REQUEST FOR GUARDIANSHIP ESTABLISHMENT FUNDS

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES DIVISION/GUARDIANSHIP PROGRAM
SFN 1177 (11-2011)

CONSUMER DEMOGRAPHIC INFORMATION

Name			
ROAP ID Number	Date of Birth	MA Number	
Address	City	State	ZIP Code
Residential Address ☐ Check box if same as mailing address	City	State	ZIP Code

If consumer is residing out of state or not a resident of North Dakota, STOP; consumer is not eligible for this program.

PROGRAM ELIGIBILITY

Is consumer eligible for Developmental Disabilities Case Management? ☐ Yes ☐ No If Yes, STOP; consumer is not eligible for this program.	
Has the consumer been diagnosed with a serious mental illness? ☐ Yes ☐ No	
Has the consumer been diagnosed with a traumatic brain injury? ☐ Yes ☐ No	Is the consumer over the age of 60? ☐ Yes ☐ No

REFERRAL SOURCE/CASE MANAGER

Name		Telephone Number	
Agency			
Address	City	State	ZIP Code
E-Mail Address		Fax Number	

REQUIRED DOCUMENTATION (for consumers with an active ROAP case, forward only information not found in ROAP)

Check all that are attached

- ☐ Evaluations (Neuropsychological, psychiatric, psychological, chemical dependency)
- ☐ Physician's notes/evaluations recommending guardianship
- ☐ Current Treatment Plan
- ☐ Progress notes for the last six weeks
- ☐ Diagnoses (all 5 axes)
- ☐ Other (specify): _____

RECOMMENDED TYPE OF GUARDIANSHIP

Check all that are attached

☐ Full Guardianship ☐ Limited Guardianship ☐ Emergency Guardianship

If Limited or Emergency Guardianship, list areas this would pertain to:

SIGNATURES

Case Manager	Date	Telephone Number
Supervisor	Date	Telephone Number

REASON FOR GUARDIANSHIP

Describe the reason/justification for guardianship including the nature and type of disability and how that disability impacts the individual's decision making. This section should accurately reflect the skills and abilities of the person as well as the deficits and problems. Attach additional sheets, if necessary. Attach any supporting documentation.

LESS RESTRICTIVE ALTERNATIVES TO GUARDIANSHIP TRIED OR CONSIDERED

Identify all alternatives to guardianship that have been tried	Describe why the alternatives not adequate or appropriate
☐ Durable Power of Attorney	
☐ Trusts	
☐ Home Health	
☐ Representative Payee	
☐ Case Aide	
☐ Other (specify):	
☐ Other (specify):	

CONSUMER'S NET INCOME, BENEFITS, AND ASSETS

Income	Monthly Amount
Wages	
Supplemental Security Income	
Social Security Disability Insurance	
Retirement Survivors Disability Insurance	
Railroad Retirement	
Pension	
Other (specify):	
Other (specify):	
Other Benefits	**Monthly Amount**
SNAP Benefits	
Housing Assistance	
LIHEAP	
Other (specify):	
Other (specify):	
Assets	**Amount**
Checking Account	
Savings Account	
Individual Retirement Account/Keough Account	
Mutual Funds	
Savings Bonds	
Stocks and Bonds	
Vehicles	
Personal Property	
Real Property	
Other (specify):	
Other (specify):	

PROPOSED GUARDIAN

Name		Telephone Number	
Agency			
Address	City	State	ZIP Code
E-Mail Address		Fax Number	
I agree to become guardian of this individual ☐ Yes ☐ No	I have been notified about the annual guardianship payment pilot program ☐ Yes ☐ No		
I request the $500 annual guardianship payment (pilot program) ☐ Yes ☐ No	I agree to participate in an annual survey for this pilot program ☐ Yes ☐ No		
Signature		Date	

For State Office Use Only

Date Received	Date Reviewed

Reviewed By (must be reviewed by all three areas):

Name of Case Manager	
Name of Aging Services Division Reviewer	
Name of Mental Health and Substance Abuse Services Reviewer	
Status of Application ☐ Approved ☐ Denied ☐ Pending Additional Information	Date
Reason for Denial	
Guardianship Payment ($500 annual payment-Pilot Program) ☐ Approved ☐ Denied	Date
Reason for Denial	
Date Case Manager Notified of Application Status	