

APPLICATION FOR GUARDIANSHIP SERVICES

The list below will help you to submit a complete application for one-time legal services to request that a guardian be appointed for an individual that may need a guardian. Please print clearly. Illegible or incomplete applications, without proper documentation, will delay processing. If any of the required documents do not apply to your case, write a letter of explanation. Otherwise, the application will be considered incomplete. Submit applications to:

Office of Guardianship
625 Silver Avenue, SW, Suite 100
Albuquerque, New Mexico 87102
Phone: (505) 841-4519; Fax: (505) 841-4455

If a family member or friend is able and willing to serve as guardian, you are considered to be applying for **Family Guardianship**, and must provide the following documentation:

1. INCOME OF PROPOSED GUARDIAN, such as most recent income tax return
2. INCOME and PUBLIC BENEFITS OF PERSON NEEDING A GUARDIAN such as most recent income tax return, Social Security Award Letter, Medicaid, TANF, trust income
3. COMPLETED REPORT OF HEALTH CARE PROFESSIONAL (form enclosed)
4. GOVERNMENT ISSUED PHOTO IDENTIFICATION OF: (color preferred)
 - a. PERSON NEEDING A GUARDIAN, and
 - b. FAMILY GUARDIAN
5. SOCIAL SECURITY CARD (copy)

If family or friend is not able or willing to serve as guardian, you are considered to be applying for **Corporate Guardianship** and must provide the following documentation:

1. INCOME and PUBLIC BENEFITS OF PERSON NEEDING A GUARDIAN, such as most recent income tax return, Social Security, Medicaid, TANF, trust income
2. COMPLETED REPORT OF HEALTH CARE PROFESSIONAL (form enclosed)
3. GOVERNMENT ISSUED PHOTO IDENTIFICATION OF PERSON NEEDING A GUARDIAN, (Copy color preferred)
4. SOCIAL SECURITY CARD (copy)

Please submit the following documents if they are relevant to your circumstance:

1. COURT DOCUMENTS REGARDING GUARDIANSHIP
2. POWER OF ATTORNEY, SURROGATE DECISION MAKER, HEALTH CARE DIRECTIVE
3. TRUST DOCUMENTS

Indicate type of guardianship requested:

LIMITED: Guardian may exercise one or two types of authority specifically designated in the order.

PLENARY (FULL): Guardian may make decisions regarding medical care, financial decisions, residential placement, safety, and supervision of the person.

TEMPORARY: Guardian is appointed for up to 60 days. Adherence to standard legal procedure would result in immediate and irreparable harm to alleged incapacitated person's physical health if guardian is not appointed prior to final hearing.

TRANSFER or SUCCESSOR: Change from one guardian to a different guardian.



APPLICATION FOR GUARDIANSHIP

OFFICIAL USE ONLY:

CASE ID # _____

INITIALS OF STAFF REVIEWING: _____

TOTAL INCOME OF HOUSEHOLD: \$ _____

FOR YEAR: 20 _____ DATE STAMP RECEIVED _____

SERVICE REQUEST: (PLEASE CHECK ONLY ONE OF THE FOLLOWING)

PROFESSIONAL (COMPANY) GUARDIANSHIP OR FAMILY GUARDIANSHIP

TYPE OF GUARDIANSHIP REQUESTING:

FULL/PLENARY TEMPORARY

LIMITED TRANSFER/SUCCESSOR

INFORMATION OF PERSON MAKING REQUEST

FIRST NAME: _____ LAST NAME: _____ RELATION: _____

ADDRESS: _____

ORGANIZATION: _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE: _____ WORK PHONE: _____ EXT. _____

CELL PHONE: _____ FAX: _____ PRIMARY LANGUAGE: _____

INFORMATION OF PERSON WHO NEEDS A GUARDIAN

FIRST NAME: _____ LAST NAME: _____ M.I.: _____

STREET ADDRESS (where this person resides): _____

MAILING ADDRESS (if different from above): _____

ZIP CODE: _____ CITY: _____ STATE: _____

PHONE NUMBER (where this person resides): _____

SOCIAL SECURITY NUMBER: _____

MALE FEMALE **PRIMARY LANGUAGE:** _____

MARITAL STATUS: MARRIED DIVORCED

CHILDREN: YES NO (If yes, please attach with Name, Address, Phone Number)

