AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Referral to Home & Community Service Division for Identification of Certified Professional Guardian/ Conservator

NOTE: SUBMIT THIS REFERRAL FORM TO REQUEST INCLUSION INTO THE HCS GUARDIANSHIP PILOT PROJECT. COMPLETED FORMS SHOULD BE SUBMITTED TO THE ASSIGNED HCS CASE MANAGER, OR TO THE DESIGNATED REGIONAL CONTACT PERSON IF THE CLIENT IS NOT ASSIGNED AT THE TIME OF REFERRAL. DESIGNATED REGIONAL CONTACT INFORMATION MAY BE OBTAINED AT: Acute Care Hospitals | DSHS (wa.gov)

I.	GENERAL INFORMATION COMPLETED BY HOSPITAL STAFF	
1.1	Hospital Name:	
	Address:	
	Contact name:	
	Telephone number:	E-mail Address:
1.2	DSHS/HCS Hospital Case Manager assigned to client/Respondent: Name:	Region:
	Address:	
	Telephone number:	
1.3	Client Name:	
	Age / Date of birth:	Social Security Number:
	Address:	
	Mailing address, if different:	
	Telephone number:	Preferred Region to Discharge:
1.4	Does the respondent have a current payee? ☐ Yes ☐ No Individual's name:	Relationship:
	Name of corporation:	Contact person:
	Address:	
	Mailing address, if different:	
	Telephone number:	

1.5	Does the client have any of the following diagnoses (check all that apply): ☐ Dementia ☐ Alzheimer's ☐ Traumatic Brain Injury ☐ Parkinson's ☐ Huntington's ☐ Stroke (CVA or TIA)
	Medicaid Status: Is this client actively on Medicaid Long-Term Support and Services benefits ☐ Yes ☐ No If not, has a long-term care application been submitted prior to this referral? ☐ Yes ☐ No; Date of submission: _________ and tracking number: _________________. Has the hospital submitted an HCS Referral for CARE Assessment? ☐ Yes ☐ No
	Is there a professional or lay guardian/conservator available to serve: ☐ Yes ☐ No
	List the names of all Certified Professional Guardians and Conservators (CPGCs) and lay guardian candidates (family and friends) that your hospital has contacted:
	Has the hospital submitted the statewide ListServ referral: ☐ Yes ☐ No • If yes, date hospital submitted ListServ referral to Office of Public Guardians: • If no, hospital to submit ListServ referral and wait the designated 14 day period prior to making this referral. ListServ referral form may be accessed at: http://www.courts.wa.gov/content/publicUpload/Office%20of%20Public%20Guardianship/OPG%20FRMReferral%20Fill%20in%20Form.pdf
1.6	**SUBMITTED BY:** Hospital Staff Signature: **Date:** Hospital Staff Printed Name:
II.	**FOR COMPLETION BY DSHS REPRESENTATIVE (*completed by GPM*)**
2.1	**Date Hospital Request Received:**
	Request Approved or Declined: ☐ Yes ☐ No Determination Date:

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	Date Request was submitted to contracted CPGCs:
	Date contracted CPGC was identified:
	Date contracted CPGC-Client visit completed:
	Date contracted CPGC accepted nomination:
	Date contracted CPGC was appointed by court:
	Contractor Name:
	Contractor Address:
	Mailing Address, if different:
	Contractor Email Address:
	Contractor Telephone number:
III.	**ASSIGNED GUARDIANSHIP CASE MANAGER:**
3.1	**GCM Name:** **Region:**
	GCM Email Address:
	Anticipated Transfer Between Regions: ☐ Yes ☐ No If yes, explain: