

Public Guardianship for the Elderly Program Intake Form 1

Date:

Personal Information

Client's Referral Date:		
Client's Full Name:	Client's Date of Birth:	Client's Social Security Number:
Client Occupation:	Client's Employer:	Client's Address, Telephone:
Mother's Maiden Name:	Mother's Place of Birth:	Mother's Date of Birth:
Father's Name:	Father's Place of Birth:	Father's Date of Birth:
Client's City, County, State, and Country of Birth:		
Current Residential Address:		
Current Mailing Address:		
Residential County:	Type of Residence:	
Directions to Residence:		
Sex:	First Language:	Race/Ethnicity:
Highest Educational Level Obtained:	Profession:	
Religious Affiliation:	Clergy's Name:	Clergy's Phone Number:
Veteran:	Branch:	Dates of Service:

Support System

Marital Status:	Number of Marriages:	Date of Marriage(s):
Spouse's residential address:		Type of residence:
Spouse's Name(even if deceased):		Spouse's date of death (if deceased):
Spouse's Social Security Number:		
If deceased, spouse's burial location:		If spouse deceased, funeral home:
Was spouse a veteran?	Branch:	Dates of Service:
Veteran's Administration Number:		
Child: Reason child not Conservator:	Address:	Phone Number:
Child: Reason child not Conservator:	Address:	Phone Number:
Child: Reason child not Conservator:	Address:	Phone Number:

Family Member:	Address:	Phone Number:
Relationship:		
Reason not Conservator:		
Family Member:	Address:	Phone Number:
Relationship:		
Reason not Conservator:		
Family Member:	Address:	Phone Number:
Relationship:		
Reason not Conservator:		
Neighbor/Friend:	Address:	Phone Number:
Neighbor/Friend:	Address:	Phone Number:
Background Information re: Family/Friends:		
Home Service Provider:	Address:	Phone Number:

Description of Home Services being provided:		
Other Home/Community Based Services being received:		
Medical Equipment Supplier:	Address:	Phone Number:
List of Medical Equipment:		

Health Information

Primary Care Physician:	Address:	Phone Number:
Other Physician/Specialist:	Address:	Phone Number:
Other Physician/Specialist:	Address:	Phone Number:
Hospital of Choice:	Address:	Phone Number:
Pharmacy of Choice:	Address:	Phone Number:
Medicaid Number:		Medicaid Effective Date:
TennCare Choices MCO:		TennCare Choices Care Coordinator:
Medicare Pt. A Number:		Medicare Pt. A Effective Date:
Medicare Pt. B Number		Medicare Pt. B Effective Date
Medicare Pt. D Provider Name, Address, and Phone Number		Medicare Pt. D Number:

Medicare Advantage Plan	Address	Phone Number
Medicare Supplement Plan Name, Address, and Phone Number	Address	Phone Number
TennCare Choices MCO		TennCare Choices Care Coordinator
Current Medical Condition		
Medical History (Please attach the most current History & Physical examination and Physician's Orders list if available)		
Current Medications Name, Amount, Dosage:		
Mental Status including all known diagnoses:		
Communication:	Cognitive Status:	Ambulation:

Financial Information

Amount of Social Security: <small>Non-applicable</small>		Amount of SSI: <small>Non-applicable</small>		Amount of SSDI: <small>Non-applicable</small>	
Amount of VA Benefit: <small>Non-applicable</small>		Type of VA Benefit:		Draws on Self or Spouse:	
Amount of Railroad Retirement: <small>Non-applicable</small>		Other Income:		Other Income:	
Amount in Additional Bank Account: Non-applicable	Type of Account:	Bank Name:		Bank Address:	
Amount in Additional Bank Account: Non-applicable	Type of Account:	Bank Name:		Bank Address:	
Amount in Additional Bank Account: Non-applicable	Type of Account:	Bank Name:		Bank Address:	
Safety Deposit Box:		Location of Safety Deposit Box:	Address:		Name of person with Key:
Real Estate Address:		Type of Real Estate:		Is the client the sole owner?	If not, who is/are the other owner(s)?
Real Estate Address:		Type of Real Estate:		Is the client the sole owner?	If not, who is/are the other owner(s)?
Personal Property (including any vehicles, jewelry, etc.):					
Life Insurance Company:		Address and Phone Number:		Policy Number:	
Amount of Life Insurance:	Is Policy paid up?	Cash Value of Policy:		Beneficiary:	

Life Insurance Company:		Address and Phone Number:		Policy Number:	
Irrevocable Trust:		Address and Phone Number:		Policy Number:	
Monthly Expenses Amount:	To Whom:	Monthly Expenses Amount:	To Whom:	Monthly Expenses Amount:	To Whom:
Monthly Expenses Amount:	To Whom:	Monthly Expenses Amount:	To Whom:	Monthly Expenses Amount:	To Whom:
Monthly Expenses Amount:	To Whom:	Monthly Expenses Amount:	To Whom:	Monthly Expenses Amount:	To Whom:
Monthly Expenses Amount:	To Whom:	Monthly Expenses Amount:	To Whom:	Monthly Expenses Amount:	To Whom:

End of Life Wishes

POST Form?	Location of POST:	Advance Directive?	Location of Advance Directive:
Does the client wish to have a funeral and be buried?	Funeral Home:	Funeral Home Address and Phone Number:	
Cemetery of Choice:		Address and Phone Number:	
Does the client wish to be cremated?	Crematory:	Crematory Address and Phone Number:	
Funeral/cremation paid for?	Actions to take with ashes/grave site:		
Does the client have a will?		Location of Will:	
Attorney who drafted Will:		Individual to contact in event of death:	

Legal Information

Does client have an attorney?	Contact information for attorney:	
Does the client have a Durable Power of Attorney?	Contact information for attorney who drafted DPOA:	
Attorney-in-fact name:	Contact information:	
Location of DPOA:	Comments:	
Is the client currently under conservatorship by another person or entity?	If yes, whom?	Address and Phone Number:

Type of Service Requested

<input type="checkbox"/> Conservator of Person and Property	<input type="checkbox"/> Durable Power of Attorney for Healthcare and Finances
<input type="checkbox"/> Conservator of Person	<input type="checkbox"/> Durable Power of Attorney for Healthcare
<input type="checkbox"/> Conservator of Property	<input type="checkbox"/> Durable Power of Attorney for Finances

Requested By

Name of Person Completing Application:	Address and Phone Number:
If there is a petitioning attorney in this case, Name:	Address and Phone Number:
APS Staff:	APS Staff contact information: