NEW MEXICO DEVELOPMENTAL DISABILITIES PLANNING COUNCIL

## OFFICE OF GUARDIANSHIP SERVICES APPLICATION

The checklist below will help you to submit the attached application for guardianship services. Accurate contact information must be provided. If any changes occur after the application is submitted, contact our office. Failure to do so may result in the application being closed. **The person needing services MUST BE age 18 or older.**

**Please print clearly. Illegible or incomplete applications will delay processing.**

If you have questions or need assistance, please call (505) 841-4519.
Applications can be submitted in person or sent via:

**Email:** DDPCOOG.Intake@state.nm.us
**Fax:** (505) 841-4455
**U.S. Mail:**
DDPC-Office of Guardianship
Attn: Intake Coordinator
625 Silver Avenue SW, Suite 100
Albuquerque, NM 87102

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### CHECKLIST OF ITEMS NEEDED REGARDING THE PERSON WHO MAY NEED A GUARDIAN

(1) Identification

- ☐ Government Issued ID
- ☐ Social Security Card/Individual Taxpayer Identification Number

(2) Financial Documentation **(as applicable)**

- ☐ Current Federal Income Tax Return
- ☐ Social Security Income
- ☐ Food Stamps
- ☐ Pension
- ☐ Unemployment Compensation
- ☐ Other: _____
- ☐ Trust Information
- ☐ Child Support

(3) Legal Documentation **(as applicable)**

- ☐ Power of Attorney
- ☐ Surrogate Decision Maker
- ☐ Healthcare Directive
- ☐ N/A

(4) Report of Health Care Professional **(form enclosed)**

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### CHECKLIST OF ITEMS NEEDED IF YOU ARE A FAMILY MEMBER OR FRIEND REQUESTING TO BE GUARDIAN

If a family member or friend is able and willing to serve as guardian, that family member or friend is considered to be applying for Family Guardianship and **must provide** their financial information to determine eligibility.

(1) Identification

- ☐ Government Issued ID

(2) Financial Documentation **(as applicable)**

- ☐ Current Federal Income Tax Return
- ☐ Social Security Income
- ☐ Food Stamps
- ☐ Pension
- ☐ Unemployment Compensation
- ☐ Other: _____
- ☐ Trust Information
- ☐ Child Support

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### CHECKLIST OF ITEMS NEEDED IF THERE IS AN EXISTING GUARDIANSHIP AND YOU ARE REQUESTING A CHANGE IN THE EXISTING GUARDIANSHIP

If the request for services is for appointment of a successor guardian; termination of the guardianship; or review of the scope of a guardian's authority, the following documentation must be provided:

(1) Guardianship Legal Documents

- ☐ Guardianship Order
- ☐ Letters of Guardianship
- ☐ Last Two Years Guardian's Annual Report

| OFFICIAL USE ONLY | DATE STAMP RECEIVED |
|---|---|
| **Staff Reviewing: _____**<br>**Date of Determination: _____**<br>☐ **Eligible** ☐ **Ineligible**<br>**Case ID#: _____**<br>**Total Household #: _____**<br>**Total Income: $_____** | |

# OFFICE OF GUARDIANSHIP SERVICES APPLICATION

**SERVICE REQUEST:**

☐ Professional Guardianship
☐ Family/Friend Guardianship
☐ Successor/Replacement Guardian
☐ Termination or Change in Level of Guardianship

## INFORMATION ABOUT YOU

Legal Name: _____
*First Name* *MI* *Last Name*

_____ _____
*Agency/Facility Name (if applicable)* *Title of Requestor (if applicable)*

Address: _____

_____
*City* *State* *Zip Code*

Mailing Address: _____
*(Only If Different from Above)*

_____
*City* *State* *Zip Code*

_____ _____
*Home & Cell Phone Numbers* *Email Address*

_____ _____
*Relationship to Person Who May Need a Guardian* *Primary Language of Requestor*

**Has the Person Been Informed That You Are Applying to Have a Guardian Appointed to Make Their Life Decisions?** ☐ Yes ☐ No
If "yes," describe their response. If "no," explain why:

