Center for At-Risk Elders
6910 North Shadeland Avenue
Suite 100
Indianapolis, IN 46220
317.955.2790 TEL
317.423.5444 FAX

VOLUNTEER ADVOCATES PROGRAM REFERRAL FORM

The following criteria are used in evaluating referrals for acceptance for our Volunteer Advocates Program:

- Incapacitated adults (18 years or over) in Marion County;
- Hospitalized at a hospital facility or an outpatient in crisis, including a patient for who end-of-life decisions may need to be made;
- Determined by their physician to require 24/7 professional supervised care services capable of being paid for through insurance or government benefit programs, whether or not such insurance of government programs have yet been applied for;
- Determined by a licensed physician to be mentally or medically incapacitated and unable to make decisions for themselves;
- Without a willing, able, or suitable relative or other significant person to serve as a guardian or decision maker;
- Determined by the Marion County Probate Court to require a guardian; and
- Be referred by an entity for whom CARE has a contractual or grant relationship.

Complete Referrals will include:

- ◆ Completed Volunteer Advocates Program Referral Form
- ◆ Completed Family Information Sheet.
- ◆ Completed Physician's Report.
- ◆ Any recent medical information/evaluations you believe helpful.

Most fields on the following forms are required in order for us to determine acceptance to the program. Please refer to the Professional Frequently Asked Questions document on the CARE website or call the CARE office if you have questions about completing the referral forms. A more complete referral will expedite the process.

This program is approved by the Marion County (Indianapolis) Probate Court as a "volunteer advocates for seniors and incapacitated adults" (VASIA) program under Indiana Code 29-3-8.5. The CARE Volunteer Advocates Program is a volunteer advocates program that trains and then matches volunteers to serve, on behalf of CARE, as the guardian for an incapacitated adult.

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Did you include:
☐ Signed physician's report
☐ Medical collateral including admission and social work notes
☐ All known information about insurance, finances, family and friends?

VOLUNTEER ADVOCATES PROGRAM REFERRAL FORM

Full Name		Marital Status	Referral Date
Birth Date	Age	Room/Bed #	Admission Date
SS # (Required)		Medicare #	Medicaid #
Gender	Race	Medical Record Number	Type of Medicaid (HIP, Traditional, etc.)

Referral Contact Person	Title	Cell
Email	Fax	Phone/Pager

Eskenazi	❑ Eskenazi Hospital	❑ Inpatient Mental Health Crisis Unit	
IU Health	❑ Methodist Hospital	❑ University Hospital	❑ Riley Hospital (adults only)
Community	❑ East	❑ North	❑ South
Community	❑ Behavioral Health Pav	❑ Heart & Vascular	
Other	❑ Adult Protective Services		

Financial Snapshot

Person lives: ❑ Home/Apt ❑ Homeless ❑ ECF Other:	Residence Address: City/Zip:	Home and/or Cell Phone:

Where does patient bank, if known _____
(Ask or check wallet for a bank card)

❑ Social Security Retirement $_____	❑ Social Security Disability $_____
❑ Supplemental Security Income $_____	❑ Other Income $_____

Medicaid:

- ❑ Patient is a current Medicaid beneficiary (ensure number and type are documented on page 1)
- ❑ Patient is not a Medicaid beneficiary
- ❑ We have submitted an application for Medicaid

  Application #_____

  Contact person_____

  Contact #_____

Medicare:

- ❑ Patient is a current Medicare beneficiary #_____
- ❑ Part A ❑ Part B ❑ Part D or Supplement _____

Other Insurance (name and ID #): _____

Veteran: ❑ Yes ❑ No

Personal items in patient's possession	*Many guardianship clients come to us with nothing but the clothes on their backs. Please assist us in estimating clothing and shoe size.*
Driver's license/ID card? ❑ Yes ❑ No	
Medicare/Medicaid/Insurance cards? ❑ Yes ❑ No (If available, please send photocopies of ID and insurance cards)	Shirt: _____
Keys? ❑ Yes ❑ No	Pants: _____
Checkbook/Bank Card? ❑ Yes ❑ No (please note name of bank above)	Shoes: _____
	❑ Boxers ❑ Briefs ❑ N/A

Snapshot

Attending Physician: _____

Circumstances Requiring Admission (attach admission notes, etc but summarize here)

Reason Involuntary Healthcare Representative is being recommended (attach social work notes, psychiatric assessments, etc. but summarize here)

Medical Treatment/Procedure Needed (if applicable)

Recommended Discharge Plan. (Our program requires a 24-hour professionally supervised setting to be eligible.)

