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Volunteer Advocates for Seniors & Incapacitated Adults Referral Form

This program is approved by the Johnson County and Shelby County Probate Courts as a "volunteer advocates for seniors and incapacitated adults" (VASIA) program under Indiana Code 29-3-8.5.

Recognizing the sensitivity of adult guardianship as a legal concept, each VASIA program shall ensure that guardianship is only sought as a “last resort” support for the protected persons served by the program. If any program has reason to believe that an individual served does not require a legal guardianship and/or meet the definition of “legal incapacity” required for a guardianship, they shall take proactive measures to ensure that other alternative supports are pursued and/or that the guardianship is terminated.

Indiana is a mandatory report state, meaning everyone is required by law to report cases of suspected neglect, battery or exploitation of an endangered adult to an APS unit or law enforcement.

An APS report and police report must be filed before submitting a VASIA referral.

The following criteria are used in evaluating referrals for acceptance to the VASIA Program:

- Incapacitated adults (18+) must reside in a nursing facility in Johnson or Shelby County;
- 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 and;
- Determined by the Johnson County and Shelby County Probate Courts to require a guardian.

Complete Referrals will include:

- ✓ Completed Referral Form
- ✓ Signed Physician’s Report
- ✓ Medication List
- ✓ History & Physical
- ✓ Therapy Evaluations
- ✓ Treatment Plans
- ✓ Neuropsychiatric Testing
- ✓ Last 30 days of nursing notes
- ✓ Facesheet
- ✓ Resident Inventory
- ✓ APS Report
- ✓ Police Report
- ✓ Resident Trust Statement
- ✓ Representative Payee for all income
- ✓ Funeral Arrangements
- ✓ Family made aware of VASIA referral

VASIA Adult Guardianship Referral Form

Client Name:_____ Date of Referral:_____

Referring Agency:_____

Contact Person:_____ Relationship:_____

Phone Number:_____ Email:_____

General Information

Home Address:_____

Status of Home: Own Rent ____ ____ Living Alone? Yes No ____ ____

Marital Status: Married Divorced Separated Never Married Widowed ____

Nursing Facility:_____ Date of Admission:_____

Date of Birth:_____ Place of Birth:_____

Social Security #:_____ Medicare #:_____

Medicaid ID #:_____ Medicaid Case #:_____

Describe the client's ability to communicate:_____

_____

Medical Information

Physician's Name and Phone #:_____

Psychiatrist's Name and Phone #:_____

Dentist's Name and Phone #:_____

Optometrist's Name and Phone #:_____

Current Diagnosis (Please attach current History and Physical report):_____

_____

_____

Advance Directives: Full Code ____No Code ____ Living Will ____

Any immediate health care concerns? Explain:_____

_____

Personal Contacts

Please list any and all family members:

Name Relationship Address Phone # Level of Involvement

Please list any involved friends:

Name Address Phone # Level of Involvement

Spouse Information

Spouse's Name:_____ Social Security #:_____

Current status: ___Divorced (Date): _____ Deceased (Date):_____

Spouse's Date of Birth:_____

Military Service: Yes ___No Branch:_____ Discharge Date:_____

Former Spouse(s):_____

Legal Information

Does this person currently have any form of advocate? (Power of Attorney, Healthcare Representative, Representative Payee, Guardian?) Yes No ____ ____

(Please list or include copies of any documentation pertaining to this.)_____

Does the client have a will? Yes____ No____ Name of will holder:_____

Any pending legal action? Yes____ No____ Please describe:_____

Life Insurance

Life Insurance: Yes ___No ____ Company Name:_____

Phone #:_____ Policy Number:_____

Type of Insurance: Whole Life ___Term Life ___Paid in full? Yes No ____

Name of Beneficiary:_____ Address:_____

Phone #:_____

Health Insurance

Medicare: Yes ___No ___ Type: Part A Part B Part D ___

Medicare Part D Provider:_____ Policy #:_____

Medicare Replacement Insurance: Yes ___No ___

Provider:_____ Policy #:_____

Medicaid: Yes ___No RID #: _____

Caseworker's Name:_____ Phone #:_____

Other Health Insurance: Yes ___No Company Name:_____

Policy #:_____ Phone #:_____

Address:_____

Financial Information

Monthly Income: (ex: SSA, SSI, SSDI, Pension, etc.)

