SENIORS FIRST OFFICE OF PUBLIC GUARDIAN (OPG)
Public Guardianship Program for Orange & Seminole Counties

Mission: Enhancing the Quality of Life of Seniors by Maintaining Their Independence and Dignity

ELIGIBILITY GUIDELINES

1. Incapacity: the individual has been alleged to be incapacitated or have a qualifying developmental disability.
2. No Family or Friend to Act as Guardian: No family member or friend is able or willing to serve as guardian AND meets the minimal qualifications of Florida law to serve as guardian, or all such persons have been refused appointment by the guardianship court or Ward has been referred by another state agency.
3. Limited Financial Means:
   a. Asset and Income information indicates that the individual may not be able to afford a private or professional guardian.
   b. Indigent Status: maximum income 200% of the Federal Poverty Level
   c. Asset limit $2,000 cash
   d. No Real Property
4. No Less Restrictive Alternative: No family member or friend is able or willing to become Healthcare Surrogate, Healthcare Proxy or Social Security Representative Payee that would be less restrictive than guardianship, and guardianship is the most appropriate available mechanism to address the needs of the Ward.
5. Needs Consistent with Program: The needs of the Ward are consistent with the scope of the program and our Mission, and the resources and experience of the guardian, taking into consideration the needs and requirements of the program’s existing Wards.
6. US Citizen or Documented Resident Alien.
7. Resident of Orange or Seminole Counties only, living in a fixed abode (Assisted Living Facility, Nursing Home, Group Home, or other supported residential setting), or in a hospital awaiting placement.
8. Complete an application and submit required documents.
9. Ability to be placed on the Waitlist if there are no openings when the completed application is received in our office.

PRIORITIZATION OF REFERRALS

OPG will prioritize the Waitlist according to the program’s prioritization schedule, which is based on the following criteria:-

1. Individual is incapacitated and needs an advocate to prevent abuse, neglect or exploitation, and an adult protective services investigation or injunction against exploitation has been initiated by the referring party.
2. Individual is profoundly developmentally disabled or non-communicative, and no other protective services are available, or an existing guardian or guardian advocate has died, resigned, or been removed.
3. Individual resides in an Assisted Living Facility, Nursing Home, Group Home, or other supported residential setting, or in a hospital awaiting placement and requires a guardian to provide consent to medical treatment, residential placement or other services.
4. Individual resides in a state psychiatric hospital and is on discharge status.

Updated 6/9/2022
GUARDIANSHIP INTAKE AND REFERRAL FORM

Thank you for requesting services from this agency. Please note that we are unable to process any applications that are not fully completed. Please refer to the Eligibility Guidelines and Checklist for documents to be submitted.

Application Date: ________________

GENERAL INFORMATION

Client's Name: Last: __________________ First: __________________ Middle: ____________
Maiden Name or other name(s) used: ____________________________________________
Date of Birth: ______/____/_______ Age: _________ Social Security #: ______ - ______ - _______
Gender: ___________ Race: __________________ Marital Status: _______________________
Spouse's Full Name (First and Last Name): _______________________________________
Reason spouse is not applying for Guardianship: __________________________________
U.S. Citizen: Yes / No / Unknown Resident Status: ___________________________________
Primary Language: ______________________ Secondary Language: _______________________ 
If not in a Facility, anyone living with the Client? Yes / No If yes, please specify:
Name: ______________________________ Relation: __________________ Phone Number: (____) _________
Current Facility/Hospital Name: ___________________________ Dates: ______/____/_______ - Present
Current Address: _______________________________ Phone Number: (____) _____________
City: ________________ State: ________ Zip: ____________ County: _______________________

Previous Facility/Hospital Name: ___________________________ Dates: ______/____/_______ - ______/
Previous Address: _______________________________ Phone Number: (____) _____________
City: ________________ State: ________ Zip: ____________ County: _______________________

Guardianship Intake and Referral Form Page 1 of 5 Revised 5/11/2022
MEDICAL INFORMATION

Primary Care or Attending Physician (First and Last Name): ________________________________

Physician Address: ___________________________ Physician Phone Number: (____) _________

City: __________________ State: _______ Zip: ___________ County: _______________________

Diagnoses: ____________________________________________________________

Medications: __________________________________________________________

Allergies: ____________________________________________________________

Has a physician deemed this person incapacitated? Yes / No

If yes, Physician’s Name: ____________________________ Physician’s Phone Number: (____) _________

Does this person have Dementia? Yes / No Mild / Moderate / Severe

Mental Status/Level of Functioning (Examples: Wandering, language or violent or aggressive behavior, Baker Act history, ambulation, and activities of daily living/ADLs).

