



Navajo County Public Fiduciary

Arizona Supreme Court License No. 20027



"Proudly Serving, Continuously Improving"

REFERRAL PACKET INFORMATION FOR FIDUCIARY SERVICES

Regarding a vulnerable adult, please consider contacting Adult Protective Service (APS) Hotline #1-877-767-2385 or complete an online APS report (<https://www.azdes.gov/forms.aspx>) prior to contacting the Public Fiduciary.

Effective January 01, 2012, the law has changed regarding guardian and/or conservator appointments. A.R.S. Article Three (A.R.S. §14-5303) and Article Four (§14-5401) outline the new requirements prior to the pursuit of a guardian and/or conservator appointment. Briefly below outlines what is needed prior to making a referral for Public Fiduciary services:

- A.R.S. §14-5303.B.7. Requests the reason why an appointment of a guardian or any other protective order is necessary.
- A.R.S. §14-5303.B.8. Requests a statement of what alternatives have been explored and why a limited OR guardian and/or conservator is not appropriate.
- A.R.S. §14-5404.B.7. Requests the reason why an appointment of a conservator or any other protective order is necessary.

Who typically refers to the Public Fiduciary: physicians, hospitals, nursing homes, attorneys, Adult Protective Services, private fiduciaries, Social Security Administration, Veteran's Administration, Arizona State Hospital, the public, social and community based organizations.

Keeping in line with the new Statutes, questions to ask prior to requesting Fiduciary services:

- Is guardianship the least restrictive approach to assist the individual on a day to day basis?
 - Is there supporting documentation showing what attempts were made to keep this individual in the least restrictive setting?
 - Is the person at physical risk in their current environment? If so, what.
 - Will the person suffer a financial loss if the assets are not protected?
 - Where/how does the family/friends fit into the individuals life?
 - Do you have family/friend contact information?
 - Does the individual require alternative placement, if yes what.
 - What is the payer source for the potential placement?
 - What actions have been taken prior to the referral to the Public Fiduciary?
 - **The Public Fiduciary does not subsidize individuals needing placement**
 - Is the Public Fiduciary the last resort for the individual?
 - What is the expectation from the referring agency of the Public Fiduciary in the individual's life?

Once it is documented and determined the Public Fiduciary services are in need, please follow and submit the requested information:

- A phone call with the Public Fiduciary with a verbal referral
 - Schedule a meeting with the Fiduciary with the potential ward, referring party and/or interested parties
 - An application/referral form—(consisting of two pages). *In order for the fiduciary to consider a referral for guardian and/or conservator (GC), payee services, the personal information on the prospective ward is necessary. Complete the form to the best of your ability.*
 - Medical Reports/Record(s)—a physician, nurse, mental health expert can complete the form(s).
 - Written request—A letter accompanying the application and/or medical report summarizing:
 - Synopsis of the reason why an appointment of a guardian or any other protective order is necessary.
 - A statement of what alternatives have been explored and why a limited or guardian and/or conservator is appropriate for the Public Fiduciary.
 - Declination Letters from appropriate family members needs to be sent also
 - Reflect the reason why an appointment of a conservator or any other protective order is necessary.

The Public Fiduciary will remain in contact until a resolve can be found to serve the individual in question.

ALL INFORMATION RECEIVED REGARDING A REFERRED INDIVIDUAL IS CONFIDENTIAL



NAVAJO COUNTY PUBLIC FIDUCIARY

100 Code Talker's Drive, P.O. Box 668, Holbrook, Arizona 86025
Phone #928-524-4353 / Fax #928-524-4359 / Attn: Intake Dept.



REFERRAL INTAKE INFORMATION

Type of Case:

- Guardian Only
- Guardian/Conservator
- Conservator Only

Required attachments to this completed form are:

- Physician's Statement (**Original Needed**)
- Case History/Assessments/Medical Info
- Statement of declination from family

This referral will not be considered without proof of residence in U.S.A. by attaching (at least two) of the following:

- | | |
|--|---|
| <input type="checkbox"/> Driver's License with Photo | <input type="checkbox"/> State Identification Card with Photo |
| <input type="checkbox"/> U.S. Passport or Foreign Passport With U.S. Visa | <input type="checkbox"/> U.S. Citizenship and Immigration Services Employment Authorization Document or Refugee Travel Document |
| <input type="checkbox"/> Copy of Birth Certificate | <input type="checkbox"/> U.S. Certified of Naturalization or Citizenship |
| <input type="checkbox"/> Tribal Certificate of Indian Blood or Indian Affairs Affidavit of Birth | |