Does Patient verbally refuse medical treatment/procedure or recommended treatment plan?

❑ Yes ❑ No

Other information that is helpful but not reflected elsewhere.

Family Information

List all regardless whether you have their contact information or whether they want to be involved. The Court requires each receives notice of guardianship action. Please attach an additional sheet if necessary

Name **Place of Birth**

Marital Status (please indicate on page 1)

Name of Spouse Phone Address

Partner/Significant Other

Name of Partner/Significant Other Phone Address

Mother ❑ Living ❑ Deceased Maiden Name: _____

Name of Mother Phone Address

Father ❑ Living ❑ Deceased

Name of Father Phone Address

Children Add additional sheets as necessary

Name Phone Address

Name Phone Address

Name Phone Address

Siblings Add additional sheets as necessary

Name Phone Address

Name Phone Address

Name Phone Address

Please attach an additional sheet for any names and contact information of others important for us to know, such as extended family, caretakers, friends, coworkers, etc.

STATE OF INDIANA	)	IN THE MARION SUPERIOR COURT
	)	PROBATE DIVISION
COUNTY OF MARION	)	
	)	CAUSE NO.

IN MATTER OF THE GUARDIANSHIP OF)
)
_____)

PHYSICIAN'S REPORT

Dr. _____, a physician licensed to practice medicine in all its branches in the State of Indiana, submits the following Report on _____, the alleged incapacitated person ("Person") named above, based on an examination of said person conducted within the last three (3) months, on the _____ day of _____, 20_____.

1. The nature and type of the Person's disability or other incapacity is:

_____

_____

_____

2. The Person's mental and physical condition, and, when appropriate, their educational condition, adaptive behavior and social skills are:

_____

_____

_____

3. In my opinion, the Person is ❑ totally or ❑ only partially incapable of making personal and financial decisions.

A. The kinds of decisions which the Person can and cannot make are:

_____

_____

_____

B. The facts and/or reasons supporting this opinion are:

_____

_____

_____

4. In my opinion, the most appropriate living arrangement for the Person is:

_____

_____

_____

A. The most appropriate treatment or rehabilitation plan for the Person is:

_____

_____

_____

B. The facts and / or reasons supporting this opinion are:

_____

_____

_____

5. The Person

- ❑ cannot appear in Court due to being hospitalized.
- ❑ can appear in Court
- ❑ cannot appear in Court without creating a threat to his or her health or safety.

Explain below the specific risk to the Person's health or safety if he or she appears in Court:

_____

_____

_____

6. Urgency (Read carefully and choose one). The Court requires clear, strong, fact-based information to determine whether a guardianship is needed urgently or emergently. Hearings on guardianship may not be set by the Court for up to 45 days unless facts support the need for an earlier hearing setting. Please be very specific.

❑ In my medical opinion, I believe a guardianship is **urgently** needed (i.e., earlier than approximately 45 days from now) to address the needs of the patient, due to the following:

_____

_____

_____

❑ In my medical opinion, I believe a guardianship is **emergently** needed (i.e., earlier than approximately 7 days from now) to address the needs of the patient. Explain the nature of the emergency and how quickly a guardianship is required:

_____

_____

_____

The report must be signed by a physician. If the description of the Person's mental, physical and educational condition, adaptive behavior or social skills is based on evaluations by other professionals, all professionals preparing or contributing evaluations must sign the report. Evaluations on which the report is based must been performed within three (3) months of the date of the filing of the petition.

I/We affirm under the penalties of perjury that the foregoing representations are true.

Physician Name (printed):_____

Physician Signature:_____

Address:_____

City: _____ State: _____ Zip: _____ Phone: _____

Other professionals who performed evaluations upon which this report is based:

Name:_____Signature:_____

Address:_____

City: _____ State: _____ Zip: _____ Phone: _____

Name:_____Signature:_____

Address:_____

City: _____ State: _____ Zip: _____ Phone: _____

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