JACKSON CLASS MEMBER: YES NO **FOLEY SETTLEMENT PARTY:** YES NO **VETERAN:** YES NO

IF NATIVE AMERICAN: LIVING ON RESERVATION LIVING OFF RESERVATION

IF RESIDING IN AN INSTITUTION OR TREATMENT SETTING

Is a Discharge Plan in place: YES NO

Is a Discharge plan required: YES NO

What is the estimated date of Discharge: / /

Will this person be homeless if and when discharged: YES NO

PAST PLACEMENTS: YES NO (if yes, please attach with Name(s), Address, Phone Number)

PLEASE WRITE IN DIAGNOSIS, DO NOT USE MEDICAL CODES OR "SEE ATTACHED"

WHAT IS THE MENTAL IMPAIRMENT OF THIS PERSON:

DATE OF LAST PSYCHIATRIC EVALUATION: / /

WHAT OTHER DISABILITIES DOES THIS PERSON HAVE:

INFORMATION OF PRIMARY CARE PHYSICIAN

FIRST NAME: LAST NAME:

PRACTICE/COMPANY:

ADDRESS:

ZIP CODE: CITY: STATE:

PHONE NUMBER: FAX NUMBER:

BENEFITS OF PERSON NEEDING GUARDIAN

DOES THIS PERSON RECEIVE SOCIAL SECURITY: YES NO IF YES, WHAT TYPE AND HOW MUCH:

SSA \$

SSI \$

SSDI \$

SSA & SSI \$

BENEFITS OF PERSON NEEDING GUARDIAN

DOES THIS PERSON RECEIVE OTHER INCOME: YES NO IF YES, WHAT TYPE AND HOW MUCH: _____
 RETIREMENT \$ _____
 TRUST OR OTHER \$ _____
 VA \$ _____
 PENSION \$ _____
 WAGES \$ _____
 DOES THIS PERSON RECEIVE PUBLIC ASSISTANCE: YES NO IF YES, WHAT TYPE AND HOW MUCH: _____
 GENERAL ASSISTANCE \$ _____
 TANF \$ _____
 SNAP BENEFITS (Food Stamps) \$ _____
 CHILD SUPPORT \$ _____
 DOES THIS PERSON HAVE A REPRESENTATIVE PAYEE: YES NO IF YES, FILL OUT BELOW: _____
 FIRST NAME: _____ LAST NAME: _____
 PRACTICE/COMPANY: _____
 ADDRESS: _____
 ZIP CODE: _____ CITY: _____ STATE: _____
 PHONE NUMBER: _____ FAX NUMBER: _____
 WILL FINANCIAL ASSISTANCE BE NEEDED TO SUPERVISE THIS PERSON'S FINANCIAL AFFAIRS: YES NO
 DOES THIS PERSON HAVE A BANK ACCOUNT: YES NO IF YES, WHAT IS THE NAME OF THE BANK(S): _____
 NAME OF BANK(S): _____
 NAME OF BANK(S): _____
 DOES THIS PERSON HAVE MEDICAL COVERAGE: YES NO IF YES, WHAT TYPE: _____ ARE THERE ANY BENEFITS PENDING FOR THIS PERSON: YES NO IF YES, LIST BELOW:
 MEDICARE PRESBYTERIAN
 MEDICAID SALUDI
 DD WAIVER LOVELESS
 MI VIA WAIVER FAMILY PLANNING FOR MEN/WOMEN
 INSTITUTIONAL MEDICAID JUL MEDICAID
 SLMB BLUE CROSS/BLUE SHEILD
 QMB/QI/WDI PRIVATE HEALTH COVERAGE
 EVERCARE MOLINA
 ICF/MR OTHER PLEASE DISCRIBE: _____

PLEASE DESCRIBE BELOW ABOUT THE PERSON YOU FEEL NEEDS A GUARDIAN

PLACEMENT/RESIDENCE PLEASE DESCRIBE THEIR LIVING ARRANGEMENTS:

SUPPORT STRUCTURE DOES THIS PERSON RECEIVE ASSISTANCE FROM OTHERS:

YES NO IF YES, WHOM:

OTHER ALTERNATIVES CONSIDERED: YES NO

IF YES, PLEASE DESCRIBE AND ATTACH COPY

(SUCH AS A POWER OF ATTORNEY, SURROGATE DECISION MAKER, HEALTH CARE DIRECTIVE)

SAFETY THREAT IS THIS PERSON A THREAT TO SELF OR OTHERS: YES NO

IF YES, TO WHOM AND HOW:

(COULD THIS PERSON BE LEFT ALONE, COULD THIS PERSON CAUSE SIGNIFICANT HARM TO SELF OR OTHERS)