__________________________________________________________________________

__________________________________________________________________________

Primary Health Insurance: ____________________________ Secondary Health Insurance: ____________

Medicare Number: ____________________________ Medicaid Number: ____________________________

Is the client Medicaid Eligible? Yes / No Has Medicaid application been initiated? Yes / No

Type of Medicaid: Community / Med Waiver / ICP Medicaid / Pending / Approved / Other: ______________

Advance Directives: DNR / Health Care Surrogate / Living Will / Last Will & Testament / Other: ______________

Prepaid Funeral Arrangements? Yes / No If yes, name of Funeral Home: ________________________________

Phone Number: (____) _______________ Contract Number: ________________________________

FINANCIAL INFORMATION (MANDATORY)

Monthly Income: ______ SS: $___________ SSI: $___________ *Pension/Annuity: $___________

Veteran? Yes / No If yes, please provide Veteran’s Number: ________________________________
FINANCIAL INFORMATION (Continued)
Dividend/Interest: ____________ VA: ____________ Other Income: ____________
Other Income Source: ____________ Total Monthly Income: ____________
*If pension is received, name of pension and address: ____________________________
Address: __________________ City: ____________ State: ______ Zip: ____________

Is there a Social Security Rep Payee? Yes / No If yes, provide name: ____________________________
Are you willing to be the Social Security Rep Payee? Yes / No
Is there a Resident Trust Fund? (Skilled Nursing Facility) Yes / No If yes, Current Balance: ____________

ASSET/PROPERTY
All personal and real estate property must be named (bank accounts, stocks, land, house, mobile homes, cars, jewelry, CD's, safe deposit box, etc.): ____________________________

Bank: ____________ Account Number: ____________ Balance: $_______ Date: ___/___/___
Bank: ____________ Account Number: ____________ Balance: $_______ Date: ___/___/___

FAMILY/SIGNIFICANT OTHERS
First Name: ____________ Last Name: ____________ Middle Initial: ____________
Address: __________________ Phone Number: (____) ____________
City: ____________ State: ______ Zip: ____________ Relationship: __________________
Has the family or significant other made any contact? Yes / No
Does the family member or significant other agree to have Seniors First, Inc. take over guardianship? Yes / No
If yes, provide reason family member or significant other is unable to act as Guardian: ____________________________

First Name: ____________ Last Name: ____________ Middle Initial: ____________
Address: __________________ Phone Number: (____) ____________
City: ____________ State: ______ Zip: ____________ Relationship: __________________
Has the family or significant other made any contact? Yes / No
FAMILY/SIGNIFICANT OTHERS (Continued)

Does the family member or significant other agree to have Seniors First, Inc. take over guardianship? Yes / No

If yes, provide reason family member or significant other is unable to act as Guardian: ______________________

____________________________________________________

First Name: __________________ Last Name: __________________ Middle Initial: __________

Address: __________________________________________ Phone Number: (____) ____________

City: _______________ State: _______ Zip: ___________ Relationship: ______________________

Has the family or significant other made any contact? Yes / No

Does the family member or significant other agree to have Seniors First, Inc. take over guardianship? Yes / No

If yes, provide reason family member or significant other is unable to act as Guardian: ______________________

____________________________________________________

REFERRER INFORMATION (MANDATORY)

Referring Party (Circle the appropriate one): Nursing Home / Rehabilitation Facility / Assisted Living Facility / Hospital / County Agency / State Agency / Court / Family Member / Friend / Other: ____________________________

Relation to the alleged incapacitated person (if applicable): ________________________________

Name of Referring Organization (if applicable): ________________________________

Name and Title of Referrer: ________________________________

Address: __________________________________________ Phone Number: (____) ____________

City: _______________ State: _______ Zip: ___________ Fax Number: (____) _____________

Email: ________________________________

Print Name of Referrer ________________________________ Referrer's Signature __________________________

Date: (MM/DD/YYYY)
CHECKLIST

The following documents are REQUESTED when returning the Referral Packet.

Items that are starred are REQUIRED* in order for us to proceed with the application.

___ Advanced Directives (Living Will, Last Will & Testament, Healthcare Surrogate or POA documents)

___ Photo Identification* (may be expired)

(Driver's License, Passport, Florida ID, (Face sheet with photo may be accepted if no government ID is available)

___ Face Sheet (if proposed Ward is in a Nursing Home*)

___ Documentation of all Baker Act notices

___ Financials (3 months most recent bank statements for any accounts indicated on the application*)

___ Social Security Card

___ Insurance Card (Medicare, Medicaid, Other)

___ Social Security Benefit Amount letter for the current year*

___ Social Security Rep Payee letter

___ Pension Award Letter

___ Resident Trust Fund and Patient liability statements (if proposed Ward is in a nursing home*)

___ Any known Real Estate ____________________________

Include any other information or documents that will assist with the referral process__________

_________________________________________________________________

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