Public Administrator
Public Guardian
Area Agency On Aging

Public Administrator

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.
Public Administrator/Guardian
Area Agency on Aging Director

Enclosure

Imperial County

Public Administrator/Public Guardian

778 W. State Street El Centro, CA 92243

Tel. (442)265-7000

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REFERRAL FOR AN INVESTIGATION FOR *PROBATE* CONSERVATORSHIP; AND/OR REPRESENTATIVE PAYEE SERVICES

FORM TO BE COMPLETED BY REFERRING AGENCY or PARTY

Informant _____ **Phone Number**_____

Referral Date _____ **Informant Relationship** _____

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 a **Probate** Conservatorship and/or Representative Payee Services:

_____

_____

_____

_____

_____

(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

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Date: _____

To Whom It May Concern:

I, _____, would like the Public Administrator, Sarah M. Enz, to be my payee. I have been informed that there will be a monthly charge for these services.

I currently receive: □ SSI $_____ □ SSA $_____ □ VA Benefits $_____

□ Other $_____

Thank You,

_____
Client

_____
SS#

_____
Witness

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

PAPERWORK REDUCTION ACT:

This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 10 minutes to read the instructions, gather the necessary facts, and answer the questions.

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Include Area Code)
( )

DATE

SSA CONTACT

Privacy Act: This report is authorized by sections 205(a) and 205(j) of the Social Security Act, as amended (42 U.S.C. 405(a) and 405(j). While you are not required to respond, your cooperation will help us decide whether any Social Security benefits that may be due should be paid directly to the patient or to someone else on the patient's behalf. Your cooperation in completing and returning this statement will be appreciated.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security Office.

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER
__ __ __ / __ __ / __ __ __ __

PATIENT'S NAME

PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)

PATIENT'S SOCIAL SECURITY NUMBER
__ __ __ / __ __ / __ __ __ __

PATIENT'S DATE OF BIRTH

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. **Please Note:** This determination affects how benefits are paid and has no bearing on disability determinations. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

1. Date you last examined the patient _____ .

2. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest?

By capable we mean that the patient:

- Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
- Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

☐ Yes — If "Yes", please omit question 3, but be sure to sign and date the form.

☐ No — If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.

☐ Unsure — If "unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

☐ Yes ☐ No

If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER *(Please print.)*	TITLE
ADDRESS *(Number and street, City, State, and ZIP Code)*	TELEPHONE NUMBER *(Include Area Code)* ( )

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PHYSICIAN/MEDICAL OFFICER	DATE