_____

_____

**Why Do You Believe This Person Needs a Guardian?**

_____

_____

_____



revised 7/22/2021

**There Are Many Alternatives to Guardianship. What Alternatives Have Been Attempted or Considered?**

☐ Power of Attorney
☐ Treatment Guardian
☐ Surrogate Decision Maker
☐ Care Coordination/Case Management
☐ Medical Power of Attorney
☐ Health Care Advanced Directive
☐ Residential Support Services
☐ Other: _____
☐ Financial Power of Attorney
☐ Representative Payee
☐ Fiduciary/Trustee

***Please Visit [www.nmddpc.com/guardianship_program](www.nmddpc.com/guardianship_program) to Learn About Alternatives to Guardianship***

**Why Were These Alternatives Unsuccessful or Not Attempted?**

_____

_____

_____

_____

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## INFORMATION ABOUT THE PERSON WHO MAY BE IN NEED OF A GUARDIAN

Legal Name: _____
*First Name* *MI* *Last Name*

Physical Address:
_____

_____
*City* *State* *Zip Code*

Mailing Address: _____

_____
*City* *State* *Zip Code*

_____
*Phone Numbers*

**Current Living Arrangement:**
☐ Lives Alone
☐ Lives with Family/Supports
☐ Tribal Land/Reservation
☐ Homeless
☐ Boarding/Group Home
☐ Hospital
☐ Facility
☐ Incarcerated
☐ Supported Living Provider
☐ Family Living Provider
☐ Other: _____

**If the Person Is Currently in A Hospital/Facility or Is Incarcerated Please Complete the Following:**

_____ _____
*Contact Person with their title or position* *Contact Person Phone Number & Email Address*

Marital Status: ☐ Single ☐ Married ☐ Significant Other ☐ Divorced ☐ Widowed

Gender: _____ Preferred Pronouns: _____ Ethnicity: _____

Date of Birth: _____ Social Security Number: _____

Primary Language: _____ Are Interpreter Services Needed: ☐ Yes ☐ No

**Describe How the Person Best Communicates:** _____

_____

**Select All That Apply to The Person:**

☐ Adult Protective Services referral ☐ Jackson Class Member ☐ Foley Settlement Party ☐ Veteran

**Is the Person Currently Receiving or Waiting for Any of the Following Benefits?**

☐ Central Registry/DD Waiver Waitlist ☐ State General Funds ☐ Case Management/Care Coordination
☐ DD Waiver ☐ Mi Via Waiver ☐ Self-Directed Community Benefit

## MEDICAL/MENTAL HEALTH INFORMATION OF PERSON WHO MAY NEED A GUARDIAN

**PRIMARY DIAGNOSES:**

_____

_____

_____

**Health and Safety Risks For The Person Who May Need A Guardian.** Select all that apply.

☐ Chronic Medical Condition(s) ☐ Refuses Medication ☐ Danger to Self
☐ Medically Fragile ☐ Refuses Medical Care ☐ Danger to Others
☐ Unable to Care for Self ☐ Substance Abuse ☐ Other: _____
☐ Unsuitable Living Conditions ☐ Elopement/Flight Risk ☐ Financial Exploitation

For any risks checked, how are they currently being addressed?

_____

_____

_____

**PRIMARY CARE PHYSICIAN:**

Physician's Name: _____

Mailing Address: _____

_____
*City* *State* *Zip Code*

_____ _____
*Phone Number* *Email Address*

**DOES THE PERSON HAVE HEALTH INSURANCE?**

☐ Institutional Medicaid ☐ Private Health Insurance: _____
☐ Medicaid MCO ☐ Other: _____
☐ Medicare ☐ None

## INCOME ELIGIBILITY & FINANCIAL INFORMATION OF THE PERSON WHO MAY NEED A GUARDIAN

| Financial Source(s) | Monthly Amount | Financial Source(s) | Monthly Amount |
|---|---|---|---|
| ☐ Retirement/Pension | $ | ☐ Trust | $ |
| ☐ SSDI | $ | ☐ Wages | $ |
| ☐ SSI | $ | ☐ Other Income | $ |

**Total Monthly Income from All Sources (provide documentation):** $ _____

**Does the Person Have A Bank Account?** ☐ Yes ☐ No

**Does the Person Own Real Property (e.g., House, Condo, Rental Property, Land)?** ☐ Yes ☐ No

If checked "yes," provide the complete property address:

_____

**Does the Person Reside at the Property Listed Above?** ☐ Yes ☐ No

**SOCIAL SECURITY BENEFITS**

**Does the Person Have A Representative Payee Appointed by the Social Security Administration?**

☐ No ☐ Yes _____
*Agency or Person Acting as Representative Payee*

If "yes," Mailing Address: _____

_____
*City* *State* *Zip Code*

_____ _____
*Phone Number* *Email Address*

**VETERANS BENEFITS**

**If the Person Receives Veteran Benefits, Does the Person Have A Fiduciary Appointed by the Federal Department of Veterans Affairs?**

☐ No ☐ Yes _____
*Agency or Person Acting as Fiduciary*

If "yes," Mailing Address: _____

_____
*City* *State* *Zip Code*

_____ _____
*Phone Number* *Email Address*

**TRUSTS**

**Does the Person Have A Trust with A Trustee?**
☐ No ☐ Yes _____
*Agency or Person Acting as Trustee*

If "yes," Mailing Address: _____

_____
*City* *State* *Zip Code*

_____ _____
*Phone Number* *Email Address*

## NEW MEXICO LAW REQUIRES SPECIFIC PERSONS TO BE NOTIFIED OF A GUARDIANSHIP COURT CASE.

**The Person's Parents**
Both parents (either biological or adoptive) MUST be identified. Please note if either parent is deceased.

Mother's Name: _____ Phone Number: _____

Address:

_____
*City* *State* *Zip Code*

Father's Name: _____ Phone Number: _____

Address:

_____
*City* *State* *Zip Code*

**Does the Person Have A Spouse Or Other Adult With Whom They Have Demonstrated A Commitment Similar To That Of A Marriage?**

☐ No ☐ Yes _____
*Name of Spouse or Partner*

If "yes," Mailing Address: _____

_____
*City* *State* *Zip Code*

_____ _____
*Phone Number* *Email Address*

**Does The Person Have Any Living Brothers Or Sisters Over 18 Years Old?** (you must include all blood-related adult siblings, even if the person no longer interacts with them)

☐ No ☐ Yes If yes, how many? _____

List the Names, Phone Numbers, & Mailing Addresses for Each Adult Sibling. If there are more than two siblings, you MUST attach a separate sheet with their names, phone numbers, and mailing addresses.

Sibling #1 Name: _____ Phone Number: _____

Address:

_____
*City* *State* *Zip Code*

Sibling #2 Name: _____ Phone Number: _____

Address:

_____
*City* *State* *Zip Code*

**Does The Person Have Any Living Adult Children Or Stepchildren?**

List the Names, Phone Numbers, & Mailing Addresses for each Adult Child. If there are more than two children, you MUST attach a separate sheet with their names, phone numbers, and mailing addresses.

Child #1 Name: _____ Phone Number: _____

Address:

_____

*City* *State* *Zip Code*

Child #2 Name: _____ Phone Number: _____

Address:

_____

*City* *State* *Zip Code*

**If there are no living parents, adult children, or adult siblings, provide the closest blood relative who can be found:**

Name: _____ Phone Number: _____

Address:

_____

Relationship: _____

**Is There Any Person Known to Have Routinely Assisted the Person with Decision Making in The Past Six Months?**

☐ No ☐ Yes _____

*Name of Support Person*

If "yes," Mailing Address: _____

_____

*City* *State* *Zip Code*

_____ _____

*Phone Number* *Email Address*

---

By signing below, I acknowledge that I have answered truthfully to the best of my ability. I understand that the Office of Guardianship reserves the right to grant services based on funding and resources available.

**Printed Name:** _____

**Signature:** _____ **Date:** _____

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## COMPLETE THIS SECTION IF YOU ARE APPLYING TO HAVE A FAMILY MEMBER, FRIEND, OR YOURSELF APPOINTED AS GUARDIAN

(skip this section if applying for a professional guardian)

**PROPOSED GUARDIAN INFORMATION:**

Legal Name: _____
*First Name* *MI* *Last Name*

Physical Address: _____

_____
*City* *State* *Zip Code*

Mailing Address: _____
*(Only If Different From Above)*

_____
*City* *State* *Zip Code*

_____ _____
*Phone Number* *Email Address*

_____ _____
*Relationship to Person* *Primary Language of Proposed Guardian*

## INCOME ELIGIBILITY OF PROPOSED NON-PROFESSIONAL GUARDIAN

New Mexico law requires that any non-professional, non-certified guardian be financially eligible for services through the Office of Guardianship.

