**REQUEST FOR GUARDIANSHIP AND / OR PROTECTIVE PLACEMENT**

# INSTRUCTIONS:

# Please read every question carefully and review the instructions form before completing this document.

# Hit tab to advance to the next form field.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date:

Requested By:

 Petitioner’s Name & Title:

 Petitioner’s Agency:

 Address:

 Phone Number:

 Email Address:

**Request for:** (*please check all that apply*)

[ ]  Guardianship of Person

[ ]  Guardianship of Estate (when assets or properties are over $50,000)

[ ]  Protective Placement - I am requesting protective placement because:

 [ ]  Proposed ward is residing or will reside in a 16+ bed CBRF, NH, or ICFMR

 [ ]  Proposed ward protests the placement I think is needed

[ ]  Temporary Guardianship of Person - for emergency, potentially life-threatening situations only

**Proposed Ward’s Information:**

Name:

 Social Security No. DOB (mm/dd/yyyy):

 Phone Number:

 Proposed Ward’s Address:

Name, Address of facility, and phone number, if not living with family or self:

Type of Residence: [ ]  Independent Home/Apt. [ ]  Supervised Apt [ ]  AFH

 [ ]  CBRF [ ]  SNF [ ]  ICFMR

Facility Size: [ ]  less than 8 beds [ ]  8 to 15 beds [ ]  16 beds or greater [ ]  n/a

**Proposed Ward’s Real Estate:**

Does the proposed ward reside in County?

 [ ]  YES

 [ ]  NO, explain how the ward came to live outside County:

Does the proposed ward own property in County?

 [ ]  YES

 [ ]  NO

 If the proposed ward owns property outside of County but in Wisconsin,

 where:

**Alternatives to Guardianship:**

Power of Attorney for Health Care (attach copy of entire POA, including activation):

 [ ]  YES [x]  NO

 Is POA-HC Activated: [ ]  YES [ ]  NO

 Date Activated:

 Name, Address and Phone Number of Agent(s):

Power of Attorney for Finances/Durable (attach copy of entire POA, including activation):

 [ ]  YES [x]  NO

 Is POA-Durable Activated: [ ]  YES [ ]  NO

 Date Activated:

 Name, Address and Phone Number of Agent(s):

Why is guardianship needed if there is a POA?

Does the Proposed Ward have Supported Decision Making Agreements (SDMA)? (attach copy)

 [ ]  YES

 [ ]  NO

Why is guardianship needed if there is a SDMA?

Representative Payee: [ ]  YES [ ]  NO

 Name, Address and Phone:

Are you aware of any previous or out-of-state guardianships on this individual?

[ ]  Yes (attach papers) [x]  No

**Proposed Guardian Information:**

Proposed Guardian’s Name:

 Address and Phone:

 Proposed guardian’s relationship to individual (ex. mother, nephew, friend, volunteer, corporate\*):

Proposed Standby Guardian Name:

 Address and Phone:

 Proposed standby’s relationship to individual (ex. mother, nephew, friend, volunteer, corporate\*):

\*If you are nominating a volunteer or a corporate guardian, *explain why family members are unsuitable or unwilling to be guardian*:

For Out-Of-State Guardians:

See *Instructions.*

**Court Proceedings:**

Is proposed ward physically able to attend court? [ ]  YES [ ]  NO

 If No, explain:

**Proposed Ward’s Income/Assets**:

Personal Property: $      Real Estate: $      Pension: $     --From:

Social Security (monthly): $

Type of Funding: [ ]  None [ ]  Family Care [ ]  IRIS [ ]  Title 19

 Other (specify):

Other Income, Compensation, Insurance, Trusts, or Allowance:

 $     --From:

Is the proposed ward a veteran or receiving VA benefits?

 [ ]  No [ ]  Yes--Amount $

**Reason Guardianship requested**:

[ ]  Medical, etc. decisions needed

[ ]  Placement needed

[ ]  Self-Neglect

[ ]  Abuse / Exploitation

[ ]  POA documents questionable

[ ]  POA not acting in the best interests of client

What are the current diagnoses:

Summary of Why a Guardianship is Requested

See *Instructions*.

**Are You Requesting a Protective Placement? If so, Why?**

See *Instructions*.

The least-restrictive environment is:

[ ]  Apartment [ ]  Nursing Home [ ]  CBRF No. of Beds =

[ ]  AFH [ ]  ICFMR

[ ]  Other—Explain:

Will proposed ward object to the protective placement: [ ]  YES [ ]  NO [ ]  Not Sure

Day Programming: **[ ]** YES [ ]  NO

 Days and Times Attending (ex. M-F 9-2):

 Program Name, Address and Phone Number:

**Interested Persons**

 See Instructions.

|  |  |  |  |
| --- | --- | --- | --- |
| **Relationship** | **Name** | **Address** | **Phone** |
| **Parents** |       |       |       |
|       |       |       |
| **Spouse** |       |       |       |
| **Adult****Children** |       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| **Adult Siblings\*** |       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| \*Re: Adult Siblings: Only list names, addresses & phone numbers If no other family is listed above. |
| **Other Relatives\*\*** |       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| \*\*Re: Other Relatives: Only list names, addresses & phone numbers If no other family is listed above. |
| **The person and/or facility having care / custody of subject** |       |       |       |