

FIRST REQUEST FOR INFORMATION

Dear Requester,

The New Mexico Developmental Disabilities Guardianship Program is State Funded. We serve only our Target Population. The paperwork is required for determining if you meet the financial eligibility criteria (200% of Poverty Guidelines).

Enclosed you will find a checklist that shows what you need to submit. Please choose the checklist as pertaining to your SERVICE REQUEST on 1st page of application.

Please allow 30 days from the date that we receive your application to process your request. If at any time, there is a change of information, please contact our office via fax, email or by telephone to update information.

Thank You,

Stephanie A. Martinez

Community & Social Services Specialist

NMDDPC Guardianship Program

Ph: 505-476-7332, Fax: 505-476-7322, Email: StephanieA.Griego@state.nm.us



**OFFICIAL USE ONLY:**

**CASE # \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Staff Completing Intake: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Total Income of Household for Year 20\_\_: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number of People in HH: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Approved □ Denied □**

**PLEASE TYPE OR PRINT**

**OFFICE CAN NOT PROCESS WITHOUT CLEAR INFORMATION.**

You may fax this request for guardianship to (505-476-7322) or e-mail to: [StephanieA.Griego@state.nm.us](mailto:StephanieA.Griego@state.nm.us)

**SERVICE REQUEST**: (Please check ***ONLY ONE*** of the following)

**Professional (Company) Guardianship -OR-**  **Family Guardianship**

*(If emergency, please attach justification. Note: at a minimum, process may take several weeks)*

**TYPE OF GUARDIANSHIP REQUESTING:**

Temporary Guardianship  Limited Guardianship

Full/Plenary Guardianship  Transfer of Guardianship

Successor Guardianship

**PERSON MAKING REQUEST:****DATE:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| FIRST NAME: | | | LAST NAME: | | |
| ADDRESS: | | | | | |
| ORGANIZATION: | | | | | |
| CITY: | | STATE: | | | ZIP CODE: |
| HOME PHONE: | | WORK PHONE: | | | CELL PHONE: |
| FAX: | | RELATION: | | | |
| YEAR OF BIRTH: |  | | | LANGUAGE: | |

**PROPOSED PROTECTED PERSON: (INFORMATION FOR THE PERSON WHO NEEDS A GUARDIAN)**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| FIRST NAME: | | | | | | LAST NAME: | | | | | |
| NAME OF FACILITY: | | | | | | | | | | | |
| **STREET** **ADDRESS** (where this person currently resides): | | | | | | | | | | | |
| **MAILING ADDRESS:** | | | | | | | | | | | |
| CITY: | | | | | STATE: | | | | | | ZIP CODE: |
| PHONE(where this person resides): | | | | | SOCIAL SECURITY NUMBER: | | | | | | |
| MALE | FEMALE | | | | DATE OF BIRTH: | | | | | | LANGUAGE: |
| ETHNICITY (OPTIONAL): | | | | | | | | | | | |
| MARITAL STATUS:  MARRIED  DIVORCED  SINGLE  CHILDREN:  **Yes**  **No** **IF YES,** ATTACH PAPER WITH NAME, ADDRESS, PHONE NUMBER | | | | | | | | | | | |
|  | | | | | | | | | | | |
| DOES THIS PERSON HAVE A BANK ACCOUNT?  Yes  No IF YES, WHAT IS THE NAME OF THE BANK(S)? | | | | | | | | | | | |
| **PLEASE WRITE IN DETAIL, DO NOT USE MEDICAL CODES OR “SEE ATTACHED FORM”:**  What is her/his MENTAL/COGNITIVE IMPAIRMENT:        What are her/his other DISABILITIES/DIAGNOSES:  Date of last psychiatric evaluation, where appropriate: | | | | | | | | | | | |
| Past Placement(s): | | | | | | | | | | | |
| Will financial assistance be needed:**(**authority to supervise this person’s financial affairs)Yes  No | | | | | | | | | | | |
| **If in an Institutional or Treatment Setting**  Is a Discharge Plan in place:  Yes  No  **N/A** | | | | | | | Is a plan required?  Yes  No | | | | |
| **Is the person who needs a guardian a:** | | | | | | | | | | | |
| Jackson Class Member:  **Yes**  **No**    Foley settlement party:  **Yes** **No** | | | Veteran:  **Yes**  **No** | | | | | | **Native American ONLY:**  LIVING:  On Reservation Off Reservation | | |
| **IF YOU WILL BE REQUESTING A TRANSFER OR SUCCESSOR GUARDIAN**  **(PLEASE COMPLETE THE FOLLOWING)** | | | | | | | | | | | |
| **Current Guardian:** | | | | | | | **Relation:** | | | | |
| **Phone:** | | **Cell Phone:** | | | | | | **E-mail:** | | | |
| **Address:** | | | | **City:** | | | | | | **State & Zip Code:** | |
| **County where original Court Order was filed:** | | | | | | | | | | **Copy of Order Available:**  **No**  **Yes** | |
| **Explain why the Transfer or Successor Guardianship is required:** | | | | | | | | | | | |

**Why does the proposed protected person need a guardian?** (Example: cannot give informed consent, needs a decision-maker and why):

     

**What alternatives to guardianship have already been considered?** If any have been completed, please attach a copy:(Power of Attorney, Advance Health Care Directive, Will/Last Will, Surrogate Decision Maker, Do Not Resuscitate Order, Uniform Health Care Decisions Act or has Adult Protective Services been contacted)

|  |  |  |  |
| --- | --- | --- | --- |
| **Benefits received by the person who needs a guardian** (SSA, SSI, SSDI, Wages, DD Waiver, Mi Via): | | | |
| **Benefit** | **Amount** | **Benefit** | **Amount** |
|  | $ |  | $ |
|  | $ |  | $ |
| DOES THIS PERSON RECEIVE : FOOD STAMPS: Yes  No | | | |
| Benefits applied for and pending: | | | |
| Services currently received by the person who needs a guardian: | | | |

|  |  |
| --- | --- |
| Is the person who needs a guardian financially eligible for Institutional Medicaid? Yes  No | |
| Waiver Status: | Date of allocation or wait-listed? |
| What waiver program is the Proposed Protected Person enrolled in? | |
| What is the Medicaid status of the Proposed Protected Person ( institutional, community, integration, full Medicaid, slim-b Medicaid, Medicare/Medicaid, none): | |
| What type of Social Security does the Proposed Protected Person have  (SSA-retirement, SSA+SSI, SSDI, SSI, SSDI, SSI, none): | |
| Who is the current representative payee?  FIRST NAME:       LAST NAME:       RELATION: | |
| **PROPOSED PROTECTED PERSONS PRIMARY CARE PHYSICIAN INFORMATION** | |

|  |  |  |  |
| --- | --- | --- | --- |
| FIRST NAME: | | LAST NAME: | |
| ADDRESS: | | | |
| CITY: | STATE: | | ZIP CODE: |
| PHONE: | FAX: | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **INFORMATION NEEDED ONLY IF THE PROPOSED GUARDIAN IS A FAMILY MEMBER**  (or anyone other than a contract guardian with the Guardianship Program): | | | |
| FIRST NAME: | | LAST NAME: | |
| ANY OTHER NAMES YOU HAVE GONE BY: | | | |
| ADDRESS: | | | |
| CITY: | STATE: | | ZIP CODE: |
| HOME PHONE: | WORK PHONE: | | CELL PHONE: |
| FAX: | E-MAIL: | | |
| RELATION: | | LANGUAGE: | |
| HAVE YOU EVER BEEN CONVICTED OF A FELONY?  **Yes**  **No** | | | |
| **ADDITIONAL FAMILY MEMBERS OR ANY KNOWN AGENTS**  **(Ex: Power of Attorney, Representative Payee, Mental Health Treatment Guardians, case managers, etc.)**  (please attach information on additional individuals if needed): | | | |
| FIRST NAME: | | LAST NAME: | |
| ADDRESS: | | | |
| CITY: | STATE: | | ZIP CODE: |
| HOME PHONE: | WORK PHONE: | | CELL PHONE: |
| FAX: | E-MAIL: | | |
| RELATION: | | LANGUAGE: | |
| FIRST NAME: | | LAST NAME: | |
| ADDRESS: | | | |
| CITY: | STATE: | | ZIP CODE: |
| HOME PHONE: | WORK PHONE: | | CELL PHONE: |
| FAX: | E-MAIL: | | |
| RELATION: | | LANGUAGE: | |

**PLACEMENT/RESIDENCE:** Please describe the living arrangements of the individual, (i.e. type of institution, at home)

**FINANCIAL:** What financial assistance is the individual receiving (i.e., Social Security, Medicaid, Pensions, Vet Pensions, etc.)

**SUPPORT STRUCTURE:** Who is assisting the individual (i.e. family, friends, case manager, residential support services)

**MEDICAL:** Please describe any medical conditions the individual has (Does the individual have a long term illness, depend upon any medications, and manage that medication independently)

**MENTAL IMPAIRMENT:** Please describe the mental impairments of the proposed protected person (i.e., advanced dementia, developmental disability, MR, Cerebral Palsy, TBI)

**SAFETY THREAT:** Is the proposed protected person a threat to him/herself, at risk of significant harm to self or others?

**Guardianship Program and the NM Developmental Disability Planning Council respects you and your privacy. We are committed to keeping all information received or created confidential.**

I have answered truthfully to the best of my ability. I understand that the Office of Guardianship/NM Developmental Disabilities Planning Council may discontinue services due to unintentional miscommunications or omissions. I also understand that the Office of Guardianship/NM Developmental Disabilities Planning Council may seek reimbursement for costs of the services provided due to purposeful miscommunications or omissions.

Signed:                                     Date:

**CHECKLIST:** (SERVICE REQUESTED on 1st page of application, use list that you are requesting)

\*If you are **REQUESTING SERVICE** for **FAMILY GUARDIANSHIP**:

|  |
| --- |
| * Income of **ALL** in household including (SSI, SSA, SSDI, Wages) |
| * Current Year Taxes |
| * Financial Assistance(Food Stamps SNAP, TANF, Child Support) |
| * Certificate of Birth of PPP(if available) |
| * Identification of PPP(if available) |
| * Bank Statement of PPP(if available) |
| * Diagnosis and information of PPP from Qualified HCP |
| * Court Documents(any)(if available) |
| IF APPLICABLE: |
| * Letter of Guardianship from Past Guardian |
| * Housing Assistance |
| * Information of Absent Parent |

\*If you are **REQUESTING SERVICE** for **CORPORATE GUARDIANSHIP:**

|  |
| --- |
| * Income and/or Social Security Recent Amount |
| * Proof of Eligibility for Institutional Medicaid |
| * Financial Assistance(Food Stamps SNAP, TANF, Child Support) of PPP |
| * Certificate of Birth of PPP(if available) |
| * Identification of PPP(if available) |
| * Bank Statement of PPP(if available) |
| * Diagnosis information from Qualified HCP |
| * Court Documents(any)(if available) |
| * Letter of Guardianship from Past Guardian |
| * Housing Assistance |
| * Information of Absent family member(s) |