Amount:_____ Source:_____

Amount:_____ Source:_____

Amount:_____ Source:_____

Bank Account: Yes ___No ___ Name of Bank:_____

Address:_____ Phone #:_____

Checking Account: Yes ___No ___ Account #:_____

Savings Account: YesNo___ ___Account #:_____

Resident Account: Yes ___No ___ Account #:_____

Other (list):_____ Relevant Info:_____

Other (list):_____ Relevant Info:_____

Current Debts and Creditors:

Rent: $_____ Mortgage: $_____ Utilities: $_____

Loans: $_____ Other: $_____

Credit Cards: $_____ Credit Card Company(s):_____

Real Estate

Please complete this section only if the client owns real estate

Address of Property:_____

Property Type: House ___Mobile Home __Other ____

Previous Address:_____

Mortgage Type: Traditional __Reverse __Balloon ____

Mortgage Paid in Full? Yes ___No ____ Total Owed $_____ Monthly Payment: $_____

Mortgage Company Name:_____

Address:_____ Phone #:_____

Years Owned:_____ Are there any liens against the property? Yes No ____

Lien Holder:_____ Amount Owed $_____

Are taxes current? Yes ___No ____ Back Taxes Owed: $_____

Funeral/Burial Arrangements

Funeral Home:_____ Address:_____

Phone #:_____ Fax #:_____

Pre-Paid Plan or Trust: Yes ___No ____ Paid in full ____Amount Owed: $_____

Company Name:_____ Policy #:_____

Burial ____ Cremation Cemetery Name:_____ Phone #:_____

Own Plot? Yes ____NoPaid in full Amount Owed: $_____

Location of Plot:_____

Own Vault? Yes ____No ____ Paid in Full? Yes ____No ____ Amount Owed: $_____

Own Headstone? Yes ____No Paid in Full? Yes No____ Amount Owed: $_____

Own Marker? Yes ____No ____ Paid in Full? Yes ____No ____ Amount Owed: $_____

STATE OF INDIANA
COUNTY OF JOHNSON)
) SS:
)

IN THE JOHNSON SUPERIOR COURT #1
CAUSE NO. 41D01-_____

COUNTY OF SHELBY

IN THE SHELBY COUNTY CIRCUIT COURT
CAUSE NO. 73C01-_____

IN THE MATTER OF
THE GUARDIANSHIP OF

_____

PHYSICIAN'S REPORT

1. General Information

Name _____

Phone (_____) _____

Office Address _____
_____

What is your License/Certification? _____

What is your area of specialty? _____

I last examined the Person on: _____, 20____

The Person is under my continuing treatment.

□ YES, since _____, 20____
□ NO

2. Evaluation of the Person's Physical Condition

Physical Diagnosis: _____
_____
_____

Severity: □ Mild □ Moderate □ Severe
Prognosis: □ Continuing □ Degenerative □ Recovering □ Relapsing

Treatment/Medical History/Additional Comments (attach additional pages, if necessary):
_____
_____ _____
_____ _____

3. Evaluation of the Person's Mental Functioning

The Person is oriented to the following (check all that apply):

□ Person □ Time □ Place □ Situation

Do you have concerns about the Person's functioning in the following areas? (check all that apply)

YES	NO	UNKNOWN	FUNCTION
			Short-term memory
			Long-term memory
			Immediate recall
			Understanding and communicating (verbally or otherwise)
			Recognizing familiar objects and persons
			Solving problems
			Reasoning logically
			Grasping abstract aspects of his or her situation
			Interpreting idiomatic expressions or proverbs
			Breaking down complex tasks into simple steps and carrying them out

Mental Diagnosis: _____

_____

Severity: □ Mild □ Moderate □ Severe

Prognosis: □ Continuing □ Degenerative □ Recovering □ Relapsing

Treatment/Medical History/Additional Comments:

_____

_____

4. Medication Information

□ YES □ NO Is the Person currently taking medication related to Person's physical or mental functioning as reported in sections 2 and 3? If "YES," please list:

_____

_____

Additional Comments: _____

_____

_____

_____

5. Decision-Making

Is the Person able to make decisions regarding the following?

