THE CORPORATION OF
GUARDIANSHIP

CLIENT INTAKE FORM

Date Services Started: _______________**Date Services Ended:** _________________

SERVICES:
☐ GUARDIAN OF THE PERSON
☐ TRUSTEE OF SPECIAL NEEDS TRUST
☐ FINANCIAL POA
☐ OTHER: ________________________________
☐ GUARDIAN OF THE ESTATE
☐ REPRESENTATIVE PAYEE
☐ HEALTHCARE POA

Please fill out every line. If the information does not apply, please indicate n/a.

THE BASICS

NAME OF PERSON COMPLETING THIS FORM:		RELATIONSHIP TO CLIENT:	
CLIENT'S FULL NAME:			
NICKNAME (if applicable):			
ADDRESS:			
CITY:	STATE:	ZIP:	COUNTY:
HOME PHONE:	CELL PHONE:	EMAIL:	
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:		
CLIENT LIVES: ☐ Independently at Home/Apt. ☐ Group Home ☐ With family ☐ Nursing Home ☐ Assisted Living ☐ Other (Specify: _________________)	HOW WAS THE CLIENT REFERRED TO CoG? ☐ Attorney (Name: ______________________________________) ☐ Other Professional (Name: ______________________________) ☐ Internet Search / Website ☐ Professional Conference / Community Presentation ☐ Other (Specify: ______________________________________)		

DOES CLIENT RECEIVE SECTION 8 HOUSING ASSISTANCE: ☐ Yes ☐ No ☐ Pending

CLIENT HAS A:
☐ Guardian of the Person - Name/Phone/Address: ______________________________
☐ Guardian of the Estate - Name/Phone/Address: ______________________________
☐ Financial Power-of-Attorney - Name/Phone/Address: ___________________________
☐ Healthcare Power-of-Attorney - Name/Phone/Address: __________________________
☐ Representative Payee - Name/Phone/Address: ______________________________
☐ Other Legal Representative - Specify: ____________________________________
☐ None. Client is his/her own responsible party

INCOME INFORMATION

Source of Income	Received? Yes / No / Pending *If Pending, Date of Application	Monthly Amount	Payee, if not beneficiary
Wages/Earnings Employer: ___________________________			
Supplemental Security Income (SSI)			
Social Security Disability (SSD)			
Social Security Retirement Benefits			
Social Security Spouse's Benefits			
Social Security Children's Benefits			
Temporary Assistance for Needy Families (TANF) – NC Work First			
Veterans Administration Benefits			
Food Stamps			
Worker's Compensation			
Child Support Child's Name:__________________________			
Alimony Former Spouse: ______________________			
Annuity: _________________________________			
Trust: ___________________________________			
Other Income: ___________________________			

ASSET INFORMATION

BANK ACCOUNTS

Bank Contact Information	Name on Account	Account Number & Type	Value

BROKERAGE ACCOUNTS

Brokerage Firm Contact Information	Name on Account	Account Number	Value

RETIREMENT ACCOUNTS

Plan Contact Information	Name on Account	Account Number	Value

LIFE INSURANCE

Insurance Company Contact Info	Policy Owner	Policy Number & Type	Value

REAL ESTATE

Property Location	Property Owner/Title	Type of Property	Value

OTHER ASSETS (EX: Personal Property, Business Interests, Etc…)

Please Describe:

FUNDING (For Special Needs Trust Clients Only)

ANTICIPATED AMOUNT OF INITIAL FUNDING: $____

SOURCE OF FUNDING:

☐ Annuity

☐ Personal Injury Settlement

☐ Inheritance

☐ Liquidation of Assets

☐ Social Security Back-Payment

☐ Other (Specify: _________________)

PRIMARY DISABILITY

What is the **PRIMARY** nature of the client's disability?

☐ Brain/Head Injury
☐ Cerebral Palsy
☐ Autism
☐ Intellectual/Developmental Disability
☐ Mental Illness
☐ Substance Abuse/Addiction
☐ Multiple Sclerosis
☐ Spinal Cord Injury
☐ Dementia/Alzheimer's Disease
☐ Other (Specify: ____)

Date of onset: ______________________

MEDICAL INFORMATION

Source of Coverage	**Received? Y / N**	**Name of Provider & Policy Number**	**Amount Client Pays Monthly (Premium, PML, Deductible)**
Medicaid			
Special Assistance			
Community Alternatives Program			
Medicare Part A			
Medicare Part B			
Medicare Part D			
Medicare Advantage			
Medicare Supplement			
Long-Term Care Insurance			
Other Health Insurance			

MEDICAL DIAGNOSES: ____

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PSYCHIATRIC DIAGNOSES: ____

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IS THERE ANY HISTORY OF VIOLENT OR CRIMINAL BEHAVIOR RELATED TO THE CLIENT THAT THE STAFF SHOULD BE AWARE OF? IF YES, EXPLAIN: ____

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SOCIAL INFORMATION

MARITAL STATUS:
☐ Single ☐ Married (Spouse's Name: ______________________) ☐ Separated ☐ Divorced ☐ Widowed
How Long? __________________________________

EDUCATION (Highest Grade Completed):

OCCUPATION (Current and/or Previous)

RELIGIOUS AFFILIATION:

MILITARY HISTORY:

ADVANCE DIRECTIVES: ☐ Living Will ☐ HCPOA ☐ DNR ☐ MOST ☐ Other: __________________________

BURIAL ARRANGEMENTS (Including name/contact info of funeral provider):

HOBBIES / INTERESTS:

CONTACTS

EMERGENCY CONTACT'S NAME:

RELATIONSHIP TO CLIENT:

ADDRESS (Street/City/State/Zip Code)

HOME PHONE:

CELL PHONE:

EMAIL ADDRESS:

OTHER KEY CONTACTS (NAME/ADDRESS/PHONE/EMAIL or N/A if Not Applicable):

FAMILY MEMBERS: ____

NEIGHBORS/FRIENDS: ____

PRIMARY CARE PHYSICIAN: ____

OTHER HEALTHCARE PROVIDERS: ____________________

FACILITY/AGENCIES: ____________________

CURRENT FINANCIAL INSTITUTION(S): ____________________

LEGAL: ____________________

OTHER: ____________________

ADDITIONAL INFORMATION

Please include any additional information that will help us to better serve the client.

CLIENT NAME:____________________