



# REQUEST FOR GUARDIANSHIP ESTABLISHMENT FUNDS


NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
AGING SERVICES DIVISION/GUARDIANSHIP PROGRAM  
SFN 1177 (5-2021)

## CONSUMER DEMOGRAPHIC INFORMATION


Name				
Date of Birth	Age	Medicaid Number		
Address		City	State	ZIP Code
Medicaid Eligible <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes,  STOP; consumer is not eligible for this program.
Does the consumer meet the definition of incapacitated* adult (NDCC 30.1-26-01)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No,  STOP; consumer is not eligible for this program.
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Household Size	100%
1	\$ 12,880
2	\$ 17,420
3	\$ 21,960
4	\$ 26,500
5	\$ 31,040

Household Size	100%
6	\$ 35,580
7	\$ 40,120
8	\$ 44,660
If more than 8 persons, for each additional person add	\$ 4,480

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

<input type="checkbox"/> Evaluations (Neuropsychological, psychiatric, psychological, chemical dependency)	<input type="checkbox"/> Progress notes for the last six weeks
<input type="checkbox"/> Physician's notes/evaluations recommending guardianship	<input type="checkbox"/> Diagnoses
<input type="checkbox"/> Other (specify): _____	

**RECOMMENDED TYPE OF GUARDIANSHIP**

Check all that are attached

<input type="checkbox"/> Full Guardianship	<input type="checkbox"/> Limited Guardianship	<input type="checkbox"/> Emergency Guardianship
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**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
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**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.

[Large empty text area for describing the reason for guardianship]

**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
<input type="checkbox"/> Power of Attorney	
<input type="checkbox"/> Healthcare Directives	
<input type="checkbox"/> Representative Payee	
<input type="checkbox"/> Informed Healthcare Consent Law	
<input type="checkbox"/> Mental Health/Psychiatric Advanced Directive	
<input type="checkbox"/> Supported Decisionmaking	
<input type="checkbox"/> Other (specify):	
<input type="checkbox"/> 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 <input type="checkbox"/> Yes (if no signature available, documentation of acceptance is required) <input type="checkbox"/> No			

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Signature	Date
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***For State Office Use Only***

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

Name of Case Manager	
Name of Aging Services Division Reviewer(s)	
Status of Application <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Pending Additional Information <input type="checkbox"/> Withdrawn	Date
Reason for Denial	
Date Case Manager Notified of Application Status	
Notes	

Return form to:

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

(701) 328-4613  
Fax: (701) 328-8744  
Email: [carechoice@nd.gov](mailto:carechoice@nd.gov)