



NMDDPC Office of Guardianship
 810 W. San Mateo Street, Suite C
 Santa Fe, NM 87505
 505-476-7332 ph 505-476-7322 fax
 Toll Free 1-888-779-6183
www.nmddpc.com/office-of-guardianship

Susana Martinez
 Governor

Cristine Marchand
 Executive Director

Frank Fajardo
 Program Manager

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: frank.fajardo@state.nm.us

Please check one of the following:

Professional (Company) Guardianship –OR– Family Guardianship

Request for:

- Temporary Guardianship (If emergency, please attach justification. Note: at a minimum, process may take several weeks)
- Limited Guardianship
- Full/Plenary Guardianship
- Transfer of Guardianship (see below)
- Successor Guardianship (see below)

PERSON MAKING REQUEST:

DATE:

FIRST NAME:		LAST NAME:	
ORGANIZATION:			
ADDRESS:			
CITY:	STATE:	ZIP CODE:	
HOME PHONE:	CELL PHONE:	WORK PHONE:	
FAX:	E-MAIL:		
RELATION:	LANGUAGE:		

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

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:		
<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	DATE OF BIRTH:	LANGUAGE:
ETHNICITY (OPTIONAL):			
MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE			
CHILDREN: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name/Address:		Name/Address:	
DOES THIS PERSON HAVE A BANK ACCOUNT? <input type="checkbox"/> Yes <input type="checkbox"/> No IF SO, WHAT IS THE NAME OF THE BANK(S)?			
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) <input type="checkbox"/> Yes <input type="checkbox"/> No			
If in an institutional or treatment setting is a Discharge Plan in place: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Is a plan required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the person who needs a guardian a:			
Jackson Class Member <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	Native American on Reservation <input type="checkbox"/>	
Foley settlement party <input type="checkbox"/> Yes <input type="checkbox"/> No		Native American off Reservation <input type="checkbox"/>	
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:		<input type="checkbox"/> Yes Copy of Order Available: <input type="checkbox"/> No	
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?

(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?) If any have been completed, please attach a copy:

Benefits received by the person who needs a guardian (ex: Medicaid, Medicare, DD Waiver, Mi Via, D&E, SSI/SSA):			
Benefit	Amount	Benefit	Amount
	\$		\$
	\$		\$
DOES THIS PERSON RECEIVE : FOOD STAMPS: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Benefits applied for and pending:			
Services currently received by the person who needs a guardian:			

NOTE:

To meet the financial eligibility criteria for our program, the person needing the guardian must meet the financial eligibility for Institutional Medicaid.

Is the person who needs a guardian financially eligible for Institutional Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	CELL PHONE:	FAX:
COUNTY:	E-MAIL:	

INFORMATION NEEDED <u>ONLY</u> IF THE PROPOSED GUARDIAN IS A FAMILY MEMBER (or anyone other than a contract guardian with the Office of Guardianship):		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
NOTE: The proposed family guardian is required to submit a copy of their most recent Federal Income Tax Return – verification of income is required for determining if you meet the financial eligibility criteria (300% of Poverty). The Office of Guardianship will follow-up with the proposed family guardian for their income information.		
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, home

FINANCIAL:

What financial assistance is the individual receiving? For example: Social Security, Medicaid, Pensions, Vet Pensions, etc.

SUPPORT STRUCTURE:

Please explain who is assisting the individual. For example: family, friends, case manager, residential support services, etc.

MEDICAL:

Please describe any medical conditions the individual has. Does the individual have a long term illness? Does the individual depend upon any medications and what kind? Can the individual take and manage that medication independently? Does the individual have a Power of Attorney for medical decisions?

MENTAL IMPAIRMENT:

Please describe the mental impairments of the proposed protected person. For example: advanced dementia, developmental disability, chronic mental illness, MR, Cerebral Palsy, TBI, etc.

SAFETY THREAT:

Is the proposed protected person a threat to him/herself or to others or at risk of significant harm?

The Office of Guardianship 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: _____

Print Name: _____

PLEASE ALLOW 30 BUSINESS DAYS TO RECEIVE THE STATUS OF YOUR CASE

**TO HAVE YOUR CASE PLACED ON OUR WAITLIST QUICKLY,
PLEASE MAKE SURE YOU HAVE THE FOLLOWING PAPERWORK ATTACHED
TO YOUR APPLICATION:**

FAMILY GUARDIANSHIP:

- 1.) Letter from Social Security showing the amount each individual may be receiving.
- 2.) Current 2009 Taxes
- 3.) All Income or Financial Assistance the family is receiving
- 4.) Information on anyone who may have further information on the case.
(Attach extra sheets if needed). Name, Address, Phone Number, Date of Birth
- 5.) Information on the Absent Parent (If Applicable)
Name, Address, Phone Number, Date of Birth
- 6.) Diagnosis of the proposed protected person

CORPORATE GUARDIANSHIP:

- 1.) Letter from Social Security showing eligibility
-OR-
Proof of Eligibility for Institutional Medicaid.
- 2.) All Income or Financial Assistance the Proposed Protected Person is receiving
- 3.) Verification from Human Services on the Amount of Food Stamps the Proposed
Protected Person is receiving.
- 4.) Information on anyone who may have further information on the case.
(Attach extra sheets if needed). Name, Address, Phone Number, Date of Birth
- 5.) Diagnosis of the proposed protected person

PLEASE ATTACH THE FOLLOWING DOCUMENTS IF AVAILABLE:

- ✓ Birth Certificate of the Proposed Protected Person
- ✓ Any type of Identification of the Proposed Protected Person
- ✓ Bank Statement of the Proposed Protected Person
- ✓ Diagnosis Information from a Qualified Health Care Professional
- ✓ Current copy of Power of Attorney, Advance Health Care Directive, Surrogate Decision Maker,
Do Not Resuscitate Order, Uniform Health Care Decisions Act or APS information.
- ✓ If this is a transfer of Guardianship case, a Letter of Guardianship from past Guardian

PLEASE NOTE:

It is important to inform the Office of Guardianship if there has been a change in any information provided in this application (example: your current address and/or telephone number, placement of the proposed protected person). Please contact us as soon as possible, so we may make this change on file. This will assist us greatly in the possibility that we may require to contact you in regards to any further legal proceedings in your case. If a change needs to be made, you may contact us by phone at 505-476-7332 or mail this information to:

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