

# **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 us 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:

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

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**MEDICAL INFORMATION**

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

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Telephone: (\_\_\_\_) \_\_\_\_\_

Dentist Name: \_\_\_\_\_

Address: \_\_\_\_\_

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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:

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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:

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3. Can the person understand simple concepts and ideas?       YES       NO

If no, give examples:

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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:**

- |   |  |                                       |   |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> Elderly        | <input type="checkbox"/> Dementia          | <input type="checkbox"/> Alzheimer's  | <input type="checkbox"/> Developmentally Disabled |
| <input type="checkbox"/> Mentally Ill   | <input type="checkbox"/> Mentally Retarded | <input type="checkbox"/> Autism       | <input type="checkbox"/> Brain Injury             |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Spina Bifida |   |

**Current Medications (If known):**

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**Known Allergies:**

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

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

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

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**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? \$ \_\_\_\_\_