**How Many People Live in the Proposed Guardian's Home?** _____

**What is the Total Monthly Household Income? (attach documentation):** $ _____

By signing below, I acknowledge that I have answered truthfully to the best of my ability. I understand that the Office of Guardianship reserves the right to grant services based on funding and resources available.

**Printed Name:** _____

**Signature:** _____ **Date:** _____

# PART II

# MEDICAL DOCUMENTATION

# PROVIDE NEXT SECTION TO MEDICAL PROVIDER TO COMPLETE

**STATE OF NEW MEXICO**
**COUNTY OF _____**
**_____ JUDICIAL DISTRICT**

**NO.**

**IN THE MATTER OF**
**THE GUARDIANSHIP PROCEEDINGS**
**FOR _____,**
**an Alleged Protected Person.**

# REPORT OF HEALTH CARE PROFESSIONAL

**Background:**

**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(E)(1)-(2)**:

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.

**"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 _____.
He/She is **_____ (___)** years old, **(DOB: ____/___/_____).**

**VI**

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

**<u>Complete if applicable</u>**:

_____ has been my patient and under my care for a period of _____ years/months, 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)**<br>Needs **Total Assistance (TA)** **Unknown (UNK)** | | | | |
|---|---|---|---|---|
| | **w/o A** | **w/A** | **TA** | **UNK** |
| **Manage the activities of daily living (ADL):** | | | | |
| Eating | | | | |
| Meal preparation | | | | |
| Dressing/undressing | | | | |
| Oral care | | | | |
| Toileting | | | | |
| 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 (circle) mental capacity and the level of his/her (circle) developmental and social functioning.

**X**

The specific physical, psychiatric, or psychological diagnosis/diagnoses of _____is/are as follows:

(Please note any current alcohol or drug use)

_____

_____

_____

_____

**XI**

_____'s **physical** condition _____ **does** -*or*- ____ **does not** affect his/her ability to **make or communicate responsible decisions**.

**XII**

_____'s **mental** condition _____ **does** -*or*- ____ **does not** affect his/her ability to **make or communicate responsible decisions**.

**XIII**

The following are my observations regarding _____'s ability to make mental and general health care decisions. (**Circle the Correct One**)

_____ **can** -*or*- **cannot** make **informed** mental health care decisions.

_____**can** -*or*- **cannot** make **informed** general health care decisions.

**Why?** _____

**XIV**

The following are my observations regarding _____ ability to manage the activities of daily living and manage his/her (circle) estate or financial affairs listed below:

| **Without Assistance (w/o A)** With **Limited Assistance (w/A)**<br>Needs **Total Assistance (TA)** **Unknown (UNK)** | | | | |
|---|---|---|---|---|
| | **w/o A** | **w/A** | **TA** | **UNK** |
| Determine appropriate living arrangements | | | | |
| Take medication as prescribed | | | | |
| Communicate | | | | |
| Behave safely | | | | |
| Access emergency response | | | | |
| Manage estate/financial matters | | | | |
| Manage other personal matters | | | | |
| **Additional Comments**: | | | | |

**XV**

**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.

**XVI**

**IT IS MY OPINION THAT THE PROPOSED PROTECTED PERSON IS**:

**(Please 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 VII, XIII, XIV and XV 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 VII, XIII, XIV and XV above.

**XVII**

**(Please Initial Applicable Lines)**

_____ 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 this statement if no additional information attached.)***

**Respectfully Submitted By**:

| | |
|---|---|
| (**Printed Name**) | **(Title)** |
| (**Signature**) | **(Date Signed)** |
| **(Facility)** | |
| **(Address)** | |
| **(City)** **(State)** **(Zip)** | |
| **(Phone)** | **(Fax)** |

**ALL SECTIONS ON THIS PAGE MUST BE COMPLETED**