ARKANSAS DEPARTMENT OF HUMAN SERVICES
Office of the Public Guardian for Adults
PO Box 1437, Slot W-105
Little Rock, AR 72203

Fax 501-682-1483

Date received by OPGA: _____

REFERRAL FOR APPOINTMENT OF PUBLIC GUARDIAN

(* Required)

Personal Information for Proposed Ward:

*Full Name: _____

* Date of Birth: _____ *Place of Birth: _____

*Social Security No.: _____ (If possible, attach copy of birth certificate)

Proposed ward also known as: _____

Address: (If in a hospital or other treatment facility list the address prior to admission.)

_____

*Marital Status: _____ *Name of spouse: _____

*Address of spouse: _____

If spouse is deceased, date and place of death: _____

If now hospitalized or residing at a facility:

*Name and address of hospital or facility: _____

*Phone number: _____ *Date of admission: _____

*Reason for hospitalization or admission: _____

*Discharge Plan: _____

*Attending physician: _____

Address: _____ *Phone: _____

*PASSE Care Coordinator: _____ *Phone: _____

***Relatives:**

Name Relationship Address Phone

_____

_____

_____

_____

_____

_____

***Medical History:**

Recent Hospitalizations:

Where: _____ When: _____

Why: _____

Psychiatric Hospitalizations:

Where: _____ When: _____

Why: _____

Current Medications: _____

***Health Issues:**

____ Diabetes ____ High Blood pressure _____ High Cholesterol

____ COPD ____ Epilepsy/Seizures _____ Stroke

____ Hepatitis ____ Tuberculosis _____ HIV/AIDS

____ Cancer — Type: _____

History of Tobacco Abuse: ____ Yes ____ No Active use: _____ Yes ____ No

History of Alcohol Abuse: ____ Yes ____ No Active use: _____ Yes ____ No

History of Substance Abuse: ____ Yes ____ No Active use: _____ Yes ____ No

***Behavior History:**

Verbally aggressive	____ Yes	____ No	Disruptive	___ Yes	___ No
Physically aggressive	____ Yes	____ No	Destructive	___ Yes	___ No
Runs away	____ Yes	____ No	Steals	___ Yes	___ No
Noncompliant with medication	____ Yes	____ No	Fearful	___ Yes	___ No
Sexually inappropriate	____ Yes	____ No	Paranoid	___ Yes	___ No
Evicted from a facility	____ Yes	_____ No	When _____		

Facility name: _____

Reason for eviction: _____

Additional evictions: _____

***Criminal History:**

Has the proposed Ward been arrested: _____ No _____ Once _____ Multiple ____ Unknown

Has the proposed ward had a Felony Conviction: ____ No ____ Yes ____ Unknown

Charges: _____

_____

Date of conviction: _____ Was Ward incarcerated: ____ Yes ____ No

Place of incarceration: _____

***Income:**

Source	Amount
Social Security (Specify SSA/SSD/SSI, etc.)	_____
Veteran's Administration:	_____
Other Income Source:	_____

*Assets:

Bank Accounts:

Bank/Branch Acct. No Type (checking or savings) Balance Location of Checks and cards

_____

_____

_____

_____

_____

Safe deposit box? If yes give the name and location of the bank and the location of the Key.

_____

_____

List any other assets:

_____

_____

_____

_____

_____

_____

_____

_____

_____

*Real Property:

Address if ward owns home: _____

Address if ward rents home: _____

Does the proposed ward have an ownership interest in any land or houses? _____ If yes, is land or house(s) located outside of Arkansas state lines? _____

If yes, does anyone else also have ownership interest in the land and/or houses? _____
List the name and address of anyone sharing any ownership interest in any land or houses.

_____

_____

_____

_____

Is anyone living in any houses that the proposed ward has an ownership interest in? _____

If yes, please list the name, address, and an explanation of why they are living in the house.

_____

_____

_____

_____

_____

_____

*Liabilities:

Type of Debt: To whom the debt is owed and the amount.

_____

_____

_____

_____

*Health Insurance:

Medicare Claim No.: _____ Medicaid Claim No.: _____

PASSE Provider: _____ Other Health Insurance: _____

Govt. agencies providing services: _____

Has proposed ward executed an Advance Healthcare Directive (Living Will)? _____

If yes, please give location of directive and/or furnish a copy. _____

*Burial Information:

Does the proposed ward have a burial policy or prearranged burial plan? If yes, please provide a COPY of the plan or the location of it.
Does the proposed ward have a will? If so, where is the location of the will? _____

*Person making referral:

Name: _____ Agency: _____

How do you know the proposed ward? _____

Address: _____

Home/Cell Number: _____ Work Number: _____

Email: _____

Are you willing to come to court and testify? _____

Request for guardianship of: Person ____ OR Person and Estate ____

Reason for this type of guardianship: _____

_____

Does the proposed ward have a legal guardian now? _____

(If yes then attach a copy of the guardianship court order and any other court documents, as well as a letter from the Circuit Judge over the guardianship requesting that the Public Guardian intervene. The Public Guardian cannot proceed without the letter from the Judge)

Has the proposed ward had a legal guardian in the past? Yes_____ No_____

(If yes then attach a copy of the previous court documents if available)

If the answer to the previous question was yes, then why was the guardianship terminated?

_____

_____

_____

_____

_____

_____

Is there any family member, friend or any other person who may be willing to be the guardian of the proposed ward? Yes ____ No ____

If the answer to the previous question is no, please explain why you believe no family member or friend is willing to be guardian for the proposed ward and what efforts have been made to secure a private individual to be guardian.

_____

_____

_____

_____

_____

_____

_____

_____

***Reason for Referral:**

Provide an explanation as to why the proposed ward is "incapacitated," to the extent of lacking sufficient capacity to make essential decisions for their health, safety and/or finances. This could be due to reasons such as mental illness, mental deficiency, physical illness, chronic use of drugs, etc.

Be as specific as possible as the facts given will be the basis of the guardianship petition. Give a detailed history of behavior, including details of any acting out, violence, or other aberrance, and any history of arrests and/or convictions. Include a description of the proposed ward's day to day behavior

*Attach a complete social history
*Attach a complete medical history
*Attach a complete behavioral/psychological history

(Add additional sheets if necessary. Please note that if staff cannot read this section the referral will be returned for clarification.)

Signature: _____ Date: _____

Revised 7/01/2024

PHYSICIAN'S AFFIDAVIT

I, _____, after being first duly sworn under oath, state that:

1. I am a professional with expertise appropriate for the determining the patient's incapacity and disability because I am a physician, licensed psychologist, or licensed certified social worker with training, experience, and knowledge of the patient's disability. I am licensed in the State of Arkansas.

2. My contact information is as follows:

   Address: _____

   Telephone Number: _____

3. I have examined and performed an evaluation of _____ (patient) within the last six months, and conclude as follows:

4. The patient's medical and physical diagnoses are:

5. The patient's adaptive behaviors are:

6. The patient's intellectual functioning is:

7. The patient is impaired by reason of a disability to such an extent as to lack sufficient understanding or capacity to make, or communicate, decisions to meet the essential requirements for their health and safety, or to manage their estate. The specific disability is:

8. My recommendation as to the specific area(s) for which assistance is needed and the least restrictive alternatives available are:

9. The patient is not able to attend court for the following reasons:

Signature: _____ Date: _____

Printed Name: _____

FURTHER AFFIANT SAYETH NAUGHT.

SUBSCRIBED AND SWORN to before me, a notary public, on this ____ day of _____, 20____.

_____

Notary Public

My Commission Expires

_____