GSSC Referral Form

Referral Source/Case Manager Name: _____ Agency: _____

Phone Number: _____ Date of Referral: _____

What service(s) are you seeking?

_____ Guardianship _____ Conservatorship _____Rep Payee _____ Trustee

Demographic Information:

_____

Last Name First Name Middle Name Maiden Name (if any)

_____

Date of Birth Place of Birth Mother's Maiden Name

_____

Cell Phone Home Phone Social Security Number

_____

Street Address

_____

City State Zip Code County

_____

Medicaid Number Medicare Number Other Insurance Name and Policy #

Marital Status: ____ Never Married ____ Married ____ Divorced ____ Widowed ____ Other

Do you have any children? Y / N If yes, how many and what ages? _____

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Railroad Service? Y / N Receive RR Benefits? Y / N

Served in the military? Y / N Receive VA Benefits? Y / N
If yes, please provide the following information:
Claim Number: _____ Branch of Service: _____ Amount Received: _____

Have you ever used another Name or Social Security Number? Y / N
If yes, please list: _____

Do you have a valid driver's license? Y / N Able to drive? Y / N State ID? Y / N
ID/License Number: _____

Is there a legal guardian involved? Y / N Is there a Power of Attorney involved? Y / N
If yes, please explain _____

Is there a payee currently? Y / N Contact Info: _____

Why do you require a payee? Is there a diagnosis impacting your ability to handle your finances?

_____

_____

Please Note (RP Only) – If you have never been assigned a Representative Payee or are currently managing your own funds then a Physician or Medical Supervisor must complete the form attached (Form SSA-787). This form must be returned with this referral packet.

Housing:
Is there stable housing in place? Y / N
If not, what are the circumstances?

_____

_____

Moved in the last 2 years? Y / N If yes, when? _____

Check the line(s) that best describes your housing:

_____ Alone _____ With a relative _____ With someone else
_____ In a nursing facility _____ In a public institution _____ In a private institution
_____ In a board and care facility

Please list names and relationships of anyone that lives in your home.

_____

_____

_____

Monthly Income:

SS: _____ SSI: _____ SSDI: _____
Employment: _____ Food Stamps: _____ Other: _____

If employed, please answer the following:

Employer: _____ Start Date: _____
Address: _____ City/State/Zip: _____
Hourly Rate: _____ Avg Hours per Week: _____ Avg Weekly Pay _____

Personal Banking Account Information:
Checking Account: Bank Name and Location: _____
Savings Account: Bank Name and Location: _____
Other Assets (Stocks, Bonds, 401K, Car, Life Insurance, Trusts, Pre-paid burials, etc):

_____
_____
_____

Emergency Contact:
Name: _____ Relationship: _____
Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Guardianship Only:

Is there an Advance Directive or a Living Will? Y / N

What is the Primary Diagnosis? _____
_____

Secondary Diagnosis? _____
_____

Physician(s) Information: _____
_____

Signature of Referring Source/Case Manager	**Date**
Signature of Individual	**Date**

Needed Paperwork:

- Guardianship Paperwork (if applicable)
- Physician's/Medical Officer's Statement of Patient's capability to manage benefits (**SSA-787**) (if applicable, **when individual is not in agreement**)

Please complete all applicable sections to the best of your ability, sign, and date.
Return to Guardianship Services of Saginaw County, Inc when completed:

- Fax: (989) 755-3104
- Postal Mail: 100 S. Jefferson Ave, Suite 102 Saginaw, MI 48607
- Or please call (989) 755-1532 for an e-mail address

FOR GSSC OFFICE USE ONLY

Date Referral Sent: _____ By (initials): _____
Date accepted: _____ By (initials): _____