

____

____

____

____

MEDICAL INFORMATION

Physician Name: ____

Address: ____

____

Telephone: (_____) ______________________________

Dentist Name: ____

Address: ____

____

Telephone: (_____) ________________________________

(If there are additional physician or health care providers, please use a separate sheet of paper)

ASSESSMENT

1. Diagnosis: disability/mental illness/developmental disability:

___

___

2. Mental Condition:

a. Does the person have impaired memory? ☐ Immediate ☐ Recent ☐ Remote
b. Is the person confused and disoriented to? ☐ Time ☐ Place ☐ Person
If yes, give examples:

___

___

___

3. Can the person understand simple concepts and ideas? ☐ YES ☐ NO
If no, give examples:

___

___

___

4. In your opinion, is the person able to?

a. Manage property and finances, make gifts, or dispose of property? ☐ YES ☐ NO

b. Exercise good judgment, and problem solving ability? ☐ YES ☐ NO

c. Determine their own residence? ☐ YES ☐ NO

d. Consent to medical treatment? ☐ YES ☐ NO

e. Make decisions about social environment or social aspects of their life? ☐ YES ☐ NO

5. Is the person ambulatory? ☐YES ☐ NO

6. Does person require? Walker? ☐ YES ☐ NO Wheelchair? ☐ YES ☐ NO

Classification of Referral:

☐ Elderly ☐ Dementia ☐ Alzheimer's ☐ Developmentally Disabled
☐ Mentally Ill ☐ Mentally Retarded ☐ Autism ☐ Brain Injury
☐ Cerebral Palsy ☐ Epilepsy ☐ Spina Bifida

Current Medications (If known):

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Known Allergies:

______________________________ ______________________________
______________________________ ______________________________

Describe person's problems which lead you to believe the person cannot manage or make decisions concerning his or her person and/or property:

____
____
____

Are there special problems this person has that will require immediate action or attention, including immediate medical needs, financial management?

____
____
____

Will this individual require placement? (Specify needs and suggested placement)

____
____
____

FINANCIAL STATUS

Monthly Income:

Source: (SSA, SSI, VA, OSS, Pension, Other) Amount

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Bank Account (s)

Bank Name: ______________________________ Telephone: (____) ______________________

Address: ____

Account Number: ____________________ ☐ Checking ☐ Savings Amount: $__________________

Bank Name: ______________________________ Telephone: (____) ______________________

Address: ____

Account Number: ____________________ ☐ Checking ☐ Savings Amount: $__________________

Certificates of Deposit

Bank Name: ______________________________ Telephone: (____) ______________________

Address: ____

Account Number: ____________________________ Amount: $______________________________

Stocks/Bonds

______________________________________ Amount: $ ____________________________

Safety Deposit Box:

☐ Yes ☐ No If yes, location if known: ____

Real Estate

Location: ____

Estimated Value: $____________________ Is the person paying rent or a mortgage? ☐ YES ☐ NO

If yes, which? ☐ Rent ☐ Mortgage Monthly Payment? $________________________________

Location: ____

Estimated Value: $____________________ Is the person paying rent or a mortgage? ☐ YES ☐ NO

If yes, which? ☐ Rent ☐ Mortgage Monthly Payment? $________________________________

Personal Property: (Attach property inventory if facility keeps one)

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Public Guardianship services do not replace Case Management services. If the individual is appointed a Guardian, their need for full Case Management services will remain. Do you understand that our office will not augment Case Management services? ____

Since the Public Guardian does not provide direct services to its Wards, what suggestions would you make from available Community Resources to meet the needs of the person?

____
____
____

This document may be filed with the Court Petition. Your signature below attests that the information contained in this Intake & Referral Form is **true, accurate, and correct**. Your signature below also indicates your agreement to testify in Court regarding the information contained in this Intake & Referral Form.

____ ____
Signature of Referring Person Date

____
Agency/Facility

*****FOR PUBLIC GUARDIAN USE ONLY*DO NOT WRITE BELOW THIS LINE*****

Date Received: ________________________________

Disposition:

☐ Advice only ☐ Accepted ☐ Denied Notification Sent: ___________________________

Priority Level:

☐ Emergency/Immediate ☐ Processing ☐ Waiting List

Comments:

____
____

Dates Reviewed: __________ __________ __________ __________ __________ __________