TO BE RETURNED TO:
Family Service & Children's Aid
Jackson County Guardian Wraparound Program
306 W Michigan Ave Jackson, MI 49202
Phone: (517) 787-7920 Fax: (517) 780-9131

GUARDIANSHIP SERVICES / WRAPAROUND PROGRAM REFERRAL FORM
JACKSON COUNTY, MICHIGAN

The Guardian Service/ Wraparound Program referral form needs to be filled out for every client requesting guardianship and/or guardianship wraparound program services. A referral may be deemed appropriate if all the following are true:

- Proposed ward/client is a resident of Jackson County, Michigan
- Proposed ward/client is an adult (18 years or older)

AND

- Proposed ward/client has at least one (1) of the following:
  - Unable to protect self from physical, emotional, or sexual abuse.
  - Unable to safely manage current medical conditions.
  - Unable to safely manage current mental health conditions/crisis.
  - Unmet needs due to physical impairment.
  - Unmet needs due to intellectual impairment.
  - Unmet needs due to advanced age.

Completion of this form does not guarantee acceptance into the Guardian Wraparound program and/or Guardianship Services. All referrals will be screened and assessed for appropriateness for the Guardian Wraparound Program and/or Guardianship Services and whether there is room in the program to accept additional clients.

Completed forms need to be returned to the Family Service & Children's Aid office by dropping off or mailing the form to the office or by e-mailing form to either of the Guardian Community Coordinators.

Family Service & Children's Aid
Jackson County Guardian Wraparound Program
306 W Michigan Ave Jackson, MI 49202
Phone: (517) 787-7920 Fax: (517) 780-9131
Email: Kristin Wesolowski: kwesolowski@strong-families.org
Email: Kelsey Marion: Kmarion@strong-families.org

GUARDIANSHIP SERVICES / WRAPAROUND PROGRAM REFERRAL FORM
JACKSON COUNTY, MICHIGAN

TO BE RETURNED TO: Family Service & Children's Aid Jackson County Guardian Wraparound Program 306 W. Michigan Avenue Jackson, MI 49202 Phone: (517)787-7920 Fax: (517)780-9131	**Office use only:** Date Received: Case #: Probate File #: Guardian Appt &Type: Conservator Appt & Type:

GUARDIANSHIP SERVICES / WRAPAROUND PROGRAM REFERRAL FORM
JACKSON COUNTY, MICHIGAN

*Please note: Proposed ward must be an **adult** and a **resident of Jackson County, Michigan.***
Please supply as much information as you have available. Completion of this form does not guarantee acceptance into the Guardian Wraparound program and/or Guardianship Services. All referrals will be screened and assessed for appropriateness for the Guardian Wraparound Program and/or Guardianship Services and whether there is room in the program to accept additional clients. All services and recommendations made by the Guardian Wraparound Program are voluntary and can be revoked at any time but are necessary to ensure least restrictive services were utilized prior to obtaining guardianship.

1. REFERRAL SOURCE CONTACT INFORMATION		
Name:		Date Submitted:
Agency:		E-mail:
Telephone:		Fax:
Relationship to proposed ward:		
Referral being made for (please check all that apply): ❒Representative Payee Services ❒Guardian ❒Conservator ❒Developmentally Disabled		
Reason for seeking services? What is your goal in getting services?		
How did you hear about our services?		
2. GENERAL INFORMATION – PROPOSED WARD		
Name (last, first, middle):		
Other names used:		
Date of Birth:	Age:	Place of Birth:
Gender Identity: ❒Male ❒Female ❒Unknown		Language:
Race/Ethnic Background: ❒Caucasian ❒Native American ❒African American ❒Latino ❒Asian/Pacific Islander ❒multi-Racial ❒Other or Unknown		
Social Security #:		Religion:

Veteran: ❒ Yes ❒No ❒Unknown	Preferred Church:
Branch of Service:	Father's Name:
VA#:	Mother's Name:
Marital Status: ❒Single/Never married ❒Married ❒Divorced ❒Widowed ❒Separated ❒Unknown	
If divorced - spouse name, date, and place of divorce:	
If widowed - spouse name, date, and place of death:	
3. CURRENT LIVING SITUATION – PROPOSED WARD	
Does currently live alone? ❒Yes ❒No	
Home address:	
Current location of proposed ward, if different than home address:	
Date admitted to current facility:	
Date(s) of previous admissions to current facility:	
Discharge Plan: ❒Skilled Nursing ❒Residential Care Facility ❒Independent Living/Home ❒Other:	
Facilities where referrals have been made:	
Anticipated discharge date:	
4. LEGAL STATUS OF PROPOSED WARD	
Does any person or institution currently have legal guardianship, power of attorney, custody and/or control of the proposed ward? ❒Yes ❒No If yes, who and status:	
5. NEED FOR GUARDIANSHIP	
In what way will guardianship benefit the client? What **unmet needs** exist that cannot be addressed by another agency or service?	
Briefly describe the chronology of recent events that resulted in the need to refer this individual for guardianship:	

