



APPLICATION FOR SUBSIDIZED GUARDIANSHIP
 ND DEPARTMENT OF HUMAN SERVICES/CFS
 SFN 1833 (Rev. 02-2001)

Guardian Name(s):			Social Security Number:
Guardian(s) Address:	City:	State:	Zip Code:
Mailing Address: (If Different)	City:	State:	Zip Code:
Designated Payee:			
Child's Name:	Date of Birth:	Sex:	
Date Guardianship Awarded:	Child's medical coverage will be provided by (source):		

Child's Income/Assets:	Amount/Value	CFS Use Only:	
Checking/Savings		Guardianship subsidy	
IRA/CD			
Stocks/Bonds			
Real Estate		Subtract any other monthly benefit	
Vehicle			
Life Insurance			
SSI/SSA/VA Benefits		Total monthly subsidy *	
Other			

(* Reference only - paid by daily rate)

I understand that I have the obligation to abide by the terms of the court's guardianship order. I understand that the amount of subsidy is based on information I have provided. I confirm that the information is true and accurate to the best of my knowledge.

Signature of Guardian:	Date:
Signature of Guardian:	Date:

CFS Use Only:

Date Received Homestudy Assessment:	Date Received Criminal Background Check:
<input type="checkbox"/> Approved	Effective Date for Guardianship Subsidy:
<input type="checkbox"/> Denied	Denial Reason:
Amount Per Month: \$	Amount Per Day: \$
Signature By: (Children & Family Services - Department of Human Services)	Date:

The Privacy Act of 1974 (P.L. 93-579, Section 7) requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

DISTRIBUTION: ORIGINAL - CFS **Copies** to Guardian(s), County Director, Regional Supervisor, Custodian