

Guardianship Program  
**Contractor Referral**

Adult Protective Services (APS) Referral Date		APS Worker's Name		APS Telephone No. (include area code)	
Name of Proposed Ward			Social Security No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Proposed Ward's County of Residence			GOLD No.		
Ethnicity <input type="checkbox"/> Anglo <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Other			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		
DADS Contact Person			DADS Contact Telephone No. (include area code)		
DADS Regional Office <input type="checkbox"/> Region 01 - El Paso <input type="checkbox"/> Region 02 - Abilene <input type="checkbox"/> Region 03 - Dallas <input type="checkbox"/> Region 04 - Longview <input type="checkbox"/> Region 05 - Beaumont <input type="checkbox"/> Region 06 - Houston <input type="checkbox"/> Region 07 - Austin <input type="checkbox"/> Region 08 - San Antonio <input type="checkbox"/> Region 09 - San Angelo <input type="checkbox"/> Region 10 - El Paso <input type="checkbox"/> Region 11 - Harlingen					
Referred to the Following Agency			Date Referral Sent to the Contractor		
Guardianship Type <input type="checkbox"/> Person Only <input type="checkbox"/> Estate Only <input type="checkbox"/> Person and Estate					
Is This a Successor Guardianship? <input type="checkbox"/> Yes <input type="checkbox"/> No If a successor guardianship, please explain:					
Current Address of Proposed Ward			Proposed Ward's Telephone No. (include area code)		
Residence Type <input type="checkbox"/> Assisted Living <input type="checkbox"/> Foster Care <input type="checkbox"/> Friends/Relatives <input type="checkbox"/> HCS <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> ICF/IID <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Personal Residence <input type="checkbox"/> State Hospital <input type="checkbox"/> State Supported Living Center <input type="checkbox"/> Treatment Center <input type="checkbox"/> Other (specify):					
Proposed Ward's Spouse's Name			Proposed Ward's Spouse's Telephone No. (include area code)		
Names and telephone numbers of any collateral contacts for potential ward (for example, friends, clergy, etc.)					
Brief description of why guardianship is necessary for proposed ward (include any medical diagnoses, if pertinent)					
List all sources, amounts and frequency of income for the potential ward					
<b>Source</b>		<b>Amount</b>		<b>Frequency</b>	

I, \_\_\_\_\_, hereby  accept  decline this referral from DADS on \_\_\_\_\_ Date  
 Contractor signatory's or designee (printed) name

\_\_\_\_\_  
Signature - Contractor Signatory

\_\_\_\_\_  
Date