SECTION FOR FAMILY GUARDIANSHIP ONLY

FIRST NAME:	LAST NAME:	RELATION:
ANY OTHER NAMES YOU HAVE GONE BY:		
ADDRESS:		
ZIP CODE:	CITY:	STATE:
HOME PHONE:	WORK PHONE:	EXT.:
CELL PHONE:	FAX:	PRIMARY LANGUAGE:
IF YOU ANSWER YES TO ANY OF THE THREE (3) QUESTIONS BELOW, PLEASE ATTACH THE FINAL REPORT		
HAVE YOU EVER BEEN CONVICTED OF A FELONY:	<input type="radio"/> YES	<input type="radio"/> NO
HAVE YOU EVER BEEN REPORTED TO CHILDREN, YOUTH AND FAMILIES AGENCY:	<input type="radio"/> YES	<input type="radio"/> NO
HAVE YOU EVER BEEN REPORTED TO THE ADULT PROTECTIVE SERVICE AGENCY:	<input type="radio"/> YES	<input type="radio"/> NO

BENEFITS OF HOUSEHOLD FOR FAMILY GUARDIANSHIP: MUST ATTACH COPIES OF ALL VERIFICATIONS

<input type="radio"/> SSA	\$
<input type="radio"/> SSI	\$
<input type="radio"/> SSDI	\$
<input type="radio"/> SSA & SSI	\$
<input type="radio"/> RETIREMENT	\$
<input type="radio"/> VA	\$
<input type="radio"/> PENSION	\$
<input type="radio"/> TRUST OR OTHER	\$
<input type="radio"/> WAGES	\$
<input type="radio"/> DOES THIS PERSON RECEIVE PUBLIC ASSISTANCE:	<input type="radio"/> YES <input type="radio"/> NO IF YES, WHAT TYPE AND HOW MUCH:
<input type="radio"/> GENERAL ASSISTANCE	\$
<input type="radio"/> TANF	\$
<input type="radio"/> SNAP BENEFITS (Food Stamps)	\$
<input type="radio"/> CHILD SUPPORT	\$

OTHERS KNOWING OF PERSON THAT NEEDS A GUARDIAN

THIS COULD BE FAMILY MEMBERS, SCHOOL OFFICIALS, HEALTH CARE PROFESSIONALS, POWER OF ATTORNEY, REP. PAYEE, CASE WORKERS

FIRST NAME:	LAST NAME:	RELATION:
PRACTICE/COMPANY:		
ADDRESS:		
ZIP CODE:	CITY:	STATE:
PHONE NUMBER:	FAX NUMBER:	
FIRST NAME:	LAST NAME:	RELATION:
PRACTICE/COMPANY:		
ADDRESS:		
ZIP CODE:	CITY:	STATE:
PHONE NUMBER:	FAX NUMBER:	
FIRST NAME:	LAST NAME:	RELATION:
PRACTICE/COMPANY:		
ADDRESS:		
ZIP CODE:	CITY:	STATE:
PHONE NUMBER:	FAX NUMBER:	

STATE OF NEW MEXICO
COUNTY OF _____
____ JUDICIAL DISTRICT

IN THE MATTER OF THE ADULT GUARDIANSHIP
PROCEEDING FOR _____, PQ _____
A Person in Need of Protection.

REPORT OF HEALTH CARE PROFESSIONAL

Background: (PLEASE PRINT CLEARLY)

I

I, _____ (Print name and title), am
duly authorized and licensed in the State of New Mexico as a ___ physician ___ psychologist ___ PA
___ nurse practitioner (or) ___ other health care practitioner.

II

I _____ am willing to be appointed by the Court to serve as the Qualified
Healthcare Professional pursuant to the New Mexico Uniform Probate Code, NMSA 1978, § 45-
5-303(D):

The person **alleged to be incapacitated** shall be examined by a qualified health care
professional appointed by the court who shall submit a report in writing to the court. The
report shall:

- (1) describe the nature and degree of the alleged incapacitated person's incapacity, if any,
and the level of the respondent's intellectual, developmental and social functioning; and
- (2) contain observations, with supporting data, regarding the alleged incapacitated
person's ability to make health care decisions and manage the activities of daily living.

NMSA 1978, § 45-5-303(U):

"qualified health care professional" means a physician, psychologist, physician assistant,
nurse practitioner or other health care practitioner whose training and expertise aid in the
assessment of functional impairment.

III

My training and expertise aids in the assessment of functional impairment/capacity.

