

### FOR THE APPLICATION

*Using this list will help you to submit a complete application for guardianship. Please print clearly, illegible or incomplete applications or applications with lack of documents will delay processing. If any of these documents do not apply to your case, please write a letter explaining that, otherwise, the application also will be considered incomplete. Submit completed applications to:*

Office of Guardianship  
625 Silver Ave. SW, Suite 100  
Albuquerque, New Mexico 87102

**IF NO FAMILY OR FRIEND IS ABLE AND WILLING TO SERVE AS A GUARDIAN, YOU ARE CONSIDERED TO BE APPLYING FOR CORPORATE GUARDIANSHIP**

- € MOST RECENT FEDERAL INCOME TAX RETURN OF PERSON NEEDING A GUARDIAN
- € ALL INCOME and PUBLIC BENEFITS OF PERSON NEEDING A GUARDIAN, SUCH AS MEDICAID, SOCIAL SECURITY, TRUST INCOME
- € COMPLETED REPORT OF HEALTH CARE PROFESSIONAL (FORM ENCLOSED)
- € GOVERNMENT ISSUED PHOTO IDENTIFICATION OF PERSON NEEDING A GUARDIAN, COLOR PREFERRED
- € BIRTH CERTIFICATE

**IF SOMEONE SUCH AS A FAMILY MEMBER OR A FRIEND IS ABLE AND WILLING TO SERVE AS A GUARDIAN, YOU ARE CONSIDERED TO BE APPLYING FOR FAMILY GUARDIANSHIP**

- € MOST RECENT FEDERAL INCOME TAX RETURN OF PROPOSED GUARDIAN
- € MOST RECENT FEDERAL INCOME TAX RETURN OF PERSON NEEDING A GUARDIAN
- € ALL INCOME and PUBLIC BENEFITS OF PERSON NEEDING A GUARDIAN, SUCH AS MEDICAID, SOCIAL SECURITY, TRUST INCOME
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**You may also submit the following documents that will assist with your case: \*If Applicable**

- € COURT DOCUMENTS REGARDING GUARDIANSHIP\*
- € TRUST DOCUMENTS\*
- € ALTERNATIVES TO GUARDIANSHIP, EXECUTED POWER OF ATTORNEY, SURROGATE DECISION MAKER, HEALTH CARE DIRECTIVE\*

### TYPES OF GUARDIANSHIP ALL APPOINTED BY THE COURT

**LIMITED** - To exercise the legal rights and powers specifically designated in the court's order.

**PLENARY (FULL)** - To make decisions regarding medical care, financial decisions, paying expenses, residential placement, safety and supervision

**TEMPORARY** - An expedited hearing. Specific powers granted by the court to prevent harm to the alleged incapacitated person during the time of his or her appointment.

