Public Administrator
Public Guardian
Public Conservator
Area Agency On Aging

778 W. State Street
El Centro, CA 92243
Telephone: (442)265-7000
Fax: (442)265-7034
www.aaa24.org

Dear Facility, Agency, or Concerned Citizen:

Thank you for bringing to our attention your concerns involving a patient, client, neighbor, friend or relative. This packet is being provided to best enable you to share with us your concerns and knowledge regarding the individual being referred. Please return the completed forms to this office as soon as possible.

Upon receiving the completed forms, we will begin the investigation process. If you are unable to complete the forms in the packet, please provide a written explanation. Your cooperation in providing as much information as possible is important in assisting us in conducting a thorough and timely investigation.

If you have questions regarding the questions on the forms or need information regarding the investigation process, please feel free to contact our office at (442)265-7000.

Sincerely,

IMPERIAL COUNTY PUBLIC ADMINISTRATOR/AREA AGENCY ON AGING

____

Sarah M. Enz, J.D.
Acting Public Administrator/Guardian/Conservator
Area Agency on Aging Acting Director

Enclosure

Imperial County
Public Administrator/Conservator/Guardian
778 W. State Street El Centro, CA 92243
Tel. (442)265-7000
www.aaa24.org

REFERRAL FOR AN INVESTIGATION FOR PROBATE CONSERVATORSHIP

FORM TO BE COMPLETED BY REFERRING AGENCY or PARTY

Informant ______________________________ **Phone Number**__________________________

Proposed Client Name _______________________________ Soc. Sec. #_____________________

Address ____

Mailing Address ____

Telephone No. _______________________________ Date of Birth__________________________

Place of Birth ___________________________ Father's Name ____________________________

Medicare # _______________________ Mother's Maiden Name ___________________________

Medi-Cal _______________________ US Citizen: Yes ☐ No ☐ Alien#_____________________

Veteran: Yes ☐ No ☐ Claim# _________________ Service Dates _____________________

Marital Status ___________________________________

Please state the reason why the referring party believes there is a need for Conservatorship:

____

____

____

____

____

(If additional space is needed, please add an extra sheet.)

RELATIVES AND INTERESTED PARTIES

Include the names of landlords as well as person providing care and assistance. Also include anyone that has been witness to abuse/ neglect of the individual. This information will be of assistance during the investigation process.

Spouse: ________________________________ Date Of Death:____________________________

Address __________________________________Phone Number: __(____)___________________

Name____________________________________Relationship_______________________________

Address __________________________________City______________________________________

State ____________Zip Code _____________ Phone ( ) _____________________________

Name____________________________________Relationship_______________________________

Address __________________________________City______________________________________

State ____________Zip Code _____________ Phone ( ) _____________________________

Name____________________________________Relationship_______________________________

Address__________________________________City______________________________________

State ____________Zip Code _____________ Phone ( ) _____________________________

ASSESSMENT OF SOCIAL AND MEDICAL NEEDS

It is important for our evaluation that you please include the following information, if at all possible. All referrals must address each area and be completed, if known. Skilled Nursing Facilities and Hospital staff should be able to address all areas.

Physician's Name and Address ____

____Phone: ( ) _________________________________

Prescription Medications (Please do not list over the counter medications)
____
____

1. Is the individual in a coma or have a terminal condition? Yes ☐ No ☐
   Life-Sustaining devices used? ____

2. Orientation to Person?Yes ☐ No ☐ Place? Yes ☐ No ☐ Time? Yes ☐ No ☐

3. Individual's knowledge and awareness of medical condition and medications: Yes ☐ No ☐

4. Is the individual in pain? Yes ☐ No ☐ To what degree? _________________________________

5. Social and Communication abilities? Yes ☐ No ☐

6. Ability to follow instructions? Yes ☐ No ☐

7. Ability to make needs known? Yes ☐ No ☐

8. Grooming and eating abilities? Yes ☐ No ☐

9. Bladder and bowel control and frequency? Yes ☐ No ☐

10. Mobility Yes ☐ No ☐, and aids used? ____

11. Ability to transfer from bed to wheelchair (if appropriate)? Yes ☐ No ☐

12. Willing to cooperate with treatment and/or assistance? Yes ☐ No ☐

13. Was placement attempted by your agency? Yes ☐ No ☐ If yes, where? ____________________

14. Where are income and/or benefits mailed? ____

15. Prior address (if currently living in hospital or care facility) ____________________________

____

16. Does the individual have any past or current history of violence, verbal or physical aggression or acting out behaviors? Yes ☐ No ☐ If so, describe in detail.__________________________

____

17. Does the individual receive services from any other agency? Yes ☐ No ☐ If yes, please list agency(ies):____

____

18. Does the individual have a communicable disease? Yes ☐ No ☐

19. Other Comments: ____

____

____

____

LEGAL

Does anyone have Power of Attorney:____
If yes, please attach copy or give name, address, and telephone number:
____
If no, is anyone handling this persona's affairs? ____
If yes, provide name, address, and telephone number:
____

Advanced Directive for health care decisions: Yes ☐ No ☐
Attorney Involved: Yes ☐ No ☐
If yes, please provide name, address, and telephone number:______________________________
____

Real Property: Yes ☐ No ☐ Address: ____

Condition: ____

Property Insured: Yes ☐ No ☐ Policy Number: _________________Exp date:______________
Landlord:
Name: ___________________________________ Phone Number: _______________________

ASSETS

Name of Financial Institution:________________________ Branch Location:________________

Checking Account No. _____________________ Savings Account No. __________________

Life Insurance: Yes ☐ No ☐
If yes, Location: ____

Stocks/Bonds: Yes ☐ No ☐
Broker:____

Pre-Need Burial Trust : ____

Automobile: Yes ☐ No ☐
Year/Model: ______________________________ Location:____________________________

Safe Deposit Box: Yes ☐ No ☐ Key: Yes ☐ No ☐
Bank Address: ____

Will: Yes ☐ No ☐ Living Trust: Yes ☐ No ☐

MONTHLY BUDGET

Income

SSI BENEFITS ________________________________ $ ______________
SSA BENEFITS ________________________________ $ ______________
PENSION ________________________________ $ ______________
OTHER ________________________________ $ ______________
TOTAL INCOME $ ______________

Expenses

RENT/Landlord ________________________________ $ ______________
Address ________________________________
City ________________________________
FOOD ________________________________ $ ______________
CLOTHING ________________________________ $ ______________

Utilities
WATER ________________________________ $ ______________
GAS ________________________________ $ ______________
ELECTRICITY ________________________________ $ ______________
PHONE ________________________________ $ ______________
CABLE ________________________________ $ ______________

Other
BURIAL ________________________________ $ ______________
SAVINGS ________________________________ $ ______________
LIFE INSURANCE ________________________________ $ ______________

TOTAL EXPENSES $ ______________

BALANCE $ ______________

________________________________ ________________________________
Signature of Referring Party Agency and Title

________________________________ ________________________________
Print Name Phone Number

Relationship to Proposed Client:

____________________ or None _______ ________________________________