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.

SeniorsFirst
Meals, in-home care and more.

Office of Public Guardian Orange and Seminole County

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Guardianship@Seniorsfirstinc.org

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: _____

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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_____