**TRANSFER/SUCCESSOR** - To continue the role of current guardian that is unable or willing to serve.



APPLICATION FOR GUARDIANSHIP

<b>SERVICE REQUEST:</b> (PLEASE CHECK <u>ONLY ONE</u> OF THE FOLLOWING)	
<input type="radio"/> PROFESSIONAL (COMPANY) GUARDIANSHIP	<input type="radio"/> OR <input type="radio"/> FAMILY GUARDIANSHIP
<b>TYPE OF GUARDIANSHIP REQUESTING:</b>	
<input type="radio"/> FULL/PLENARY	<input type="radio"/> TEMPORARY
<input type="radio"/> LIMITED	<input type="radio"/> TRANSFER/SUCCESSOR
<b>OFFICIAL USE ONLY:</b>	
CASE ID # _____	INITIALS OF STAFF REVIEWING: _____
TOTAL INCOME OF HOUSEHOLD: \$ _____	DATE STAMP RECEIVED _____
FOR YEAR: 20 _____	
<b>INFORMATION OF PERSON MAKING REQUEST</b>	
FIRST NAME: _____	LAST NAME: _____
ADDRESS: _____	RELATION: _____
ORGANIZATION: _____	
ZIP CODE: _____	CITY: _____ STATE: _____
HOME PHONE: _____	WORK PHONE: _____ EXT. _____
CELL PHONE: _____	FAX: _____
PRIMARY LANGUAGE: _____	
<b>INFORMATION OF PERSON WHO NEEDS A GUARDIAN</b>	
FIRST NAME: _____	LAST NAME: _____
STREET ADDRESS(where this person resides): _____	M.I.: _____
MAILING ADDRESS(if different from above): _____	
ZIP CODE: _____	CITY: _____ STATE: _____
PHONE NUMBER(where this person resides): _____	
SOCIAL SECURITY NUMBER: _____	DATE OF BIRTH: _____ / _____ / _____
<input type="radio"/> MALE <input type="radio"/> FEMALE	PRIMARY LANGUAGE: _____
MARITAL STATUS: <input type="radio"/> YES <input type="radio"/> MARRIED <input type="radio"/> NO	ETHNICITY (optional): <input type="radio"/> SINGLE
CHILDREN: <input type="radio"/> YES <input type="radio"/> NO	(if yes, please attach with Name, Address, Phone Number)
JACKSON CLASS MEMBER: <input type="radio"/> YES <input type="radio"/> NO	FOLEY SETTLEMENT PARTY: <input type="radio"/> YES <input type="radio"/> NO
IF NATIVE AMERICAN: <input type="radio"/> LIVING ON RESERVATION <input type="radio"/> LIVING OFF RESERVATION	VETERAN: <input type="radio"/> YES <input type="radio"/> NO



IF RESIDING IN AN INSTITUTION OR TREATMENT SETTING	
Is a Discharge Plan in place:	<input type="radio"/> YES <input type="radio"/> NO
Is a Discharge plan required:	<input type="radio"/> YES <input type="radio"/> NO
What is the estimated date of Discharge:	/ /
Will this person be homeless if and when discharged:	<input checked="" type="radio"/> YES <input type="radio"/> NO
PAST PLACEMENTS:	<input type="radio"/> YES <input type="radio"/> 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:
PHONE NUMBER:	STATE:
	FAX NUMBER:

BENEFITS OF PERSON NEEDING GUARDIAN		
DOES THIS PERSON RECEIVE SOCIAL SECURITY:	<input type="radio"/> YES	<input type="radio"/> NO
<input type="radio"/> SSA	\$	
<input type="radio"/> SSI	\$	
<input type="radio"/> SSDI	\$	
<input type="radio"/> SSA & SSI	\$	

# BENEFITS OF PERSON NEEDING GUARDIAN

DOES THIS PERSON RECEIVE OTHER INCOME:		<input checked="" type="radio"/> YES	<input type="radio"/> NO	IF YES, WHAT TYPE AND HOW MUCH:
<input type="radio"/> RETIREMENT	\$			
<input type="radio"/> TRUST OR OTHER	\$			
<input type="radio"/> VA	\$			
<input type="radio"/> PENSION	\$			
<input type="radio"/> WAGES	\$			
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	\$			
DOES THIS PERSON HAVE A REPRESENTATIVE PAYEE:		<input type="radio"/> YES	<input type="radio"/> 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 <input type="radio"/> NO <input type="radio"/>				
DOES THIS PERSON HAVE A BANK ACCOUNT:		<input checked="" type="radio"/> YES	<input type="radio"/> 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:		<input type="radio"/> YES	<input type="radio"/> NO	IF YES, WHAT TYPE: ARE THERE ANY BENEFITS PENDING FOR THIS PERSON:
<input type="radio"/> MEDICARE	<input type="radio"/> PRESBYTERIAN	<input type="radio"/> YES	<input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
<input type="radio"/> MEDICAID	<input type="radio"/> SALUD!			
<input type="radio"/> DD WAIVER	<input type="radio"/> LOVELESS			
<input type="radio"/> MI VIA WAIVER	<input type="radio"/> FAMILY PLANNING FOR MEN/WOMEN			
<input type="radio"/> INSTITUTIONAL MEDICAID	<input type="radio"/> JUL MEDICAID			
<input type="radio"/> SLMB	<input type="radio"/> BLUE CROSS/BLUE SHEILD			
<input type="radio"/> QMB/QI/WDI	<input type="radio"/> PRIVATE HEALTH COVERAGE			
<input type="radio"/> EVERCARE	<input type="radio"/> MOLINA			
<input type="radio"/> ICF/MR	<input type="radio"/> 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:			
<input type="radio"/> YES		<input type="radio"/> NO	
IF YES, WHOM:			
OTHER ALTERNATIVES CONSIDERED:			
<input type="radio"/> YES		<input type="radio"/> 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:			
<input type="radio"/> YES		<input type="radio"/> 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**

