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) 841-4590

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.

NEW MEXICO DEVELOPMENTAL DISABILITIES PLANNING COUNCIL

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: - -		DATE OF BIRTH: / /
○ MALE ○ FEMALE	PRIMARY LANGUAGE:	ETHNICITY (optional):
MARITAL STATUS: ○ MARRIED	○ DIVORCED	○ SINGLE
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: ○ES 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:**
○MEDICARE	○PRESBYTERIAN			○ YES ○ NO IF YES, LIST BELOW:
○MEDICAID	○SALUD!			
○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 DESRIBE 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:	⬭ YES	⬭ NO
HAVE YOU EVER BEEN REPORTED TO CHILDREN, YOUTH AND FAMILIES AGENCY:	⬭ YES	⬭ NO
HAVE YOU EVER BEEN REPORTED TO THE ADULT PROTECTIVE SERVICE AGENCY:	⬭ YES	⬭ NO

BENEFITS OF HOUSEHOLD FOR FAMILY GUARDIANSHIP: **MUST ATTACH COPIES OF ALL VERIFICATIONS**			
⬭ SSA	$		
⬭ SSI	$		
⬭ SSDI	$		
⬭ SSA & SSI	$		
⬭ RETIREMENT	$		
⬭ VA	$		
⬭ PENSION	$		
⬭ TRUST OR OTHER	$		
⬭ 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	$		

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

CURRENT GUARDIAN:		**RELATION:**
ADDRESS:		
ORGANIZATION:		
ZIP CODE:	**CITY:**	**STATE:**
PHONE NUMBER:	**CELL PHONE:**	**FAX NUMBER:**
EMAIL:		
COUNTY WHERE ORIGINAL COURT ORDER WAS FILED:		
COPY OF ORDER AVAILABLE: ⬭ YES	⬭ NO	IF YES, PLEASE ATTACH COPY.

EXPLAIN WHY THE TRANSFER OR SUCCESSOR GUARDIANSHIP IS REQUIRED:

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:** ____ /_____/_____

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 actvities:

(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 arrangments				
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