



PROGRAM OVERVIEW & REFERRAL GUIDELINES

Southern Indiana Adult Guardianship Services (SIAGS) is a nonprofit organization operating a Volunteer Advocates for Seniors and Incapacitated Adults (VASIA) guardianship program. SIAGS may be appointed by the Court to serve as guardian for incapacitated adults when no willing, capable, and appropriate person is available to serve.

Guardianship is a significant legal intervention that removes certain rights from an individual and should be considered only when less restrictive alternatives are unavailable or insufficient to adequately protect the person. SIAGS supports decision-making in the least restrictive manner possible while promoting the individual's rights, preferences, safety, and well-being. As a limited-capacity guardianship program, SIAGS prioritizes referrals involving urgent health, safety, medical, financial, or placement concerns requiring timely decision-making or protective intervention.

SIAGS GENERALLY CONSIDERS REFERRALS WHEN:

- The individual is age 18 or older
- The individual appears to meet Indiana's legal standard for incapacity
- Less restrictive alternatives have been explored and determined to be unavailable, inappropriate, or insufficient
- No willing, capable, and appropriate family member, agent, surrogate, or other support is available to serve
- A physician medical report or supporting clinical documentation is available or can reasonably be obtained
- The individual is unable to safely meet essential needs without substantial support, supervision, or intervention
- A significant health, safety, medical, financial, or placement concern exists
- Reasonable efforts have been made to identify and contact family members and other possible supports
- The individual resides within SIAGS service area or otherwise meets jurisdictional requirements
- A completed SIAGS referral form has been submitted

PRIORITY REFERRAL SITUATIONS INCLUDE:

- Immediate medical consent or treatment decisions
- End-of-life, hospice, POST, or code-status decisions
- Hospital discharge delays due to lack of decision-maker
- APS involvement with immediate safety concerns
- Unsafe living conditions or placement instability
- Significant exploitation, neglect, or self-neglect concerns
- Individuals at risk of harm due to inability to make or communicate informed decisions
- Urgent need for protective placement or supervision

SIAGS MAY DECLINE, DEFER, OR REDIRECT REFERRALS WHEN:

- The situation is stable, and no urgent decision-making need exists
- Appropriate family, POA, health care representative, or other surrogate is available

- Less restrictive alternatives have not yet been attempted
- The referral is primarily for case management, placement assistance, or long-term planning without a need for legally authorized substitute decision-making
- The primary concern relates to facility payment, insurance, or financial reimbursement without guardianship necessity
- Guardianship does not appear to be the least restrictive option
- The referral falls outside program scope, jurisdiction, or current program capacity *Submission of a referral does not guarantee acceptance into SIAGS program. Referrals are reviewed individually based on urgency, appropriateness, available alternatives, jurisdiction, and program capacity.

REQUIRED DOCUMENTS

Please submit the following with the referral whenever available:

- Completed SIAGS Referral Form
- Completed Physician Medical Report
- Admission notes or discharge information, if applicable
- APS information, if applicable
- Relevant medical, social work, or facility documentation
- Copies of any available advance directives, POA documents, guardianship papers, or other legal documents

REFERRAL FOR GUARDIANSHIP SERVICES

Section 1: Referral Source

Date: _____

Person/Agency Referring to SIAGS: _____

Relationship to Client: _____

Phone: _____ Email: _____

Section 2: Urgent Need and Reason for Referral

Describe the urgent decision or immediate concern requiring guardianship review

What will happen if no decision is made promptly?

☐ Health/Safety Crisis

☐ No Decision - Maker Available

☐ Hospital Discharge Delay Check

all that apply:

☐ Unsafe Environment / Placement Instability

☐ Cognitive Impairment

☐ Financial Exploitation Risk

☐ Homelessness / Eviction Risk



1490 W. Main Street, Mitchell, IN 47446

(812) 675-4166

Fax: (812) 541-1585

www.sia.gs.net

☐ End-of-Life / Medical Consent Urgency
☐ APS Involvement
☐ Other: _____

Section 3: Client Information

Name: _____
DOB: _____ Place of Birth: _____
Current Location / Facility: _____
Admission Date: _____
Home Address (if different): _____

Previous Address, if known: _____
U.S. Citizen: ☐ Yes ☐ No ☐ Unknown
Sex: _____ Race: _____
Social Security Number: _____

Medicare #: _____ Medicaid ID: _____ Is the individual currently in a 24/7 supervised setting? ☐ Yes ☐ No If no, explain why 24/7 supervised care is needed:

Circumstances requiring admission or current placement:

Section 4: Capacity and Communication

Has a physician completed a medical report? ☐ Yes ☐ No
Describe the client's disability, incapacity, or decision-making impairment:

Describe the client's ability to communicate with others and express preferences:

Advance Directives / Code Status:

☐ Full Code ☐ DNR / No Code ☐ Living Will ☐ POST Completed ☐ Unknown Any immediate medical concerns needing attention?

Section 5: Family, Friends, and Other Possible Supports

List all known relatives, friends, and other people who may need notice or who may be possible supports.



1490 W. Main Street, Mitchell, IN 47446

(812) 675-4166

Fax: (812) 541-1585

www.siags.net

Marital Information

Marital Status: _____

Spouse's Name: _____

Parents

Mother Living? ☐ Yes ☐ No ☐ Unknown

Mother's Name / Maiden Name: _____

Address: _____

Father Living? ☐ Yes ☐ No ☐ Unknown

Father's Name: _____

Address: _____

Children

Name: _____ Address / Phone: _____

Name: _____ Address / Phone: _____

Name: _____ Address / Phone: _____

Name: _____ Address / Phone: _____

Siblings

Name: _____ Address / Phone: _____

Name: _____ Address / Phone: _____

Name: _____ Address / Phone: _____

Name: _____ Address / Phone: _____

Other Family / Friends / Supports

Name: _____ Relationship: _____ Address / Phone: _____

Name: _____ Relationship: _____ Address / Phone: _____

Name: _____ Relationship: _____ Address / Phone: _____

Name: _____ Relationship: _____ Address / Phone: _____

Describe efforts made to contact family, friends, or other possible decision-makers:

Is there anyone who could potentially serve?

☐ No known option

☐ Yes, but unwilling

☐ Yes, but not appropriate

☐ Yes, but unavailable / cannot be located Explain:



1490 W. Main Street, Mitchell, IN 47446

(812) 675-4166

Fax: (812) 541-1585

www.siags.net

Section 6: Legal Information

Is there currently a legal guardian, Power of Attorney, health care representative, or other advocate?

☐ Yes ☐ No ☐ Unknown

If yes, explain: _____

Does the client have a will? ☐ Yes ☐ No ☐ Unknown

Name of Will Holder: _____

Does the client have any pending legal action or court deadlines? ☐ Yes ☐ No ☐ Unknown If yes, explain: _____ Less restrictive

alternatives considered:

☐ POA ☐ Health Care Representative ☐ Representative Payee ☐ Supported Decision-Making ☐ Case Management / Community Support ☐ Other: _____ Why were those alternatives not available or not sufficient?

Section 7: Financial Information Income

Source: _____ Amount: \$ _____

Source: _____ Amount: \$ _____

Source: _____ Amount: \$ _____

Financial Risk / Urgent Concerns

☐ Suspected exploitation

☐ Unpaid bills / utilities at risk

☐ No access to funds

☐ Benefits issue

☐ Other: _____

Explain any immediate financial concern:

Known Assets (if known)

Bank / Financial Institution: _____

Checking: _____ Savings: _____

Money Market / CD / Stocks / Bonds / Other: _____

Online Assets / Other Known Financial Information:

Section 8: Insurance and Medical Providers

Medicare: ☐ Yes ☐ No Part: _____

Medicaid: ☐ Yes ☐ No Caseworker: _____ Phone: _____

Other Insurance: _____

Primary Care Physician: _____

Eye Doctor: _____



1490 W. Main Street, Mitchell, IN 47446

(812) 675-4166

Fax: (812) 541-1585

www.siaags.net

Dentist: _____

Psychiatrist / Behavioral Health Provider: _____

Current Diagnoses: _____

Section 9: Property and Other Assets (if known) Vehicles

Vehicle 1: Make _____ Model _____ Year _____ Currently Owned? ☐ Yes ☐ No

Vehicle 2: Make _____ Model _____ Year _____ Currently Owned? ☐ Yes ☐ No

Real Estate

Property Location: _____

Currently Owned? ☐ Yes ☐ No Jointly Owned? ☐ Yes ☐ No **Other Assets**

Life Insurance

Company: _____ Policy #: _____

Beneficiary: _____

Funeral / Burial Arrangements

Funeral Home / Cemetery / Prepaid Plan Information: _____

Section 10: Other Information

Religious Preference: _____ Church

Preference: _____

Military Service: ☐ No ☐ Yes Branch: _____

Discharge: _____ Education: _____

☐ 8th Grade or Less ☐ 12th Grade or Less ☐ High School Graduate ☐ College

Graduate ☐ Unknown Additional Notes: _____



1490 W. Main Street, Mitchell, IN 47446

(812) 675-4166

Fax: (812) 541-1585

www.siags.net

To Physicians:

You are being asked to complete a medical report for an individual believed to be impaired in decision-making and who may require a legal guardian. Guardianship is a legal process in which a court appoints a substitute decision-maker for someone unable to make essential decisions for themselves. The court must find, based on clear and convincing evidence, that the individual is incapable of managing personal, medical, or financial affairs.

Guardianship should be considered only when there is clear evidence that the person meets the legal definition of an incapacitated person under Indiana law and when less restrictive alternatives are not sufficient.

Guardianship decisions are not based on whether a person's choices seem unwise, but on whether the person can understand relevant information, appreciate likely consequences, and communicate choices in a meaningful way.

When answering the questions below, please consider whether the individual:

- Understands their current living situation, medical condition, and services being provided
- Understands the activities needed to meet daily care and safety needs
- Recognizes limitations and can seek help appropriately
- Has capacity that fluctuates over time
- Can communicate decisions when needed

Your input is essential to the court's determination.

STATE OF INDIANA
IN THE _____ CIRCUIT / SUPERIOR COURT
COUNTY OF _____
CAUSE NO: _____ IN THE MATTER OF
THE GUARDIANSHIP OF:

PHYSICIAN'S REPORT

Note: This report will accompany the petition for guardianship and should be based on examination(s) completed within 6 months of filing the petition.

Date of Examination: _____

Name of Alleged Incapacitated Person: _____

Sex: _____ Age: _____

Address: _____

1. Known medical history and findings

Include functional, neurological, psychiatric, and other relevant history. Attach additional sheets if necessary.

2. Pertinent evaluations

Date: _____

[] Complete medical examination

- ☐ Mental status examination
☐ Neurological testing for organic brain disorder or damage ☐
 Psychiatric or psychological testing ☐ Other:

3. Diagnoses

4. Please rank the person's ability to make decisions in each area below

Use a scale of **1 to 5**, where **1 = cannot make decisions** and **5 = fully able to make decisions**.

Area	1	2	3	4	5	Capacity Varies (Y/N)	Insufficient Information
Personal Safety	☐	☐	☐	☐	☐	_____	☐
Nutrition	☐	☐	☐	☐	☐	_____	☐
Clothing	☐	☐	☐	☐	☐	_____	☐
Personal Hygiene	☐	☐	☐	☐	☐	_____	☐
Healthcare	☐	☐	☐	☐	☐	_____	☐
Day-to-Day Finances	☐	☐	☐	☐	☐	_____	☐
Property / Investments	☐	☐	☐	☐	☐	_____	☐

5. Can the person communicate decisions in the areas listed above? Explain.

6 . Does the person's ability to communicate decisions vary over time? Explain.

7 . Summarize the prognosis for recovery or improvement.

8. What interventions are necessary to achieve recovery or improvement in decision - making ability?

9. Do any of the following conditions affect the person's capacity to make or communicate decisions regarding care, medical needs, or finances?

- ☐ Hearing loss
☐ Vision loss
☐ Malnutrition
☐ Medication-related reaction
☐ Delirium
☐ Depression or other treatable mental disorder
☐ Dementia
☐ Intellectual / developmental disability
☐ Receptive or expressive speech impairment



1490 W. Main Street, Mitchell, IN 47446

(812) 675-4166

Fax: (812) 541-1585

www.siags.net

- ☐ Stroke
☐ Traumatic brain injury
☐ Other: _____
☐ Do not have enough information

10. Has a POST form been completed?

- ☐ Yes ☐ No ☐ Unknown

11. Social / Cultural Context

- ☐ Level of education affects understanding or essential life skills
☐ Limited life experience or opportunities for social interaction
☐ Language barrier
☐ Lack of awareness about community resources
☐ Other: _____

12. Additional information helpful to the court

13. Are there interventions that would remediate the effects of the factors above?

14. Based on this examination, summarize the person's medical, functional, neurological, or psychiatric status. Include comments on the duration and course of disease as appropriate.

15. Would it be detrimental for the alleged incapacitated person to appear in Court? ☐ Yes ☐ No If yes, explain:

I affirm under the penalties of perjury that the foregoing representations are true. Licensed Physician (MD/DO) Name (must be licensed in the State of Indiana):

Licensed Physician Signature (MD/DO):

Indiana Medical License Number: _____

Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Other professionals who performed evaluations upon which this report is based:

Name: _____



1490 W. Main Street, Mitchell, IN 47446

(812) 675-4166

Fax: (812) 541-1585

www.siags.net

Signature: _____

Profession: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

16. Names of people who provided information used in making this assessment