<b>FIRST NAME:</b>		<b>LAST NAME:</b>		<b>RELATION:</b>	
<b>ANY OTHER NAMES YOU HAVE GONE BY:</b>					
<b>ADDRESS:</b>					
<b>ZIP CODE:</b>		<b>CITY:</b>		<b>STATE:</b>	
<b>HOME PHONE:</b>		<b>WORK PHONE:</b>		<b>EXT.:</b>	
<b>CELL PHONE:</b>		<b>FAX:</b>		<b>PRIMARY LANGUAGE:</b>	
<b>IF YOU ANSWER YES TO ANY OF THE THREE (3) QUESTIONS BELOW, PLEASE ATTACH THE FINAL REPORT</b>					
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					

<b>BENEFITS OF HOUSEHOLD FOR FAMILY GUARDIANSHIP: MUST ATTACH COPIES OF ALL VERIFICATIONS</b>			
<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	\$		
<b>DOES THIS PERSON RECEIVE PUBLIC ASSISTANCE:    <input type="radio"/> YES    <input type="radio"/> NO    IF YES, WHAT TYPE AND HOW MUCH:</b>			
<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:			

SECTION FOR TRANSFER OR SUCCESSOR GUARDIAN

[illegible]

The Guardianship Program and The NMDDPC respects you and your privacy. We are committed to keeping all information received or created confidential. Information that is requested other than Income, is requested and used by the contract Attorney for each case assigned.

By signing below, I acknowledge that I have answered truthfully to the best of my ability. I understand that the Guardianship Program/NMDDPC may discontinue services due to false communications, misrepresentations, or omissions. I also understand that the Guardianship Program/NMDDPC may seek reimbursement for costs of the services provided due to purposeful misrepresentations or omissions.

PRINTED NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_  
DATE SIGNED: \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE SIGNED: \_\_\_\_/\_\_\_\_/\_\_\_\_



STATE OF NEW MEXICO  
COUNTY OF \_\_\_\_\_  
\_\_\_\_ JUDICIAL DISTRICT

IN THE MATTER OF THE ADULT GUARDIANSHIP  
PROCEEDING FOR \_\_\_\_\_, PQ \_\_\_\_\_  
an alleged incapacitated person.

**REPORT OF HEALTH CARE PROFESSIONAL**

**Background**

I

I, \_\_\_\_\_, am  
duly authorized and licensed in the State of New Mexico as a \_\_ physician \_\_ psychologist \_\_ PA  
\_\_ nurse practitioner (or) \_\_ other health care practitioner.

II

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

III

For the purpose of this evaluation, the following definition applies:  
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."

IV

\_\_\_\_\_ is age \_\_\_\_\_, (DOB  
\_\_\_\_\_).

V

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

**Complete if applicable:**

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

## Physical Status

### VI

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

### VII

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

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### VIII

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.

### IX

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

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X

\_\_\_\_\_ 's physical condition \_\_\_\_ does \_\_\_\_ does not affect his/her ability to make or communicate responsible decisions.

XI

\_\_\_\_\_ 's mental condition \_\_\_\_ does \_\_\_\_ does not affect his/her ability to make or communicate responsible decisions.

XII

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

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.

XV

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.

XVI

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

\_\_\_\_\_  
(Signature)

Address: \_\_\_\_\_

Phone: \_\_\_\_\_