Southern Indiana Adult Guardianship Services

Located at The Solutions Center
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REFERRAL PACKET

Southern Indiana Adult Guardianship Services (SIAGS) is a non-profit corporation that operates as a volunteer advocates for seniors and incapacitated adults (VASIA) guardianship program that is appointed by the Court as guardian over incapacitated seniors and adults with no willing or capable family to serve as guardian in Lawrence Orange, Washington and Crawford County in the State of Indiana.

We are a decision-making agency and stand in as the voice and assist individuals who have been deemed incapacitated by the Court in making medical, personal and financial decision.

SIAGS recruits, trains and supervises volunteers to serve as advocates for the seniors and incapacitated adults where SIAGS is the guardian of the person and/or estate.

The following criteria are used by SIAGS in evaluating referrals for acceptance in our program:

a. The individual must be an adult over the age of 18 who has been declared incapacitated by a physician AND a Medical Report must be completed by the person's treating physician licensed in the State of Indiana; and
b. The individual must have in place 24/7 professional supervised care services;
c. A SIAGS Referral Form must be completed; and
d. The individual being referred to SIAGS must have no capable or willing family or significant person to serve; and
e. The potential client must be a resident of Lawrence, Orange, Washington and/or Crawford County, Indiana.

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MEDICAL REPORT

PHYSICIANS: You are being asked to complete the attached Medical Report for a person who is alleged to be impaired in decision-making and in need of a guardian. Guardianship is a form of substitute decision-making established through a legal proceeding. The guardian is appointed by the court to act as a substitute decision-maker for another person. The court bases decisions on clear and convincing evidence that the person has been found to be unable to make necessary decisions on his or her own behalf. Guardianship should be used only when there is clear evidence that the individual meets the legal definition of an incapacitated person. According to Indiana law a person is incapacitated if they are **unable to manage in whole or in part the individual/s property; to provide self-care; or both because of insanity, mental illness, mental deficiency, physical illness, infirmity, habitual drunkenness, excessive use of drugs, incarceration, confinement, detention, duress, fraud, undue influence of others on the individual or other incapacity; or the individual has a developmental disability.**

Thus, in a guardianship adjudication, the concern is not whether the person/s actions or choices appear reasonable or will put them at increased risk, but whether the person is able to understand critical information and appreciate the reasonable foreseeable consequences of his or her decisions or lack of them. In short, are the decisions consistent with an expressed personal belief system, known values, and reality?

Some questions to ask regarding day to day decision-making (Question 4):

- Explore the factual understanding of present personal care circumstances, can the person describe his/her present living arrangements, perceived physical and medical status, and recollection of services received?
- Ask what activities must be performed in order to meet basic care needs and safety. Does the person have the requisite knowledge to meet these personal care needs? Can the person appraise the adequacy of his/her functioning in each area? Does the person recognize limitations and seek appropriate assistance when necessary?
- Does the persons capacity in specific areas vary over time, i.e. due to physical or mental illness or other influencing factors?
- In addition to making a decision, is the person able to express or communicate decisions to others when the need arises?

STATE OF INDIANA
COUNTY OF _____

IN THE _____ CIRCUIT COURT
CAUSE NO: _____

IN THE MATTER OF THE
GUARDIANSHIP OF

_____

PHYSICIAN'S REPORT

Note: This report will accompany the petition for guardianship and shall be based on examinations(s) of the person that has/have been completed within 3 months of filing the petition. Your completing this form is appreciated.

Date of examination: _____

Name of Alleged Incapacitated Person: _____

Male or Female Age_____

Address:_____

1. Known medical history and findings, including but not limited to functional, neurological, or psychiatric history: (Attach additional sheets, if necessary.)

2. Pertinent evaluations: Date: _____
   - ___Complete medical examination:
   - ___Mental-Exam
   - ___Neurological testing for organic brain disorder or damage
   - ___Psychiatric or psychological testing:
   - ___Other

3. Diagnosis: _____

_____

_____

_____

4. Please rank the persons ability to make decisions in each of the areas below on a scale of 1 to 5: 1= the person lacks the ability to make decisions and 5= the person is fully able to make decisions.

	Capacity to make decisions 1	2	3	4	5	Capacity varies over time Yes or No	Insufficient Information
Personal Safety							
Nutrition							
Clothing							
Personal Hygiene							
Healthcare							
Day-to Day finances							
Property, investments							

5. Can the person communicate decisions in the areas listed above? Explain.

_____

_____

_____

6. Does the person/s ability to communicate decisions vary over time? Explain.

_____

_____

_____

7. Summarize the prognosis for recovery or improvement in the above areas:

_____

_____

_____

8. State what interventions are necessary to achieve recovery or improvement in the ability to make decisions:

_____

_____

_____

9. Do any of the following conditions affect the persons/s capacity to make or communicate decisions regarding his/her personal care, medical, or financial needs?

Medical, Psychiatric, Developmental, or Physical Condition

	Hearing loss		Vision loss
	Malnutrition		Medication-related reaction
	Delirium		Depression or other treatable mental disorders
	Dementia		Mental retardation
	Receptive or expressive speech impairment		Stroke
	Traumatic brain injury		Other
			Do not have enough information

Social/ Cultural Context:

___Level of education which hinders ability to understand information and to develop essential life skills.
___Limited life experience or opportunities for social interaction
___Language barrier
___Lack of awareness about community resources
___Other:

10. Please provide additional information, if any, which you think the court would find helpful to explain how any of the items above affect the person=s capacity to make or communicate decisions.

_____

_____

_____

11. Are there interventions that would remediate the effect of those factors indicated above on the persons/s ability to make or communicate decisions?

_____

_____

_____

12. Based on this examination, summarize the medical, functional, neurological, or psychiatric status of the person. Include comments on the duration and course of the disease as appropriate.

_____

_____

_____

13. Please list the names of persons who have provided information used in making this assessment.

_____

_____

_____

14. Would it be detrimental for the alleged incapacitated person to appear in Court? Yes or No
If yes, please Explain: _____

_____

_____

I/We affirm under the penalties of perjury that the foregoing representations are true.

Physician Name: _____

Physician Signature: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Other professionals who performed evaluations upon which this report is based:

Name: _____Signature: _____

Profession: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

*Add additional names as appropriate

Southern Indiana Adult Guardianship Services

Referral for Guardianship Services

Date: _____

Name of Person or Agency Referring to SIAGS: _____

Relationship to Potential Ward: _____

Phone Number: _____

Clients Name: _____
First Middle Last

Current Address:

Nursing Facility:_____ Admission Date:_____

Home Address: _____

Status of home: Own Rent Apartment? Yes No

Live Alone? Yes No If No, whom?_____

Admission Date: _____

Circumstances Requiring Admission (please attach Admission Notes): _____

_____

_____

Previous Address, if known: _____

Date of Birth: ___/___/_____ Place of Birth: _____

U.S. Citizen: Yes No Male or Female

Social Security #:_____ Race:_____

Medicare #:_____ Medicaid ID: _____

Has Adult Protective Services been involved with this client? _____

_____

Has a physician filled out a Medical Report? _____ Yes _____ No (If No, explain that a Medical Report will need to be completed by a physician).

Describe the client's disability or incapacitation: _____

_____

_____

Describe the client's ability to communicate with others: _____

_____

_____

Family Information

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Never Married

Spouse's Name: _____
Address:_____

Mother: Living? ☐ Yes ☐ No Maiden Name: _____
Name: _____ Address: _____

Father: Living? ☐ Yes ☐ No
Name: _____ Address: _____

Living Children: (list all regardless of whether you have contact information or whether they want to be involved. The Court requires each receive a notice of the guardianship action)

_____
Name Address City/State/Zip

_____
Name Address City/State/Zip

_____
Name Address City/State/Zip

_____
Name Address City/State/Zip

Living Siblings: (list all regardless of whether you have contact information or whether they want to be involved. The Court requires each receive a notice of the guardianship action)

Name	Address	City/State/Zip
Name	Address	City/State/Zip
Name	Address	City/State/Zip
Name	Address	City/State/Zip

Living Cousins/Aunts/Uncles and/or Close Friends: (list all regardless of whether you have contact information or whether they want to be involved. The Court requires each receive a notice of the guardianship action)

Name	Address	City/State/Zip
Name	Address	City/State/Zip
Name	Address	City/State/Zip
Name	Address	City/State/Zip

Financial Information

Monthly Income: (i.e. Social Security, Pensions, Annuities, etc.)

Amount $_____ Source:_____

Amount $_____ Source: _____

Amount $_____ Source:_____

Bank Account: Yes No Name of Bank: _____

Bank Address: _____ Phone: _____

Contact Person: _____ Title: _____

Checking Account: Yes No Account: _____

Savings Account: Yes No Account: _____

Money Market: Yes No Account: _____

C.D.: Yes No Account: _____

Stocks: Yes No Account: _____

Bonds: Yes No Account: _____

Online Assets Yes No

Accounts & Passwords: _____

_____

Legal Information

Is there currently a legal guardian, Power-of-Attorney, or other advocate? Yes No

_____

Does the client have a will? Yes No Name of Will Holder: _____

Does the client have any pending legal action? Yes No

Health Insurance

Medicare: Yes No **Type:** Part A Part B Part D

Medicare D Provider: _____ Policy #: _____

Medicare Replacement Insurance: Yes No

Provider:_____ Policy #: _____

Medicaid: Yes No Caseworker's name:_____Phone #:_____

Other (Supplemental Health) **Insurance:** Yes No

Company Name:_____Policy #:_____

Address:_____

Phone #: _____ Monthly Premium:_____

Medical Information

Physician's name:_____ Eye Doctor's name:_____

Dentist's name:_____ Psychiatrist's name:_____

Current Diagnosis:_____

_____

_____

Advance Directives: Full Code No Code Living Will

Any immediate concerns needing addressed? _____

_____

Vehicles

Currently or recently owned

Make: _____ Model:_____ Year:_____

Currently Own? No Yes If Sold, Date of Sale: _____

Car Payments: $_____ Location of Car: _____

Real Estate or Interest in Real Estate

Currently or recently owned

Property Location: _____

Currently Own? No Yes If Sold, Date of Sale: _____

Loan Payments: $_____

Is this property owned jointly with another individual? _____

Other Assets (Crops, Business, etc.)

Currently or recently owned

_____

_____

_____

Life Insurance

Life Insurance: Yes No Company Name: _____

Address: _____ Phone#:_____

Policy #: _____

Whole Life Insurance? Yes No Term Insurance: Yes No

Paid in Full? Yes No Monthly Premium: $_____

Named Beneficiary: _____

Address: _____

Phone #: _____

Funeral/Burial Arrangements

Funeral Home:_____ Contact Person:_____

Address: _____

Phone #: _____ Fax#: _____

Pre-Paid Plan or Trust? Yes No Pd in Full Amount owed: $_____

Company Name: _____ Policy #: _____

Burial **Cremation**

Cemetery: _____ Contact Person: _____

Address: _____

Vault/Headstone/ Marker/Lot: _____

Other

Religious Preference: _____

Church Preference: _____

Military Service No Yes, Branch: _____ Discharge:_____

Education: 8th Grade or Less 12th Grade or Less

High School Graduate College Graduate

Other Info: _____

_____

TO BE COMPLETED BY SIAGS STAFF/DIRECTOR:

☐ Accepted Referral. SIAGS to do assessment of potential Ward on: _____

☐ Denied Acceptance into Guardianship Program.

Reason: _____

_____

_____

Referred to: ☐ Living Well Home Care ☐ SICIL ☐ So. IN Payee ☐ Other