TWIN FALLS COUNTY
BOARD OF COMMUNITY GUARDIANS

WARD REFERRAL APPLICATION

Date: _____

Potential Ward Information:

Legal Name: _____ Date of Birth: _____

Address: _____ City/Zip:_____

Phone: _____ SSN: _____ Gender: ____ Marital Status: _____

Individual is currently at: [ ] Home [ ] Hospital: _____ [ ] Care Facility: _____

Referral Source:

Name: _____ Title/Relationship: _____

Address: _____ City/Zip:_____

Phone: _____ Email: _____

Reason for Referral: *Be as detailed as possible- use additional paper if needed*

_____

_____

_____

_____

_____

_____

_____

Medical Information:

Physicians Name: _____ Phone: _____

Address: _____ City/Zip:_____

Prescribed Medications: _____

Medical Diagnosis and Prognosis: *Be as detailed as possible- use additional paper if needed*

_____

_____

_____

_____

_____

_____

_____

An affidavit from the Physician stating why this person is in need of a Guardian MUST accompany this referral. If it's not, referral can NOT be processed.

Financial Information:

Source	Amount	Source	Amount
Social Security		Property Owned	
SSI		State Cash Assistance	
Veteran Benefits		Interest/Dividends	
Food Stamps		Inheritance/Trust	
Retirement		Checking	
Tribal Assistance		Savings	
Other:		Other:	

Person Handling Finances:

Name: _____ Relationship: _____

Address: _____ City/Zip:_____

Phone: _____

Next of Kin Information: (Parents, Spouse, Children, any living relatives)

Name: _____ Relationship: _____

Address: _____ City/Zip:_____

Phone: _____

Name: _____ Relationship: _____

Address: _____ City/Zip:_____

Phone: _____

Name: _____ Relationship: _____

Address: _____ City/Zip:_____

Phone: _____

An affidavit from the Physician stating why this person is in need of a Guardian MUST accompany this referral. If it's not, referral can NOT be processed.

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BOARD OF COMMUNITY GUARDIANS

WARD REFERRAL APPLICATION

Grant P. Loebs
Twin Falls County Prosecutor
425 Shoshone St. N.
P.O. Box 126
Twin Falls, Idaho 83303-0126
(208)736-4190
civ.inbox.pros@tfco.org.

IN THE DISTRICT COURT OF THE FIFTH JUDICIAL DISTRICT OF THE STATE OF IDAHO, IN AND FOR THE COUNTY OF TWIN FALLS
MAGISTRATE DIVISION

IN THE MATTER OF THE PERSON AND THE ESTATE OF _____, An Alleged Incapacitated Person	)))))))	Case No: _____ AFFIDAVIT OF Dr. _____

STATE OF IDAHO, COUNTY OF TWIN FALLS, safe and sober.

I, Dr. _____, being first duly sworn, depose and say:

1. That I am over 18 years of age and a citizen of the United States.
2. That I am a physician as defined by Idaho Code.
3. That _____ is _____ years of age, born _____, and resides at _____.
4. I have been treating _____ for _____ months.
5. (Pertinent patient information and diagnosis)

6. _____ is an incapacitated person by reason of the following facts:

7. _____ will be substantially harmed if he/she does

not receive a guardianship before a hearing on the appointment can be held.

Dated this _____ day of _____, 20____.

Dr. _____

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20____.

_____
Notary Public

Residing at:

Commission Expires: