A charity helping the elderly and adults with disabilities live the fullest lives possible.

P.O. Box 23491, Waco, TX 76702-3491
5000 Lakewood Dr., Waco, TX 76710
Phone 254.772.7600 - Fax 254.772.3900
www.friendsforlife.org
Referrals@friendsforlife.org

Thank you for your interest in Friends for Life! We would love to help if we can.

Please, know for guardianship to be effective and beneficial to the proposed ward he/she will need to have established/confirmed income, stable placement in a licensed facility & verified health benefits. Friends for Life has now had to enforce these requirements to be able to serve as guardian. If these requirements have been met, please fill out the referral application form and the certified medical examination form. The referral application form is a pdf fillable form and must be filled out electronically and the Certified Medical Examination must be completed by a doctor and signed by a doctor. After you have completed the forms, please email them to referrals@friendsforlife.org or fax at 254-772-3900.

Also, if you can please provide proof of identification, a copy of the face sheet if in a nursing home, the award letter (if the proposed ward is receiving government benefits), and the most recent applied income notice from Medicaid. In addition, we must have the name(s) of the nearest relative(s). Failure to provide this information can result in delay or denial of your referral.

Once all the documents and information are received, we will submit the referral to our referral team and they will assign a care manager to visit the purposed ward to do an assessment to make sure the purposed ward can benefit from our services.
Should you have any questions or comments, please do not hesitate to contact Friends for Life.

Sincerely,

Management

Guardianship Referral Application

Rev 8/4/2023

Reason for Referral **Date**

Is this person in imminent danger? **Yes** **No**

Upon completion please include the patient's Proof of Identification, Certificate of Medical Examination, Admission/Case Sheet if applicable when you send the application back to Friends for Life.

Failure to provide the requested information/documents will result in delay or denial of this referral.

Name of Referral (first, middle & last) **Sex**

Date of Birth **Age**

Social Security No.

Type of Residence

Name of Residence or Provider (if applicable) **Phone No. (include area Code)**

Physical Address, City, State, Zip **County**

Administrator Name:

Email Address:

Admittance Date

Please, provide the referral's both mental and physical diagnosis:

Primary Form of Communication

The below information must be filled out in it's entirety or your application will not be accepted

Is this person on Applied Income? **Yes** **No** **Amount of Applied Income Each Month**

Medicaid No.

Medicare No.

Part A Effective Date

Part B Effective Date

Part D Effective Date

Does the person own his or her own home? **Yes** **No**

Does the person own any other real estate? **Yes** **No**

If yes, please list address and type:

Total Monthly Income Amount:

Social Security

SSI/SSDI

Pension

Other (Alimony, Child Support, ETC.)

If other please list:

Note: ***If person has checking account we need the last 3 months bank statements***

Other Assets:

- Checking Account
- Savings Account
- Trust fund
- Annuity
- Insurance
- Stocks/Bonds
- Mineral Rights

Financial Management Assistance (Choose all that apply)

- Power of Attorney
- Trustee
- Representative payee
- Bill payer
- Surrogate decision-maker

If any of the above options were checked, please provide the name and relationship of the person providing that assistance below.

Marital Status

<u>Family Information: (If not current, most recent contact info)</u>

Name (Last, First)

Relationship

Address, City, State, Zip:

Home **Cell** **Work**

Name (Last, First)

Relationship

Address, City, State, Zip:

Home **Cell** **Work**

Name (Last, First)

Relationship

Address, City, State, Zip:

Home **Cell** **Work**

Special Family Circumstances:

<u>Contact Person</u>

Name (Last, First) **Referral Date**

Title:

E-mail

Address, City, State, Zip:

How long have you known the referral?

Fax No. **Phone No.**

Person Referring Information

Name (Last, First)

Referral Date

Title:

E-mail

How long have you known the referral?

Address, City, State, Zip:

Fax No.

Phone No.

An incapacitated person is an adult individual who, because of a physical or mental condition, is substantially unable to provide food, clothing, or shelter for himself or herself, to care for the individual's own physical health, or to manage the individual's own financial affairs.

Below is for Friends for Life office use only

Date Referral Received

Assigned Care Manager

Approved by:

Date Approved

Upon completion please include the patient's Proof of Identification, Certificate of Medical Examination, Admission/Case Sheet if applicable when you send the application back to Friends for Life.

Failure to provide the requested information/documents will result in delay or denial of this referral.