If exploitation, abuse, or neglect is suspected, has a police report been filed? ❒Yes ❒No

If yes, please attach a copy and provide case #:

Does the proposed ward have a private attorney? ❒Yes ❒No

If yes, please provide name and full contact information:

6. ALTERNATIVES TO GUARDIANSHIP

The purpose of the Guardian Wraparound Program is to ensure all available and appropriate resources are utilized prior to filing for the Guardianship Program. Guardianship is a last resort. Please check below alternatives to guardianship that have already been used and include dates of service and outcomes.

	Assistance from family and/or friends
	Case Management
	DHS Services
	Mental Health Services
	Day Program
	Homemaker / Chore Services
	Meals on Wheels
	Representative Payee and/or money management services
	Senior Services
	VA Services
	Other
	Other
	Other

Other agencies or professionals/social workers involved or providing services (include phone number or e-mail for each one listed):

7. MEDICAL & MENTAL HEALTH PROVIDERS AND INFORMATION

Type	Name and address	Telephone
Primary Care Physician		
Dentist		
Eye Care		
Mental Health		
Specialist		

Is there a history of, or any recent, violent threats or actions noted? ❒Yes ❒No If yes, describe:		
What is the current mental status of the client? Are there any psychiatric concerns?		
What is the drug/alcohol history of the client?		

8. HEALTH INSURANCE

Type	Name of Company Policy and/or Member #	Effective Date of Coverage	Copy of Card?
Medicare A			
Medicare B			
Medicare D			
Medicaid Case #			
Medicaid ID #			
VA Health			
Private			
Supplemental			
Other			

9. ADULT RELATIVES AND SIGNIFICANT OTHERS

Full Name:
Full Address:

Verified Phone #:
Relationship to the client:
Date of Contact:
Method of Contact:
Reason he/she has refused to act as guardian:
Explanation of the current relationship status:

Full Name:
Full Address:

Verified Phone #:
Relationship to the client:
Date of Contact:
Method of Contact:
Reason he/she has refused to act as guardian:
Explanation of the current relationship status:

Full Name:
Full Address:

Verified Phone #:

Relationship to the client:
Date of Contact:
Method of Contact:
Reason he/she has refused to act as guardian:
Explanation of the current relationship status:

Full Name:
Full Address:

Verified Phone #:
Relationship to the client:
Date of Contact:
Method of Contact:
Reason he/she has refused to act as guardian:
Explanation of the current relationship status:

10. FUTURE ARRANGEMENTS

Do you have knowledge of an existing will? ❒Yes (attach copy if available) ❒No

Is there an Advance Directive? ❒Yes (Date and Location of Document)
❒No

Are there existing funeral arrangements?
Funeral Home:
Cemetery:
Irrevocable: ❒Yes ❒No
Amount owed:

11. INCOME

Source	Monthly Amount OR Date of Application	Payee? If so, please list
SSA/SSD		
SSI		
Veterans Benefits		
Railroad		
Pension/Annuity		
Other		
Other		
Other		

12. FINANCIAL ACCOUNTS

Account Type	Location	Account Number	Approximate Value	Any name in addition to proposed client?
Checking				
Checking				
Savings				
Savings				
CD				

CD				
IRA				
Stocks/Bonds				
Stocks/Bonds				
Patient Trust Account				
Other				
Other				

13. ASSETS				
Type	**Location and/or Make and Model**	**Approximate Value**	**Monthly payment, if applicable**	**Any name in addition to proposed ward's?**
Real Property - House				
Real Property - Land				
Mobile Home				
Vehicle				
Vehicle				
Life Insurance Policy				
Burial Plot				
Burial Plan				
Cash				
Safety Deposit Box				
Other				

14. ADDITIONAL INFORMATION
Is there any additional information you would like us to know?

Date of Form: March 20, 2023