



# ENTRUST FIDUCIARY SERVICES, INC.

LICENSED FIDUCIARY NO. 20545

P. O. BOX 249 YUMA, AZ 85366-0249

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## REFERRAL FORM

Please provide as much information as possible:

Individual/ Agency initiating referral: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

### PERSONAL INFORMATION REGARDING POTENTIAL CLIENT:

Name (Please include their full legal name): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Marital Status: \_\_\_\_\_

### RELATIVES:

Spouse: \_\_\_\_\_ Is address the same as above? \_\_\_\_\_

If not, address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

If spouse is deceased, date of death: \_\_\_\_\_

Is the spouse willing and/or able to act as the guardian/conservator for their spouse? \_\_\_\_\_

Why do you believe that the spouse is not capable and/or willing to act as the guardian/conservator for their spouse? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Adult Children (if any): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Is the adult child(ren) willing and/or able to act as the guardian/conservator for their parent? \_\_\_\_\_

Why do you believe that the adult child(ren) is not capable and/or willing to act as the guardian/conservator for their parent? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Interested Parties: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**BASIS FOR REFERRAL:**

Why do you believe this individual needs the involvement of a fiduciary? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you believe that substantial harm will come to this individual without immediate involvement? If so, why?\_\_\_\_\_

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Do you believe that this individual has assets that will be lost or stolen without immediate involvement? If so, why?\_\_\_\_\_

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Has this individual been the subject of an investigation by Adult Protective Services?\_\_\_\_\_

Do you know if this person has created prior estate planning documents, such as a Medical Power of Attorney, Durable Power of Attorney, Living Will and/or Living Trust?\_\_\_\_\_

If so, please supply our office with a copy of these documents as the individual named in those documents may have priority for appointment, should that be necessary.

Does this individual have a prior relationship with a local attorney?\_\_\_\_\_

Name of the Attorney:\_\_\_\_\_

Address:\_\_\_\_\_

Telephone:\_\_\_\_\_ Facsimile:\_\_\_\_\_

**MEDICAL INFORMATION:**

Primary Care Physician:\_\_\_\_\_

Address:\_\_\_\_\_

Telephone:\_\_\_\_\_ Facsimile:\_\_\_\_\_

Specialist:\_\_\_\_\_

Address:\_\_\_\_\_

Telephone:\_\_\_\_\_ Facsimile:\_\_\_\_\_

Medicare No. \_\_\_\_\_ Medicare A & B Coverage? \_\_\_\_\_

Does the individual have Medicare Part D coverage? \_\_\_\_\_

Medicare Part D Provider: \_\_\_\_\_ Policy No. \_\_\_\_\_

Supplemental Health Provider: \_\_\_\_\_ Policy No. \_\_\_\_\_

Has a physician prepared a statement regarding this person's ability to manage their own person and/or their financial affairs? If so, please provide us with a copy. \_\_\_\_\_

What was the determination of the physician? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is the individual's medical diagnosis: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list all medications the individual is currently taking, to include over-the-counter medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FINANCIAL INFORMATION:**

Financial Institution: \_\_\_\_\_

Checking Account No. \_\_\_\_\_ Current Value: \_\_\_\_\_

Savings Account No. \_\_\_\_\_ Current Value: \_\_\_\_\_

Brokerage/Investment Company: \_\_\_\_\_

Brokerage/Investment Account No. \_\_\_\_\_

Value of Brokerage/Investment Account: \_\_\_\_\_

Please list any other assets and the value of each asset: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Income Sources:**

Social Security Administration: \_\_\_\_\_ Monthly Value: \_\_\_\_\_

Veterans Benefits: \_\_\_\_\_ Monthly Value: \_\_\_\_\_

Other Income: \_\_\_\_\_ Monthly Value: \_\_\_\_\_

**Real Estate:**

Owned or Rented: \_\_\_\_\_

If owned, is there a mortgage? \_\_\_\_\_ Value Owing: \_\_\_\_\_

Is there real property in any other states: \_\_\_\_\_

Location of real property: \_\_\_\_\_

**Vehicle:**

Make: \_\_\_\_\_ Model: \_\_\_\_\_ Year: \_\_\_\_\_

Is there a lien holder? \_\_\_\_\_ Value Owing: \_\_\_\_\_

**ADDITIONAL INFORMATION:**

Please provide any additional information you believe would be useful to our office:

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