Attached is our standard form to apply for public guardianship. It must be filled out as completely as possible.

1. Complete referral form
2. Doctor's statement as to capacity.
3. Copy of all ID's
4. Copy of proof of income and assets.
5. All known family members' names, addresses and telephone numbers.

Any missing information may result in a delay of processing the request. It is particularly important that we know the client's income and assets and any known relatives.

PLEASE RETURN COMPLETED REFERRAL TO
REFERRAL.COLLIERCOUNTYPG@aol.com

IF THE REFERRAL IS NOT RECEIVED TO THE ABOVE EMAIL IT WILL NOT BE PROCESSED AND REVIEWED FOR PUBLIC GUARDIANSHIP

PUBLIC GUARDIANSHIP
REFERRAL SHEET
TODAY'S DATE _____

WARD'S NAME:_____

ADDRESS:_____
_____
HOW LONG:_____
TELEPHONE:_____

NAME OF FACILITY:_____
FACILITY ADDRESS:_____
_____
FACILITY TELEPHONE:_____

ADMISSIONS DATE TO FACILITY:_____
IS THIS A LONG TERM PLACEMENT:_____

WARD'S COUNTY OF RESIDENCE:_____

WARD'S PREVIOUS RESIDENCE ADDRESS:_____
_____

WARD'S DATE OF BIRTH:_____
WARD'S STATE AND COUNTY OF BIRTH:_____
(Please provide copy of birth certificate, if available)
WARD'S AGE:_____
WARD'S SEX: MALE _____ FEMALE _____
WARD'S RACE: WHITE_____ HISPANIC_____BLACK_____OTHER_____
WARD'S PRIMARY SPOKEN LANGUAGE:_____
LEGAL RESIDENT/CITIZEN OF U.S.:_____
IMMIGRATION NO.:_____
WARD'S SOCIAL SECURITY NUMBER:_____
WARD'S MEDICAID NUMBER:_____
IF NO MEDICAID NUMBER, HAS APP BEEN COMPELTED:_____
WARD'S MEDICARE NUMBER:_____

DOES WARD HAVE AN EXISTING: (IF YES PLEASE PROVIDE NAME AND CONTACT INFORMATION)
POA: _____
HEALTHCARE SURROGATE: _____

PLEASE PROVIDE COPIES OF ANY/ALL IDENTIFICATIONS (IE: MEDICARE; MEDICAID; DRIVER'S LICENSE; SOCIAL SECURITY CARD)
DOES THE WARD HAVE:
LIVING WILL:_____
ADVANCED DIRECTIVES:_____
PREPAID BURIAL:_____
WILL OR ESTATE PLAN:_____

IS THE WARD A VETERAN:_____
VETERAN ID NUMBER:_____

WARD'S MARITAL STATUS:_____
WARD'S EDUCATION LEVEL:_____
WARD'S PREVIOUS OCCUPATION:_____
WARD'S FATHER'S NAME:_____
WARD'S MOTHER'S MAIDEN NAME:_____
WARD'S RELIGION:_____

WARD'S BANKING INFORMATION:
NAME OF BANK:_____
ACCOUNT NUMBER:_____
APPROXIMATE BALANCE:_____

WARD'S INCOME:_____
SOCIAL SECURITY:_____
SSI:_____
PENSION:_____
VA BENEFITS:_____

IS FACILITY REP PAYEE FOR SSA BENEFITS/VA/PENSION:_____
IF NO IS FACILITY WILLING TO APPLY TO BE REP PAYEE:_____

APPROXIMATE VALUE OF WARD'S ASSETS:_____

WARD'S PRIMARY PHYSICIAN:
NAME:_____
ADDRESS:_____
TELEPHONE NUMBER:_____

DIAGNOSIS:_____

REASON WARD IS ALLEGED TO BE INCAPACITATED:_____
_____
_____

NAME, ADDRESSES AND TELEPHONE NUMBERS OF ALL PERSONS KNOWN TO PETITIONER WHO HAVE PERSONAL KNOWLEDGE OF THE WARD'S INCAPACITY:

NAME ADDRESS TELEPHONE NUMBER

_____
_____
_____

PETITIONER'S NAME:_____
PETITIONER'S ADDRESS:_____
PETITIONER'S EMAIL ADDRESS:_____
PETITIONER'S RELATIONSHIP TO THE WARD:_____

NEXT OF KIN & OTHER INTERESTED PARTIES - NAME, ADDRESS, TELEPHONE NUMBER AND RELATIONSHIP (& BIRTH DATES OF MINORS)
(IF WARD HAS FAMILY MEMBER, ATTEMPT MUST BE MADE TO HAVE FAMILY MEMBER PETITION FOR GUARDIANSHIP)

_____
_____
_____
_____
_____
_____
_____
_____