YES	WITH SUPPORT	NO	UNKNOWN	ACTION/DECISION
				Make complex business, managerial, and/or financial decisions.
				Manage a personal bank account. If "YES," or "WITH SUPPORT," should amount deposited in any such bank account be limited? □ YES □ NO
				Pay his or her own bills.
				Safely operate a motor vehicle.
				Make decisions regarding marriage.
				Determine the Person's own residence.
				Live alone.
				Obtain food.
				Administer own medications daily.
				Attend to basic activities of daily living (ADLs) (e.g., bathing, grooming, dressing, walking, and/or toileting) with/out services.
				Attend to instrumental activities of daily living (e.g., shopping, cooking, traveling, and/or cleaning).
				Make appropriate judgments that will protect them personally, physically, and/or financially.
				Consent to medical and dental treatment.
				Consent to psychological and/or psychiatric treatment.

Additional Comments:

_____
_____
_____
_____
_____
_____

"Incapacitated person" means an individual who:

(1) cannot be located upon reasonable inquiry;

(2) is unable:

(A) to manage in whole or in part the individual's property;

(B) to provide self-care; **or**

(C) both;

because of insanity, mental illness, mental deficiency, physical illness, infirmity, habitual drunkenness, excessive use of drugs, incarceration, confinement, detention, duress, fraud, undue influence of others on the individual, or other incapacity; or

(3) has a developmental disability (as defined in IC § 12-7-2-61).

Ind. Code § 29-3-1-7.5

(a) **"Less restrictive alternatives"** means an approach to meeting a person's needs that restricts fewer rights of the person than would the appointment of the guardian.

(b) "**Less restrictive alternatives"** may include, but are not limited to, the following:

(1) A supported decision making agreement (as defined in IC § 29-3-14-2).

(2) Appropriate technological assistance.

(3) The appointment of a representative payee.

(4) The appointment of a health care representative (as defined in IC § 16-36-1-2).

(5) The creation of a power of attorney (as defined in IC § 30-5-2-7).

Ind. Code § 29-3-1-7.8

6. Evaluation of Less Restrictive Alternatives

According to the definition in Ind. Code § 29-3-1-7.8 and based upon your last examination and observations of the Person, in your opinion, the following less restrictive alternatives could be considered or implemented:

YES	NO	UNKNOWN	LESS RESTRICTIVE ALTERNATIVE
			Supported decision making agreement
			Appropriate technological assistance
			Representative payee
			Health care representative
			Power of attorney
			Other_____

7. Evaluation of Capacity

According to the definition in Ind. Code § 29-3-1-7.5 and based upon your last examination and observations of the Person, in your opinion, the Person is:

□ Not incapacitated
□ Not incapacitated with use of the following less restrictive alternative:
_____
_____
_____
□ Partially incapacitated
□ Personal OR □ Financial
□ Totally incapacitated

Additional Comments:
_____
_____
_____
_____

8. Recommendation of Living Arrangement

In your opinion, what is the least restrictive living arrangement that you consider appropriate for the Person?

□ At home/at home with services
□ Community based residence
□ Facility based residence
□ Hospital based residence

Additional Comments:
_____
_____

9. Ability to Attend Court Hearing

□ YES There is no significant threat to the Person's health and/or safety that would prevent them from attending the court hearing.

□ NO There is a significant threat to the Person's health and/or safety that would prevent them from attending the court hearing.

□ YES Appear via Zoom held by the court.

10. Additional Information of Benefit to the Court

Please provide any additional information that would benefit the court (attach additional pages, if necessary).
_____
_____
_____

11. Additional Professional Evaluations

If the descriptions of the Person's condition or skills is based on evaluations or assistance by other professionals, please provide the names and contact information of those professionals who are able to provide additional information or evaluations.

Professional's Name_____ Phone (_____)_____

Office Address or E-mail _____

Professional's Name_____ Phone (_____) _____

Office Address or E-mail _____

I affirm under the penalties for perjury that the foregoing representations are true.

_____ _____

Signature Date

_____

Name Printed

_____