



Office of the Public Guardian

Supreme Court of Guam

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HON. KATHERINE A. MARAMAN
CHIEF JUSTICE

HON. ALBERTO C. LAMORENA, III
PRESIDING JUDGE

ANDREW T. PEREZ ESQ.
PUBLIC GUARDIAN

INTAKE GENERAL INFORMATION SHEET [CONFIDENTIAL]

THIS FORM MUST BE THOROUGHLY COMPLETED. PLEASE PRINT OR TYPE.

<i>REFERRAL SOURCE</i>			
OPG Number:		Required Documents Checklist	
Referral Date:		<input type="checkbox"/> Gov. issued ID of Proposed Ward	
Referred By:		<input type="checkbox"/> Gov. issued ID of Proposed Guardian(s)	
Agency (if applicable):		<input type="checkbox"/> Guardianship Plan	
Contact Number:		<input type="checkbox"/> Medical Evaluation	
Email:		<input type="checkbox"/> Consent(s) from Family Members*	
Proposed Client Name:			
Client Status: <input type="checkbox"/> New <input type="checkbox"/> Active <input type="checkbox"/> Former Client		Client Type: <input type="checkbox"/> Elderly <input type="checkbox"/> Adult with Disability <input type="checkbox"/> Dual	
Reason for Referral: <input type="checkbox"/> No appropriate guardian available <input type="checkbox"/> No permanent placement <input type="checkbox"/> No family support			
<input type="checkbox"/> APS Referral – <i>Referral Date:</i>		<input type="checkbox"/> <i>Other (please specify):</i>	
Reason for Guardianship (Select all that apply)			
<input type="checkbox"/> Unable to manage personal care			
<input type="checkbox"/> Unable to manage finances due to cognitive or functional limitations			
<input type="checkbox"/> Unable to make personal decisions regarding safety, living arrangements, or daily care			
<input type="checkbox"/> Difficulty in managing healthcare needs independently			
<input type="checkbox"/> Memory or judgement impairments affecting informed decision-making			
<input type="checkbox"/> Vulnerability to exploitation, abuse, or neglect			
Brief Background:			
<i>PROPOSED WARD INFORMATION</i>			
Height:	Weight:	Eye Color:	Hair Color:
Date of Birth:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No:
Military Service: <input type="checkbox"/> Never served <input type="checkbox"/> Veteran		Branch:	Discharge Type:

Highest Level of Education Completed: <input type="checkbox"/> Elementary school <input type="checkbox"/> Middle school <input type="checkbox"/> Some high-school <input type="checkbox"/> High-school diploma or GED <input type="checkbox"/> Some college <input type="checkbox"/> College degree or higher				
Race: <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other (please specify):				
Ethnicity: <input type="checkbox"/> CHamoru <input type="checkbox"/> Filipino <input type="checkbox"/> Palauan <input type="checkbox"/> Chuukese <input type="checkbox"/> Other (please specify):				
Primary Language(s):		Preferred Language(s): <input type="checkbox"/> Interpreter required		
Occupation History:				
Mobility Status: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Uses Mobility Device(s) <input type="checkbox"/> Bedbound				
Mobility Device(s): <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> E-Scooter <input type="checkbox"/> Other (please specify):				
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Common-Law				
Spouse's Full Legal Name:				Age:
Date of Marriage:		Country/City of Marriage:		
Spouse's Home Address:				
Number of Marriages:		Former Spouse's Name:		
Separation/Divorce Date:			Former spouse deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No	
No. of Children:		<i>If Applicable, list name of children below.</i>		
Full Name	DOB	Age	Contact Number/Email	Home Address
Other Relatives				
Full Name	DOB	Age	Contact Number/Email	Home Address
Emergency Contact				
Full Name:				

Relationship:	Date of Birth:	Age:
Contact Number:	Email:	
Mailing Address:	Home Address:	
SEE PAGE 5 FOR MORE SPACE		
Daily Living Skills Assessment <i>(Select all activities the proposed ward can complete. If they can complete all listed, select "No known deficit")</i>		
Basic Activities of Daily Living	<input type="checkbox"/> eating <input type="checkbox"/> feeding <input type="checkbox"/> bathing <input type="checkbox"/> dressing <input type="checkbox"/> toileting <input type="checkbox"/> grooming <input type="checkbox"/> No known deficit	
Instrumental Activities of Daily Living	<input type="checkbox"/> meal preparation <input type="checkbox"/> housekeeping <input type="checkbox"/> shopping <input type="checkbox"/> personal finances <input type="checkbox"/> managing medications <input type="checkbox"/> arranging transport <input type="checkbox"/> telephone/internet use <input type="checkbox"/> No known deficit	
Residential/Placement Information		
Current Living Arrangement: <input type="checkbox"/> Private Residence (House/Apartment) <input type="checkbox"/> Residential Care Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Homeless <input type="checkbox"/> Other (please specify):		
Returning home? <input type="checkbox"/> Yes <input type="checkbox"/> No	With Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Placement Address:		
<i>If currently placed in a facility or hospital:</i>		
Hospital/Facility Name:	Date of Admission:	
Name of Social Worker:	Contact Number:	
Email Address:		
PROPOSED GUARDIAN'S INFORMATION		
Guardian's Full Name:		
Date of Birth:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Ward: <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other (please specify):		
Highest Level of Education Completed: <input type="checkbox"/> Elementary school <input type="checkbox"/> Middle school <input type="checkbox"/> Some high-school <input type="checkbox"/> High-school diploma or GED <input type="checkbox"/> Some college <input type="checkbox"/> College degree or higher		
Race: <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other (please specify):		
Ethnicity: <input type="checkbox"/> CHamoru <input type="checkbox"/> Filipino <input type="checkbox"/> Palauan <input type="checkbox"/> Chuukese <input type="checkbox"/> Other (please specify):		
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Other (please specify):		
Occupation:		

