



**Lito Morillo - Director**  
**Public Guardian/Conservator**  
 5357 Truxtun Avenue  
 Bakersfield, CA 93309  
 (661) 868-1010; (661) 247-8401 FAX  
 PublicGuardian@kerncounty.com

## REFERRAL FOR PROBATE CONSERVATORSHIP INVESTIGATION

DATE: \_\_\_\_\_

REFERRAL MADE BY: \_\_\_\_\_ TITLE or RELATIONSHIP: \_\_\_\_\_

ADDRESS or AGENCY NAME / ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ PHONE 2: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

### CONFIDENTIAL INFORMATION

NAME: \_\_\_\_\_ ALIAS: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last, First Middle

RESIDENCE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Street, City

PLACEMENT: \_\_\_\_\_ TYPE OF FACILITY: \_\_\_\_\_  
Facility Name, Address

PHONE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ RACE: \_\_\_\_\_ GENDER: \_\_\_\_\_

PHONE 2: \_\_\_\_\_ BIRTHPLACE: \_\_\_\_\_ VETERAN?:  Y  N BRANCH: \_\_\_\_\_

MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  WIDOWED CITIZENSHIP: \_\_\_\_\_

PRIMARY LANGUAGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ EYE COLOR: \_\_\_\_\_ HAIR COLOR: \_\_\_\_\_

RELIGIOUS PREFERENCE: \_\_\_\_\_ DISTINGUISHING MARKS: \_\_\_\_\_

MOTHER'S MAIDEN NAME: \_\_\_\_\_ HIGHEST EDUCATION: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

SPOUSE'S NAME/ADDRESS: \_\_\_\_\_

### MEDICAL / SOCIAL INFORMATION

1. MEDICAL ISSUES / DIAGNOSES:

Check All That Apply:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Combative          | <input type="checkbox"/> Wanders             | <input type="checkbox"/> Incontinent          |
| <input type="checkbox"/> Uses Walker / Cane | <input type="checkbox"/> Uses Wheelchair     | <input type="checkbox"/> Uses Hearing Aids    |
| <input type="checkbox"/> Bedbound           | <input type="checkbox"/> Decubiti / Bedsores | <input type="checkbox"/> Sitter / Supervision |
| <input type="checkbox"/> Dentures           | <input type="checkbox"/> Glasses             | <input type="checkbox"/> Smokes               |
| <input type="checkbox"/> Has Animals        | <input type="checkbox"/> Homeless            | <input type="checkbox"/> Alcohol / Drug Use   |

2. MEDICATIONS / DOSAGES: (Please list all medications: use reverse side, if necessary)

Medication	Dosage	Treatment for ??	Medication	Dosage	Treatment for ??

3. PHYSICIANS / TREATMENT PROVIDERS:

Physician	Specialty	Address	Phone	Next Appointment

4. RELATIVES: LIST PARENTS, CHILDREN, SIBLINGS, GRANDPARENTS, AND GRANDCHILDREN  
(Identify if deceased. If no living relatives listed above, include all other relatives and close friends)

Relationship	Name	Address	Phone
Father			
Mother			

**FINANCIAL INFORMATION**

INSURANCE INFORMATION:  Medi-Cal  Medicare  VA  Private: \_\_\_\_\_  
(Check all that apply)

ESTATE PLANNING:  Power of Attorney  Trust  AHCD  POLST  Will **Attach copies, provide contacts, and location of documents:**  
(Check all that apply)

	Name	Address	Phone	Relationship	Location of Documents
Attorney in Fact					
Trustee					
Executor					

BURIAL ARRANGEMENTS:  Yes  No Location/Details: \_\_\_\_\_

INCOME & AMOUNT:

Source	Monthly Amount	Source	Monthly Amount	Source	Monthly Amount
SSI					
Social Security					
VA					

BANK ACCOUNTS / INVESTMENTS:

Institution Name / Address	Balance	Account #	Institution Name / Address	Balance	Account #

OTHER INCOME INFORMATION:

REAL PROPERTY:  None

Location / Address:		Mortgage Company / Address:		Balance Owed:	Mortgage Current?	
Mortgage Due Date:	Taxes Current?	Tax Amount:	Assessed Value:	Insurance Carrier:	Address	Phone
IF Property is rented, Tenants Name:		Rental Amount:	Who Collects Rent?			Current?
Liens:		Litigation:		Comments:		

PERSONAL PROPERTY:  Yes  No If yes, list and identify location below:

AUTOS / MOBILE HOMES:  None

TYPE	YEAR/MODEL	LOCATION	LICENSE	STATUS	PAYMENT	LOAN BALANCE

Loan Contact:

**BASIS FOR CONSERVATORSHIP**

check all that apply:

- Unable to provide properly for physical health, food, clothing, or shelter
- Substantially unable to manage personal financial resources
- Unable to resist fraud or undue influence

1. Why is Conservatorship **REQUIRED**?

2. Describe the crisis that lead to these issues:

3. How did you become aware of these issues?

4. How are this person's basic needs for medical care, food, clothing and shelter being met?

5. What health services have been provided to this person during the last year?

6. What social services have been provided to this individual during the last year?

7. What estate management or money management services have been provided to this person during this year?

8. In seeking assistance for this person, what other agencies have you contacted?

9. Does this person have a psychiatric history?

10. If Hospitalized, what is the discharge plan?

11. **HOSPITALS ONLY** - Please provide: \_\_ Admit Face Sheet \_\_ History & Physical \_\_ Psych Eval/Competency Info.  
\_\_ If Skilled Nursing Placement, proof of payment source, applications,

12. **SKILLED NURSING ONLY** - Please provide: \_\_ Admit Face Sheet \_\_ History & Physical \_\_ Psych-Social  
\_\_ Trust Fund Accounting \_\_ Correspondence Sent to Family re: Conservatorship Referral

Referring Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY AGING & ADULT SERVICES STAFF ONLY**

APS Supervisor (if from APS): \_\_\_\_\_ Date: \_\_\_\_\_

Referral received by: \_\_\_\_\_ Date: \_\_\_\_\_

Assigned to: \_\_\_\_\_ Date: \_\_\_\_\_

Response Level:  Priority  Standard