Lauren Rynerson, NCG – VASIA Director
lrynerson@co.johnson.in.us
www.indianavasia.org
Phone: 317.346.4414

Johnson County Courthouse
5 East Jefferson Street
Franklin, IN 46131
Fax: 317.738.5698

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: Yes ____ No ____ 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 ____No ____ Paid 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:
)

COUNTY OF SHELBY

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

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
____