IV

For the purpose of this evaluation, pursuant to the New Mexico Uniform Probate Code,
NMSA 1978, §§ 45-5-101(F)–(H) the following definition applies:

(F) An "incapacitated person" means "any person who demonstrates over time either partial
or complete functional impairment by reason of mental illness, mental deficiency, physical illness or
disability, chronic use of drugs, chronic intoxication or other cause, except minority, to the extent

that" one "is unable to manage" one's "personal affairs", one's "estate" or one's "financial affairs or both."

(G) "inability to manage the person's personal care" means the inability, as evidenced by recent behavior, to meet one's needs for medical care, nutrition, clothing, shelter, hygiene or safety so that physical injury, illness or disease has occurred or is likely to occur in the near future;

(H) "inability to manage the person's estate or financial affairs or both" means gross mismanagement, as evidenced by recent behavior, of one's income and resources or medical inability to manage one's income and resources that has led or is likely in the near future to lead to financial vulnerability.

V

The alleged incapacitated person's name is _____ is age _____, (DOB _____).

VI

I _____ examined/ evaluated _____, on _____, 20____, and have submitted this report pursuant to NMSA 1978 § 45-5-303(D) and § 45-5-407(C).

Complete if applicable:

_____ has been my patient and under my care for a period of _____ beginning on or about _____.

Physical Status

VII

The following are my observations regarding _____'s ability to do the below activities:

	(without assistance (w/o A)	with limited assistance (w/ A)	needs total assistance (TA)	unknown (UNK)
	w/o A	w/ A	TA	UNK
manage the activities of daily living				
eating				
meal preparation				
dressing/undressing				
oral care				
toileting				
bathing				
ambulating				
housework				
driving				
shopping				
Additional Comments:				

Cognitive Status

VIII

My examination/evaluation of _____, included the following diagnostic procedures: _____

_____.

IX

The examination of _____ and the review of medical and behavioral health records were sufficient to allow me to make a determination of his/her mental capacity and the level of his/her developmental and social functioning.

X

The specific physical, psychiatric or psychological diagnosis(es) of _____ is (are) as follows (please note any current alcohol or drug use):

_____.

XI

_____’s physical condition ___ does ___ does not affect his/her ability to make or communicate responsible decisions.

XII

_____’s mental condition ___ does ___ does not affect his/her ability to make or communicate responsible decisions.

XIII

The following are my observations regarding _____’s ability to do the following:

(circle the correct one)

_____ can / cannot make **informed** mental health care decisions.

_____ can / cannot make **informed** general health care decisions.

Why? _____

The following are my observations regarding _____’s ability to do the below tasks:

(without assistance (w/o A) with limited assistance (w/ A) needs full assistance (FA) unknown (UNK)				
	w/o A	w/ A	FA	UNK
Determine appropriate living arrangements				
take medication as prescribed				
communicate				
behave safely				
access emergency response				
manage estate/financial matters, and				
manage other personal matters:				
Additional Comments:				

XIV

BASED ON THE ABOVE INFORMATION AND THE DEFINITION OF INCAPACITY AS OUTLINED IN PARAGRAPH III.

IT IS MY OPINION THAT THE PROPOSED PROTECTED PERSON

(check only those that apply):

- is substantially unable to provide food, clothing or shelter for himself/herself;
- is substantially unable to care for his/her own physical health;
- is substantially unable to manage his/her own financial affairs.

XIV

IT IS MY OPINION THAT THE PROPOSED PROTECTED PERSON IS (check one):

Not incapacitated.

It is my opinion my opinion that the proposed protected person is not incapacitated, and the proposed protected person is able to make reasonable arrangements for his/her care and safety as well as for his/her personal and financial matters.

Partially incapacitated.

It is my opinion that the proposed protected person is partially incapacitated. A guardian should be appointed and granted the powers necessary to make decisions for the proposed protected person concerning the matters that require assistance under paragraph XIII above.

Totally incapacitated.

It is my opinion that the proposed protected person is totally incapacitated. A guardian should be appointed and granted powers necessary to make decisions for the proposed protected person concerning all, but not limited to, the matters listed under paragraph XIII above.

XV

My medical opinions and recommendations are supported by observation, medical records
and reports.

 **I have attached additional information that might assist the Court in resolving the issue
of capacity of the proposed protected person. (Cross out these lines if inapplicable.)**

Respectfully submitted by: **PRINT CLEARLY**

Print Name and Credentials Clearly

Signature

Date Signed

Print Medical Facility Clearly

Print Address Clearly

Print Phone Number Clearly