Primary Language(s):		Preferred Language(s): <input type="checkbox"/> <i>Interpreter required</i>	
Contact Number:		Email:	
Home Address:			
Mailing Address:			<input type="checkbox"/> <i>Same as Home</i>
Co-Guardian's Full Name:			
Date of Birth:		Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Ward: <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> <i>Other (please specify):</i>			
Highest Level of Education Completed: <input type="checkbox"/> Elementary school <input type="checkbox"/> Middle school <input type="checkbox"/> Some high-school <input type="checkbox"/> High-school diploma or GED <input type="checkbox"/> Some college <input type="checkbox"/> College degree or higher			
Race: <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> <i>Other (please specify):</i>			
Ethnicity: <input type="checkbox"/> CHamoru <input type="checkbox"/> Filipino <input type="checkbox"/> Palauan <input type="checkbox"/> Chuukese <input type="checkbox"/> <i>Other (please specify):</i>			
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> <i>Other (please specify):</i>			
Occupation:			
Primary Language(s):		Preferred Language(s): <input type="checkbox"/> <i>Interpreter required</i>	
Contact Number:		Email:	
Home Address:			
<input type="checkbox"/> <i>Same as Primary Guardian's Home Address</i>			
Mailing Address:			<input type="checkbox"/> <i>Same as Home</i>
<i>PROPOSED WARD'S FINANCIAL INFORMATION</i>			
Bank Accounts <i>(Select all that apply)</i>			
<input type="checkbox"/> Checking	Bank Name:	Account No:	
Co-Owner(s):		Balance: \$	
<input type="checkbox"/> Savings	Bank Name:	Account No:	
Co-Owner(s):		Balance: \$	
<input type="checkbox"/> Cert. of Deposit	Bank Name:	Account No:	
Co-Owner(s):		Balance: \$	
Loans			
<input type="checkbox"/> Personal	Bank Name:	Account No:	

Co-Owner(s):		Balance: \$	
<input type="checkbox"/> Mortgage	Bank Name:	Account No:	
Co-Owner(s):		Balance: \$	
Sources of Income (Select all that apply)			
<input type="checkbox"/> Pension	Amount: \$	<input type="checkbox"/> Social Security	Amount: \$
<input type="checkbox"/> Public Benefits-SNAP	Amount: \$	<input type="checkbox"/> Public Benefits-Cash	Amount: \$
<input type="checkbox"/> Sec. 8-Housing Voucher	Amount: \$	<input type="checkbox"/> Sec. 8-Utility Reimbursement	Amount: \$
<input type="checkbox"/> VA Pension	Amount: \$	<input type="checkbox"/> VA Disability	Amount: \$
<input type="checkbox"/> Other (please specify):			Amount: \$
Property and Assets (Select all that apply)			
<input type="checkbox"/> Real Estate	Address:		
Co-Owner(s):			
Value of estate: \$		<input type="checkbox"/> Building(s) on Property	<input type="checkbox"/> Deed of Gift
<input type="checkbox"/> Vehicle(s)	Make/Model/Year:		
Title Location:		Active/Current Driver:	
<input type="checkbox"/> Life Insurance	Company:		Value: \$
Name(s) of Beneficiary:			
<input type="checkbox"/> Safe Deposit Box	Amount: \$	Location/Contents:	
CURRENT LEGAL INSTRUMENTS			
<input type="checkbox"/> Will	Executor/Trustee:		Date Executed:
<input type="checkbox"/> Trust	Executor/Trustee:		Date Executed:
<input type="checkbox"/> POA	Type: <input type="checkbox"/> Durable <input type="checkbox"/> Non-Durable <input type="checkbox"/> Financial <input type="checkbox"/> Medical		Date Executed:
Agent of Attorney-in-fact:			
Contact Number:		Email:	
GENERAL HEALTH INFORMATION			
<input type="checkbox"/> Health Insurance	Company:		Policy No:
<input type="checkbox"/> Medicaid	Medicaid No:	<input type="checkbox"/> MIP	MIP No:
<input type="checkbox"/> Medicare	Part: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		Medicare No:
<input type="checkbox"/> VA/Tricare	Tricare No:	ID No:	
Primary Physician:		Clinic:	
Known Medications:			

Known Medical Conditions/Diagnoses:

USE THIS SECTION IF ADDITIONAL SPACE IS NEEDED.

Completed By:

Sign:

Date:

FOR OFFICIAL USE BY OPG PERSONNEL ONLY

NATURE OF CASE

- Petition for appointment of Public Guardian
- Assess and support appointment of guardian
- Pursue Court request or direction to assist or supervise guardian
- Provide advice, information, and guidance to persons who have been appointed as guardian
- Offer guidance and counsel to persons requesting assistance to encourage maximum self-reliance and independence, and consider less restrictive alternatives
 - * Hired/family caregiver home/community-based services Medical POA Rep. payee
 - Hired/family fiduciary Joint account Financial POA
- Case Not Opened

Brief Description of service(s) likely to be provided:

CLOSURE INFORMATION

Services provided:

Date Closed:

Referral To:

Referral Date:

OPG Staff:

Sign:

Date: