

ST. JAMES COMMUNITY SERVICE SOCIETY

Adult Guardianship Program

CLIENT PROFILE

Client _____ Date of referral _____

TYPE OF AUTHORITY

Pension Management Contract Involuntary Pension Management Joint Trust

DOB _____ / _____ / _____ Place of Birth _____
(month / day / year) (city / province / country)

SIN _____ Gender: Male Female Other _____

Living Status: Common-law / Single / Widowed / Divorced / Married

RESIDENCE

Current address: _____
_____ Phone _____

Current Per Diem / Rental Rate _____

Facility/Landlord Name _____
_____ Phone _____

Is address change necessary? Yes / No

Will client be moving? Yes / No

If Yes please outline moving arrangements _____

FAMILY AND FRIENDS (Contact information)

Name _____

Name _____

Relationship _____

Relationship _____

Address _____

Address _____

Phone _____

Phone _____

REFERAL INFORMATION

Referring Agency _____

Name of person referring or contact _____ Title _____

Agency Address _____

Phone _____ Fax _____

REASON FOR REFERRAL

MEDICAL INFORMATION PHN _____
Doctor's Name _____ Phone _____

GOALS AND EXPECTATIONS/ (upcoming purchases): _____

OTHER SUPPORT AGENCY Organization _____
Contact Name _____ Title _____
Address _____
Phone _____ Fax: _____

FINANCIAL INFORMATION - INCOME

OAS \$ _____ CPP\$ _____ GIS \$ _____

DVA \$ _____ R/K #: _____ Sen. Supp. _____

Gain / Other \$ _____

Do you have any instructions regarding the income?

INCOME TAX Filed taxes current year: _____ Last Year Income Tax filed _____

Do you want to store financial documents in SJCSS fire-safe vault? Yes / No

Do you want your money transferred from your bank account to AGP for easy access. Yes / No

Should you wish to transfer any money you're your account, you would need to arrange it.

BILL PAYMENTS

Charge accounts

Company _____ Card# _____ Amount owed \$ _____

Instructions: _____

UTILITIES

Hydro account # _____

Cable account # _____ Service provider _____

Phone account # _____ Service provider _____

Other _____

DISABILITY TAX CREDIT

Would you qualify for a Disability Tax Credit? This refers to people who have disabilities where normal functions are impaired or movement and abilities are severely restricted.

Do you want the AGP to send a DTC application? Yes _____ No _____

BUDGET PLAN

WILL: Do you have a Will? Yes / No Is your Will current? Yes / No

If Yes, please state the location of the Will:

Name & location of Executor/ix:

Phone: _____

If Will is outdated, do you want a codicil to your Will? Yes / No

If you have no Will, do you want a Will? Yes / No

Would you like a referral to a notary public to acquire a Will? Yes / No

Do you want a copy of your Will stored in a SJCSS fire safe vault? Yes / No

FUNERAL ARRANGEMENTS Do you have pre-arrangements made: Yes / No

If Yes, name of funeral home: _____ Phone: _____

Do you have any instructions that you want the AGP to carry out? _____

OTHER RELEVANT INFORMATION