REQUEST FOR GUARDIANSHIP ESTABLISHMENT FUNDS

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES DIVISION/GUARDIANSHIP PROGRAM
SFN 1177 (2-2017)

Clear Fields

CONSUMER DEMOGRAPHIC INFORMATION

Name			
ROAP ID Number	Date of Birth	MA Number	
Address	City	State	ZIP Code
Residential Address ☐ Check box if same as mailing address	City	State	ZIP Code

If consumer is residing out of state or not a resident of North Dakota,

STOP; consumer is not eligible for this program.

PROGRAM ELIGIBILITY

Is consumer eligible for Developmental Disabilities Case Management? ☐ Yes ☐ No If Yes,

STOP; consumer is not eligible for this program.

Does the consumer meet the definition of incapacitated* adult (NDCC 30.1-26-01)? ☐ Yes ☐ No

*Incapacitated Person - any adult person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, or chemical dependency to the extent that the person lacks capacity to make or communicate responsible decisions concerning that person's matters of residence, education, medical treatment, legal affairs, vocation, finance, or other matters, or which incapacity endangers the person's health or safety.

Does the consumer have income at, or below, one hundred percent of the federal poverty or is the consumer Medicaid-eligible?

☐ Yes ☐ No If No,

STOP; consumer is not eligible for this program.

Household Size	100%
1	$ 12,060
2	$ 16,240
3	$ 20,420
4	$ 24,600
5	$ 28,780

Household Size	100%
6	$ 32,960
7	$ 37,140
8	$ 41,320
For each additional person, add	$ 4,180

If funds exceeding 100% of federal poverty level are found during the establishment of the guardianship and the individual is no longer Medicaid eligible, the proposed ward will no longer be eligible for this program. At this time the funds for guardianship establishment should come from the ward's estate.

REFERRAL SOURCE/CASE MANAGER

Name			Telephone Number
Agency			
Address	City	State	ZIP Code
E-Mail Address			Fax Number

REQUIRED DOCUMENTATION (for consumers with an active ROAP case, forward only information not found in ROAP)

Check all that are attached

- ☐ Evaluations (Neuropsychological, psychiatric, psychological, chemical dependency)
- ☐ Physician's notes/evaluations recommending guardianship
- ☐ Current Treatment Plan
- ☐ Progress notes for the last six weeks
- ☐ Diagnoses (all 5 axes)
- ☐ Other (specify): _____

RECOMMENDED TYPE OF GUARDIANSHIP

Check all that are attached

☐ Full Guardianship ☐ Limited Guardianship ☐ Emergency Guardianship

If Limited or Emergency Guardianship, list areas this would pertain to:

SIGNATURES

Case Manager/Referral Source	Date	Telephone Number
Supervisor	Date	Telephone Number

REASON FOR GUARDIANSHIP

Describe the reason/justification for guardianship including the nature and type of disability and how that disability impacts the individual's decision making. This section should accurately reflect the skills and abilities of the person as well as the deficits and problems. Attach additional sheets, if necessary. Attach any supporting documentation.

LESS RESTRICTIVE ALTERNATIVES TO GUARDIANSHIP TRIED OR CONSIDERED

Identify all alternatives to guardianship that have been tried	Describe why the alternatives not adequate or appropriate
☐ Durable Power of Attorney	
☐ Trusts	
☐ Home Health	
☐ Representative Payee	
☐ Case Aide	
☐ Other (specify):	
☐ Other (specify):	

CONSUMER'S NET INCOME, BENEFITS, AND ASSETS

Income	Monthly Amount
Wages	
Supplemental Security Income	
Social Security Disability Insurance	
Retirement Survivors Disability Insurance	
Railroad Retirement	
Pension	
Other (specify):	
Other (specify):	
Other Benefits	**Monthly Amount**
SNAP Benefits	
Housing Assistance	
LIHEAP	
Other (specify):	
Other (specify):	
Assets	**Amount**
Checking Account	
Savings Account	
Individual Retirement Account/Keough Account	
Mutual Funds	
Savings Bonds	
Stocks and Bonds	
Vehicles	
Personal Property	
Real Property	
Other (specify):	
Other (specify):	

PROPOSED GUARDIAN

Name		Telephone Number	
Agency			
Address	City	State	ZIP Code
E-Mail Address		Fax Number	
I agree to become guardian of this individual ☐ Yes ☐ No			
Signature		Date	

For State Office Use Only

Date Received	Date Reviewed

Reviewed By (must be reviewed by all three areas):

Name of Case Manager	
Name of Aging Services Division Reviewer	
Name of Mental Health and Substance Abuse Services Reviewer	
Status of Application ☐ Approved ☐ Denied ☐ Pending Additional Information	Date
Reason for Denial	
Date Case Manager Notified of Application Status	

Return form to:

Elder Rights Program Administrator
Aging Services
1237 W. Divide Ave, Suite 6
Bismarck, ND 58501

(701) 328-4613
Fax: (701) 328-8744
Email: mgayette@nd.gov