KERN COUNTY
AGING & ADULT SERVICES

Jeremy Oliver - Director
Public Guardian/Conservator
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REFERRAL FOR PROBATE CONSERVATORSHIP INVESTIGATION

DATE:_____

REFERRAL MADE BY:_____ TITLE or RELATIONSHIP:_____

ADDRESS or AGENCY NAME / ADDRESS:_____

PHONE:_____ PHONE 2:_____ E-MAIL ADDRESS:_____

CONFIDENTIAL INFORMATION

NAME:_____ ALIAS:_____ SSN:_____
Last, First Middle

RESIDENCE:_____ ZIP:_____
Street, City

PLACEMENT:_____ TYPE OF FACILITY:_____
Facility Name, Address

PHONE:_____ DATE OF BIRTH:_____ AGE:_____ RACE:_____ GENDER:_____

PHONE 2:_____ BIRTHPLACE:_____ VETERAN?: ☐ Y ☐ N BRANCH:_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED CITIZENSHIP:_____

PRIMARY LANGUAGE:_____ HEIGHT:_____ WEIGHT:_____ EYE COLOR:_____ HAIR COLOR:_____

RELIGIOUS PREFERENCE:_____ DISTINGUISHING MARKS:_____

MOTHER'S MAIDEN NAME:_____ HIGHEST EDUCATION:_____ OCCUPATION:_____

SPOUSE'S NAME/ADDRESS:_____

MEDICAL / SOCIAL INFORMATION

1. MEDICAL ISSUES / DIAGNOSES:

Check All That Apply:

☐ Combative	☐ Wanders	☐ Incontinent
☐ Uses Walker / Cane	☐ Uses Wheelchair	☐ Uses Hearing Aids
☐ Bedbound	☐ Decubiti / Bedsores	☐ Sitter / Supervision
☐ Dentures	☐ Glasses	☐ Smokes
☐ Has Animals	☐ Homeless	☐ Alcohol / Drug Use

2. MEDICATIONS / DOSAGES: (Please list all medications: use reverse side, if necessary)

Medication	Dosage	Treatment for ??	Medication	Dosage	Treatment for ??

3. PHYSICIANS / TREATMENT PROVIDERS:

Physician	Specialty	Address	Phone	Next Appointment

4. RELATIVES: LIST PARENTS, CHILDREN, SIBLINGS, GRANDPARENTS, AND GRANDCHILDREN
(Identify if deceased. If no living relatives listed above, include all other relatives and close friends)

Relationship	Name	Address	Phone
Father			
Mother			

FINANCIAL INFORMATION

INSURANCE INFORMATION: ☐ Medi-Cal ☐ Medicare ☐ VA ☐ Private:_____
(Check all that apply)

ESTATE PLANNING: ☐ Power of Attorney ☐ Trust ☐ AHCD ☐ POLST ☐ Will **Attach copies, provide contacts, and location of documents:**
(Check all that apply)

	Name	Address	Phone	Relationship	Location of Documents
Attorney in Fact					
Trustee					
Executor					

BURIAL ARRANGEMENTS: ☐ Yes ☐ No Location/Details:

INCOME & AMOUNT:

Source	**Monthly Amount**	**Source**	**Monthly Amount**	**Source**	**Monthly Amount**
SSI					
Social Security					
VA					

BANK ACCOUNTS / INVESTMENTS:

Institution Name / Address	Balance	Account #	Institution Name / Address	Balance	Account #

OTHER INCOME INFORMATION:

REAL PROPERTY: ☐ None

Location / Address:			Mortgage Company / Address:		Balance Owed:	Mortgage Current?
Mortgage Due Date:	Taxes Current?	Tax Amount:	Assessed Value:	Insurance Carrier:	Address	Phone
IF Property is rented, Tenants Name:		Rental Amount:	Who Collects Rent?			Current?
Liens:		Litigation:	Comments:			

PERSONAL PROPERTY: ☐ Yes ☐ No If yes, list and identify location below:

AUTOS / MOBILE HOMES: ☐ None

TYPE	YEAR/MODEL	LOCATION	LICENSE	STATUS	PAYMENT	LOAN BALANCE

Loan Contact:

BASIS FOR CONSERVATORSHIP

check all that apply:

- ☐ Unable to provide properly for physical health, food, clothing, or shelter
- ☐ Substantially unable to manage personal financial resources
- ☐ Unable to resist fraud or undue influence

1. Why is Conservatorship **REQUIRED**?

2. Describe the crisis that lead to these issues:

3. How did you become aware of these issues?

4. How are this person's basic needs for medical care, food, clothing and shelter being met?

5. What health services have been provided to this person during the last year?

6. What social services have been provided to this individual during the last year?

7. What estate management or money management services have been provided to this person during this year?

8. In seeking assistance for this person, what other agencies have you contacted?

9. Does this person have a psychiatric history?

10. If Hospitalized, what is the discharge plan?

11. **HOSPITALS ONLY -** Please provide: __ Admit Face Sheet __ History & Physical __ Psych Eval/Competency Info.
__ If Skilled Nursing Placement, proof of payment source, applications,

12. **SKILLED NURSING ONLY -** Please provide: __ Admit Face Sheet __ History & Physical __ Psych-Social
__ Trust Fund Accounting __ Correspondence Sent to Family re: Conservatorship Referral

Referring Party's Signature: _____ Date: _____

THIS SECTION TO BE COMPLETED BY AGING & ADULT SERVICES STAFF ONLY

APS Supervisor (if from APS): _____ Date: _____

Referral received by: _____ Date: _____

Assigned to: _____ Date: _____

Response Level: ☐ Priority ☐ Standard