Referral Agency _____

Referral Agency Address/Phone: _____

Name of Potential Ward: _____ SSN: _____ Sex: _____ Race _____

Home Address: _____ Religion: _____

Current Address: _____ Phone: _____

Is this ward's residence Home or Apartment Group Home: _____

Name of Home

Contact Person

Other (describe): _____

Number of years of County Residency _____ U.S. Citizen: Yes No **Attach Proof**

Alien Status _____ Country _____ Date of Birth: _____

Place of Birth _____
County City State

Language Barrier: Yes No Number of Years of Formal Education _____

Marital Status _____ Name of Spouse _____

Current Address of Spouse: _____

Is the ward or spouse a Veteran: _____ If yes, what branch of service: _____ Discharge date: _____

To what extent does spouse demand on potential ward's fund for support? _____

Relative or Friends: List in Order: Parents, Adult Children, Next of Kin, Persons Having Care of Custody, and Friends. Indicate if Deceased. **Statement of inability or unwillingness to serve, or evidence of notification thereof, must accompany this form.** (If more room needed, attach separate sheet of paper.)

Name	Address (City, State & Zip)	Phone	Relationship

Does Person have a Will? Yes _____ No _____ Location _____
 Does Person have Burial Arrangements? Yes _____ No _____ Location _____
 Does person have a Living Will? Yes _____ No _____ Location _____
 Does person have Power at Attorney? Yes _____ No _____ Location _____
 Does person have Medical Power of Attorney? Yes _____ No _____ Location _____
 Does person have Medical Advance Directives? Yes _____ No _____ Location _____
 Does Person have Life Insurance? Yes _____ No _____ Location _____

If yes:

Company	Policy #	Beneficiary	Location	Cash Surrender Value

MEDICAL INSURANCE (Including Medicare-give number and indicate Parts A and/or B and/or D, also date coverage began); copies of cards will be accepted.

Company	Policy #	Location

Attach Physician's Statement from: _____
 (Name)

 (Address) (Phone)

Attached Case History Report from: _____
 (Name)

 (Address) (Phone)

FINANCIAL INFORMATION ON POTENTIAL WARD

Source	Account #	Amount	Payable: Monthly; Quarterly; Annually	Payee or Source
Social Security				
SSI				
Veterans Administration				
Civil Service				
Pension or Annuities				
Other				

BANK ACCOUNTS

Checking	Location (Name & Branch)	Account # and Name	Amount
Savings (Include Credit Unions)			
Investment Accounts			

Safe Deposit Box

Bank Branch (Name and Location)	Box #	Location of Keys
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STOCKS, BONDS AND OTHER SECURITIES INCLUDING GOVERNMENT SECURITIES

Name of Investment Account	Location	Account #	Amount

REAL PROPERTY

Property #1

Street Address: _____

Parcel No. and/or Legal Description: _____

Filed in the Name(s) of: _____

Mortgage: _____ Insured By: _____

Local Agent: _____ Policy #: _____

Value of Property in Dollars (per Assessor's records):\$ _____

Property #2

Street Address: _____

Parcel No. and/or Legal Description: _____

Filed in the Name(s) of: _____

Mortgage: _____ Insured By: _____

Local Agent: _____ Policy #: _____

Value of Property in Dollars (per Assessor's records):\$ _____

CARS, TRAILERS AND/OR OTHER VEHICLES

Make and Model	Title in Name(s) Of	Title No.	Location of Title and Vehicle
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Insurance with: _____ Policy No: _____

Liens: _____

Other necessary information: _____

THIS FORM MUST BE ACCOMPANIED BY A PHYSICIAN'S STATEMENT OR IT WILL BE RETURNED.

Referral Submitted by: _____
Signature

Print Name and Title: _____

Agency: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Date: _____

**May use company stamp here:*

LETTER OF ACCEPTANCE - DECLINATION

I, the undersigned [relative/nominee] of _____, agree that the proposed ward's physical, medical or mental condition warrants the appointment of a Guardian and/or conservator. I understand that a Guardian makes decisions involving the PERSON, like those that a parent makes for a child. I understand that a Conservator makes financial decisions and handles money.

The Arizona State Law, ARS § 14-5311, designates that a certain relatives and nominees have priority to serve as Guardian/Conservator. The Public Fiduciary, pursuant to ARS § 14-5206.A, will be appointed by the Court only if there is no other, relative or nominee able to serve.

(Please sign only one if you are willing to serve, or declining/unable to serve at this time)

ACCEPTANCE: I am able to assume the duties of Guardian/Conservator; I will contact the Public Fiduciary and begin proceeding to have myself appointed in that capacity.

I am willing to serve as Guardian/Conservator:

Signature _____ Date _____

Address _____

Telephone _____ Relationship _____

DECLINATION: I care about the proposed ward and I am concerned about his/her welfare, I am unable to serve as Guardian/Conservator at this time. I agree that Guardian/Conservatorship is necessary. I would like the Navajo County Public Fiduciary to legally proceed to become appointed Guardian/Conservator by the Probate Court. If at any time I become able to assume the duties of Guardian/Conservator, I will contact the Public Fiduciary and begin proceedings to have myself appointed in that capacity.

I further agree that I will not serve as payee for any entitlements, such as: Social Security, retirement, or other pension or disability benefits accruing to my relative referred to above, and hereby waive my right to serve as such during the term of this Guardian and Conservatorship.

***I UNDERSTAND THAT UPON APPOINTMENT OF THE PUBLIC FIDUCIARY ALL EXISTING POWER OF ATTORNEY(S) MAY BE REVOKED, IF IN THE BEST INTEREST OF THE PROPOSED WARD.**

I am declining to serve as Guardian/Conservator at this time:

Signature _____ Date _____

Address _____

Telephone _____ Relationship _____

*Does not normally include living wills or similar instruments.

REPORT OF PHYSICIAN AND/OR PSYCHOLOGIST/PSYCHIATRIST/REGISTERED NURSE

Name: _____

CASE NO: S-0900-_____

INSTRUCTIONS TO PHYSICIAN: The individual named above has a guardian and/or conservator. Before the court grants continuation of the guardian and/or conservatorship, the court must decide if mental, physical, or other cause exists which necessitates a guardianship and/or conservatorship. "Pursuant to A.R.S. 14-5303(C) this document may only be signed by a licensed physician, psychologist, or registered nurse." Therefore, the court needs to know what you, as the physician for the person, think about the person's health, whether the person needs inpatient mental health treatment, and whether the person's driving privileges should be suspended. The court's goal is to do all that is possible to help the person about whom this case involves to live as fully as his or her mental or physical impairments allow. Your time is valuable, and our office has developed the following questions to make it easier for you to prepare your report. If you want to use some other format to submit your report, please feel free to do that too, so long as you provide the same type of information the court needs. If the Petitioner is seeking the authority to consent to inpatient mental health treatment, this report must be signed by a licensed psychiatrist or psychologist. After you complete the report, give the original report to the Petitioner and he or she will see to it that the report is submitted to the court as a confidential document. Please do not file your report with the Clerk of the Court. PLEASE DATE AND SIGN YOUR REPORT. THANK YOU FOR YOUR TIME AND ASSISTANCE.

QUESTIONS FOR PHYSICIAN TO ANSWER:

- 1. _____ [physician] [psychiatrist/psychologist] [registered nurse] (circle one);
2. How long have you been his or her medical provider? _____ [days] [weeks] [months] [years] (circle one)
3. What is the date you last saw your patient: _____
4. Does the person appear to be having difficulty in any other the following areas? (check all that applies)
Mental disorder
Physical illness
Chronic intoxication or drug use
Cognitive abilities
Anything else _____
5. Specify the nature of illness, disorder, etc. (include person's diagnosis) _____
6. Has the person been treated or hospitalized before for this diagnosis? Yes No Unknown
If yes, when and where? _____
7. Is it the opinion of the undersigned that the patient is currently in need of inpatient mental health care and treatment? Yes No (For the purpose of this question, the term "currently" means, based upon the medical professional's experience and training, and to a degree of medical probability, that the patient does now or will within a reasonably imminent, immediate or within 12 months time require inpatient mental health treatment.) If yes, please explain your position: _____
8. If the person is currently on medications, please list them: _____
9. Do you believe the person's condition could improve within 6 months to a year? Yes No

10. Is the person able to do the following things? *If the person is able, please check each applicable box.*

- Perform daily self-help skills
- Take medication appropriately
- Live alone
- Make appropriate judgments that will protect him or her personally, physically, or financially.
- Drive a motor vehicle

If you believe the person is still able to drive a motor vehicle, but is in need of the assistance of a guardian, please explain why the person should be allowed to keep driving: _____

11. Where do you think the person should live today?

- At home with assistance (if possible)
- In a group home
- In a supervisory care facility
- In a nursing home
- In a hospital
- In a level one behavioral health care facility for inpatient mental health treatment. Explain: _____

12. Does the patient [**need**] or if the patient [**already**] has a guardian/conservator, should it be considered and/or continued:

- | | | |
|-----------------|------------------------------|-----------------------------|
| Guardianship | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Conservatorship | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

13. Is there any reason the patient should not personally appear in court? Yes No If "yes", please briefly explain: _____

14. Please make any additional comments or suggestions you feel would be valuable to the court: _____

DATE: _____

Signature _____

Printed name: _____

Address: _____

Telephone: _____

Please return this completed form to:

NAVAJO COUNTY PUBLIC FIDUCIARY
P.O. Box 668 – NC# 09
Holbrook, Arizona 86025
Phn: 928-524-4353 Fax: 928-524-4359
Email: pub.fiduciary@navajocountyaz.gov