Casey Ball Supports Coordination, LLC

National Certified Guardian

1346 Moose Lane, Ligonier, PA 15658 - (724) 382-8876

Date of Application _____

1. IDENTIFYING INFORMATION
2. Consumer Name _____
3. County of Residence _____ D.O.B. _____ Gender: _____
   Social Security Number: _____
4. Current Address: _____

- Current Phone: _____
  Height: _____
- Weight: _____
- Hair Color: _____
- Eye Color: _____

5. Contact Residential Service Provider_____ Phone: _____
6. Contact Day Program (if applicable) _____ Phone: _____

7. 2. PRESENTING PROBLEMS/NEED FOR GUARDIANSHIP Briefly Describe:
   _____
   _____
   _____
   _____
8. Has There Been Any Previous Adjudication for Incapacitation / Incompetency? Yes/No
9. If Yes, briefly describe including date(s) if known: _____
   _____
10. PERSONAL DATA Marital Status: _____ Date:
    _____
11. Education Level: _____
12. Occupation: _____
13. History of Forensic Involvement: Yes/No
14. Veteran: Yes/No
15. Blind: Yes/No
16. Deaf: Yes/ No
17. Religion: _____
18. Most Recent State Facility Stay: _____
19. Place of Birth: _____
20. Mother's Maiden Name: _____
21. Father's Full Name: _____
    Friends/Relatives Involved:
    _____

22. Name Relationship Telephone
    _____
23. Name Relationship Telephone
    _____
24. Name Relationship Telephone
    _____
25. Name Relationship Telephone
    _____
26. Name Relationship Telephone

27. REFERRAL SOURCE Name of person filling out referral:
    _____
28. Supports Coordinator: _____
- Phone #: _____
- Agency, Organization: _____
- Cell #: _____

29. MEDICAL INFORMATION Diagnosis (DSM IV):
    _____
30. Date of Last Psychiatric Evaluation: _____
31. Last Psychological Evaluation: _____
32. Medical Conditions (e.g. diabetes, heart condition): _____
    ____ _____
    _____

33. Current Medications: Name of Medication Reason Prescribed *** ATTACH ADDITIONAL SHEETS IF NEEDED ***
    _____
    _____
    _____
    _____
    _____
    _____
    _____

34. Name of Medication Reason Prescribed Allergies:
    _____
    _____

35. Primary Medical Doctor: _____ Telephone: _____
    Primary Psychiatrist: _____ Telephone: _____

36. Other Doctors Involved with Consumer:
    _____

37. Name Telephone
_____

38. Name Telephone
_____

39. Name Telephone Most Recent Psychiatric Admission:
_____

40. Name of Institution Date of Hospitalization:
_____

41. HEALTH INSURANCE Private Insurance (name): _____

42. Policy #: _____

43. Active _____

44. Medicare (policy #): _____

45. Medical Assistance (name and policy #): _____

46. Other Insurance: _____

47. 7. FINANCIAL / LEGAL Source of Income Amount Frequency Employment: _____ _____

48. Social Security: _____ _____

49. SSI: _____ _____ SSD: _____ _____

50. Food Stamps: _____ _____

51. Monthly Living Expenses Amount Frequency Rent: _____ _____

52. Mortgage: _____ _____

53. Utilities: _____ _____ _____ _____

54. Other known expenses: (e.g. spend money, bus pass, food allowance)_____
_____
_____

55. Income Producing Assets: (including CD's, Property, Life Insurance) Value Account #

56. Name of Financial Institution Savings Account: _____ _____ __
57. Checking Account: _____ _____ _____
58. Burial Account: _____ _____ _____
59. Life Insurance: _____ _____ _____
60. Cert. of Deposit: _____ _____ _____
61. Other: _____ _____ _____ _____
62. Does the consumer currently have a Representative Payee? Yes/No
    _____
63. Name Address Telephone Does anyone currently have Power of Attorney? Yes/No
    _____
64. Name Address Telephone Last Will and Testament:
    _____
65. Living Will: _____
66. Power of Attorney: _____
67. Burial Plans: _____
    _____
68. Other Legal Concerns: _____
    _____
69. GUARDIANSHIP 1. Type of Guardianship being sought:

- Estate: _____
- Limited Estate: _____
- Person: _____
- Limited Person: _____

70. Physician who will testify: _____
71. Phone: _____
72. Physician or person completing referral form: _____
73. Name: _____

Address: _____

Phone Numbers: _____

Please return completed form to Casey Ball, CEO, ceo@caseyball.com or fax to 1-888-614-3955.