REQUEST FOR GUARDIANSHIP ESTABLISHMENT FUNDS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING SERVICES/GUARDIANSHIP PROGRAM
SFN 1177 (1-2024)

Clear Fields

CONSUMER DEMOGRAPHIC INFORMATION

Name				
Date of Birth	Age	Medicaid Number		
Address	City	State	ZIP Code	
Medicaid Eligible ☐ Yes ☐ No				
Explain				

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.

Does the consumer meet the definition of incapacitated* person (NDCC 30.1-26-01)? ☐ Yes ☐ No

*Incapacitated Person - any adult person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, or chemical dependency to the extent that the person lacks capacity to make or communicate responsible decisions concerning that person's matters of residence, education, medical treatment, legal affairs, vocation, finance, or other matters, or which incapacity endangers the person's health or safety.

Does the consumer have income at, or below, one hundred percent of the federal poverty or is the consumer Medicaid-eligible?

☐ Yes ☐ No If No, STOP; consumer is not eligible for this program.

Household Size	100%
1	$ 15,060
2	$ 20,440
3	$ 25,820
4	$ 31,200
5	$ 36,580

Household Size	100%
6	$ 41,960
7	$ 47,340
8	$ 52,720
If more than 8 persons, for each additional person add	$ 5,380

If funds exceeding 100% of federal poverty level are found during the establishment of the guardianship and the individual is no longer Medicaid eligible, the proposed ward will no longer be eligible for this program. At this time the funds for guardianship establishment should come from the ward's estate.

REFERRAL SOURCE/CASE MANAGER (family member, agency, provider, etc.)

Name			Telephone Number
Agency			
Address	City	State	ZIP Code
Email Address			Fax Number

DOCUMENTATION OF INCAPACITY REQUIRED

NOTE: Applications cannot be processed without medical documentation recommending guardianship or supporting the need for a guardian.

Check all that are attached

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

RECOMMENDED TYPE OF GUARDIANSHIP

Check all that are attached

☐ Full Guardianship ☐ Limited Guardianship ☐ Emergency Guardianship

SIGNATURES

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information. NDCC 9-16

Case Manager/Referral Source	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 or considered	Describe why the alternatives are not adequate or appropriate
☐ Power of Attorney	
☐ Healthcare Directives/Advanced Directives	
☐ Representative Payee	
☐ Informed Healthcare Consent Law	
☐ Supported Decisionmaking	
☐ 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):	
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):	

Reason Financial Information Not Included

PROPOSED GUARDIAN (proposed guardian agreement necessary for consideration)

Name		Telephone Number	
Agency	Relationship to Proposed Ward		
Address	City	State	ZIP Code
Email Address		Fax Number	

I agree to become guardian of this individual
☐ Yes (if no signature available, documentation of acceptance is required) ☐ No

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information. NDCC 9-16

Signature	Date

For State Office Use Only

Date Received	Date Reviewed

Reviewed By

Name of Case Manager/Referral Source	
Name of Aging Services Reviewer(s)	
Status of Application ☐ Approved ☐ Denied ☐ Pending Additional Information ☐ Withdrawn	Date
Reason for Denial	
Date Case Manager/Referral Source Notified of Application Status	
Notes	

Return form to:

Guardianship Establishment Fund
Aging and Adult Services
1237 W. Divide Ave, Suite 6
Bismarck, ND 58501

(701) 328-4613
Fax: (701) 328-8744
Email: dhsvaps@nd.gov

Email Completed Form Here
(by clicking this button, the form is emailed to dhsvaps@nd.gov)