



# LifeSpan, Inc. Guardianship Application

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### I.

Referral Source:  
Referred By:  
Why Referred?

Phone:

Date:  
Emergency:  Y  N

Emergency Health Needs:

Expert Evaluation Completed by:

Date:

### II.

Client Name:

DOB:

SSN:

Sex:  M  F

Race:

Marital Status:

Spouse Name:

Facility:  Y  N Name:

Admission Date:

Current Address:

Phone:

Previous Address:

Phone:

Retired From:

Income Source	Amount

### III. Benefits Eligibility

Medicare #:

Medicaid #:

Other:

Comments:

### IV.

Current/Previous Guardian:	<input type="checkbox"/> Y <input type="checkbox"/> N	Court:	
Name:	Relationship:	Phone:	

### V. Support System (Include family, friends, neighbors, other contacts)

Name	Relationship to Client	Address	Phone

### VI. Physicians

Name	Specialty	Phone

Specific Diagnosis		

**(Check all that apply)**

- Alzheimer/Dementia   
  MH   
  MR/DD   
  Physical   
  Substance Abuse

### VII. Functional Limitations

- Ambulation:**     Independent     Walker     Cane     Wheelchair  
**ADL's:**     independent     Verbal Prompt     Needs Assistance     Total Care  
**Vision:**     Glasses  
**Hearing:**     Hearing Aids     Left     Right     Both  
**Dentures:**     Upper     Lower     Both     Partial  
**Prosthesis:**     Y     N    Where:  
**Other:**

### VIII. Nutrition/Diet

### IX. Formal Care Providers currently involved in case

Name of Agency & Contact	Phone	Services Provided

### X.

- Funeral Plans:**     Y     N     Prepaid     Preplanned  
**Cemetery:**    **Phone:**  
**Funeral:**    **Phone:**  
**Religion:**    **Church:**  
**Living Will:**     Y     N    **Where:**  
**Life Insurance:**