IOWA DEPARTMENT ON AGING

Department of HUMAN SERVICES

FOR OFFICE USE ONLY:
Date Received: _____
Review Deadline: _____
Initial Review: Complete ☐ Incomplete ☐
Decision: Accept ☐ Decline ☐ Wait List ☐
Priority: Abuse ☐ Medical ☐ Serious Harm ☐

Application for Care Transitions Project

Instructions

Complete all sections of this application. If there is not enough room on the form, attach additional pages as necessary and number accordingly. Please attach the following documents:

- ☐ **Report of Decision-Making Capacities (REQUIRED)**
- ☐ Copies of any capacity reports, functional assessments, neuropsychiatric evaluations, or other medical documentation from the last 12 months that document the individual's capacity to make decisions.
- ☐ Copies of any advance directive or power of attorney documents (if applicable)
  - ☐ Financial Power of Attorney
  - ☐ Durable Healthcare Power of Attorney
  - ☐ Representative payee or VA fiduciary
  - ☐ Living Will, IPOST, or other healthcare advance directive

The Office of Public Guardian and DHS Adult Services Program Manager will make a determination regarding eligibility of the consumer and acceptance or denial of the case into the Care Transitions Project. Incomplete applications, including applications submitted without the Report of Decision-Making Capacities form, will not be considered. Please note, communication with the Office of Public Guardian/DHS Adult Services Program Manager or the submission of an application does not imply an appointment and does not create any type of fiduciary relationship between the Office of Public Guardian and the consumer.

PLEASE SUBMIT THIS FORM AND REQUESTED DOCUMENTATION TO:
Gloriana Fisher, Adult Services Program Manager, at gfisher@dhs.state.ia.us
Upon receipt, additional information and documentation may be requested.

Section 1 - Referring Agency/Individual

Date of Application:	Service Area:
Name:	Position:
Phone:	Email:
Supervisor:	SWA:

Section 2 - Individual In Need Of Services

Name (First, Middle, Last):			
Maiden Name/Other Name(s) Used:			
Date of Birth:	Age:	Social Security Number:	
Marital Status:		Spouse's Name (if applicable):	
Sex:	Iowa Resident: Yes ☐ No ☐	Veteran: Yes ☐ No ☐	
Home Address:			

Is this individual currently living at his/her home address? Yes ☐ No ☐		
If no, where is the individual currently living? Address:		
When did the individual move into this location?	Facility Type:	Is there a pending discharge? Yes ☐ No ☐
If the individual is in a facility, is there anyone that can speak to needs/current condition?		

Section 3 - Individual's Sources Of Income & Benefits

Sources of Monthly Income: SS: $ SSI: $ SSDI: $ Pensions: $ VA Benefits: $ Other: $	Is the individual currently receiving benefits from the following? Medicaid: Yes ☐ No ☐ Medicare: Yes ☐ No ☐ VA Benefits: Yes ☐ No ☐ Private Insurance: Yes ☐ No ☐
If the individual has private insurance, please list the company name and policy number: Private Insurance Company: Policy Number:	
Please list any other assets the individual owns (e,g., bank accounts, land, annuities, life insurance):	

Section 4 - Decision Making Capacity

In what areas is the individual perceived to be unable to make his or her own decisions?

Money Management ☐ Paying bills ☐ Managing bank accounts, income, and property **Community Living** ☐ Living independently ☐ Maintaining habitable conditions ☐ Accessing community resources **Health Care** ☐ Making decisions about medical treatment ☐ Taking medications as needed ☐ Maintaining hygiene and diet ☐ Avoiding high-risk behaviors	**Relationships** ☐ Behaving appropriately with friends, family, and workers ☐ Making safe decisions about sexual relationships **Personal Safety** ☐ Avoiding common dangers ☐ Recognizing and avoiding abuse or financial exploitation ☐ Knowing what to do in an emergency **Personal Decision-Making** ☐ Understanding legal documents (contracts, leases, etc.) ☐ Communicating wishes ☐ Understanding legal consequences of behavior
What event(s) led to this referral?	What current medical diagnoses impair the individual's ability to make decisions for himself/herself?

Has a medical professional stated that the individual cannot make decisions for himself/herself? Yes ☐ No ☐	If yes, please list the medical professional's name and contact information and attach a copy of their report(s). Name: Phone:
Is there a facility considering taking the individual into care? Yes ☐ No ☐	Is the facility requiring a "guardianship" before admission? Yes ☐ No ☐
For what specific purpose is the facility considering admission requiring a guardianship?	

Section 5 - Substitute Decision-Making Instruments	
Has the individual executed a Financial Power of Attorney document? Yes ☐ No ☐	If yes, please list the Agent's name and contact information and attach a copy of that document. Name: Phone:
Has the individual executed a Durable Health Care Power of Attorney document? Yes ☐ No ☐	If yes, please list the Attorney-in-Fact's name and contact information and attach a copy of that document. Name: Phone:
Does the individual currently have a representative payee or VA fiduciary? Yes ☐ No ☐	If yes, please list the payee's name and contact information and attach a copy of that document. Name: Phone:
Has the individual executed a Living Will or other advance directive for medical or end-of-life care? Yes ☐ No ☐	If yes, please attach a copy of that document.

Section 6 - Other Sources Of Assistance	
What services (e.g. SCL, case manager, home healthcare) are currently being provided to the individual and by whom?	
Service(s):	Provider:
Service(s):	Provider:
Service(s):	Provider:
What other options have been utilized to assist the individual with decision-making, and what were the outcomes associated with that assistance?	

Please list all known family members of the individual or other involved persons (friends, neighbors, etc.) and indicate whether they have been contacted to assist the individual. If no contact has been made, please explain why.

Name:	Relationship:	Contacted? Yes ☐ No ☐
Address:	Phone:	Willing to assist? Yes ☐ No ☐
Name:	Relationship:	Contacted? Yes ☐ No ☐

Address:	Phone:	Willing to assist? Yes ☐ No ☐
Name:	Relationship:	Contacted? Yes ☐ No ☐
Address:	Phone:	Willing to assist? Yes ☐ No ☐
Reason(s) contact has not been made:		

Section 7 - Court Involvement	
Is there any current court involvement with the individual?	
Guardianship: Yes ☐ No ☐	County: Case Number:
Conservatorship: Yes ☐ No ☐	County: Case Number:
Civil Commitment: Yes ☐ No ☐	County: Case Number:
235B Protective Services: Yes ☐ No ☐	County: Case Number:
Other: Yes ☐ No ☐	County: Case Number:
Is the County Attorney where the adult resides willing to file a 235B or 633 petition? Yes ☐ No ☐	If not, have you contacted the Service Help Desk for assistance? Yes ☐ No ☐
Does the individual have an attorney? Yes ☐ No ☐	Name:
Does the individual have a guardian ad litem? Yes ☐ No ☐	Name:

Section 8 - Additional Information	
Does this case involve abuse, neglect, or exploitation of the individual? Yes ☐ No ☐	If yes, please describe:
Has suspected abuse been reported to the Department of Human Services, Department of Inspections and Appeals, and/or law enforcement? Yes ☐ No ☐	If yes, what was the outcome?
Does this case require a critical medical decision be made for the individual? Yes ☐ No ☐	If yes, please describe:
Does this case involve a situation that may cause serious or irreparable harm to the individual's mental or physical health or estate? Yes ☐ No ☐	If yes, please describe: