

KIPS Investigation ID: _____

Guardianship/Conservatorship Referral/Notification

DCF Service Center _____ DCF Region _____ Send copy to: State of Kansas Guardianship Program
 County _____ 3248 Kimball Ave. Manhattan, KS 66503-0353
 Date Sent to KGP _____ Telephone 785-587-8555
 Worker _____
 E-mail address _____
 Telephone Number _____

I. REFERRAL INFORMATION (completed by DCF)

A. Client Information

Name (last, first, middle initial) _____
 Address (facility, state, city, county & zip code) _____
 Phone #(s) Home, Cell, Facility, Etc.: _____
 Soc. Sec. No. _____ Birth date: _____ Gender: _____ Medicaid No. _____

B. Services requested:

Conservatorship Involuntary Voluntary
 Guardianship
 Guardianship & Conservatorship Successor

C. Prospective Guardian/Conservator

Available? (check one) Yes No (If Yes, complete name, address & phone number below)
 Name (last, first, middle initial) _____
 Address _____
 City _____ State _____ County _____ Zip Code _____
 Telephone Number(s) _____

II. NOTIFICATION FROM KGP (COMPLETED BY KGP)

Name (last, first, middle) _____
 Address _____
 City _____ State _____ County _____ Zip Code _____
 Telephone numbers Work _____ Home _____
 Volunteer will contract with KGP? Yes No
 KGP approval _____ Date _____

III. COURT ACTION (COMPLETED BY KGP)

A. Action (Check One)

Guardian Only Conservator Only Guardian & Conservator

B. Appointment Date _____ C. Name of Presiding Judge _____

D. District Court / Case Number: _____

IV. KGP ELIGIBILITY (completed by DCF) - Must meet all requirements

<input type="checkbox"/>	No Family (willing or appropriate)
<input type="checkbox"/>	Disabling condition (e.g., MI, I/DD, Aging-related) Circle Condition(s) Other Conditions: _____
<input type="checkbox"/>	Financial (Medicaid, SSBG, SSI)
<input type="checkbox"/>	APS referral

V. DESCRIBE CURRENT CRISIS OR ISSUES

Current/previous ANE investigation Yes No Date of Investigation _____

Describe outcome of investigation(s) _____

VI. ADDITIONAL INFORMATION

What less restrictive interventions have been tried? _____

Describe results and why intervention was unsuccessful. _____

Is there an Advance Directive?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Is there a Durable Power of Attorney for Health Care?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Is there an advance Durable Power of Attorney for Finances?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Is there currently a Power of Attorney?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown
Is there a representative Payee?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unknown

Name of attorney in fact/Agent: _____

Address/Telephone: _____

Is there a will? Yes No Unknown

VII. PROPOSED WARD/CONSERVATEE (W/C) SUMMARY OF FACTS

A. Family History

1. Names of nearest relatives, their addresses and relationship to proposed ward/conservatee

2. Describe contact, if any, proposed w/c has with immediate or extended family member?

3. Name of family members contacted by the social worker. _____

Date of contact(s) _____

Reason family member unable to serve as G/C. _____

4. What other extended family options have been explored (e.g., niece)? _____

Date of contact(s) _____

Outcome _____

B. Health Status, Service and Supports Provider

1. Diagnosis (if known): primary & secondary _____

2. Medications _____

3. Health status _____

4. Name and address of physician, include primary physician and specialists and frequency of appointments, if known

5. Behavior problems/issues _____

6. Special needs including adaptive devices, etc. _____

C. Services and Supports

Telephone Number: _____

1. Case Manager/Agency _____ Telephone Number: _____

2. How was the intervention unsuccessful _____

D. Financial Information Status (if unknown, please indicate)

1. Income per month - amount and source \$ _____

Bank account (name, address, type of account) _____

Certificate of Deposit (Name & Amount) _____

Other types of income (e.g., VA Benefits) _____

2. What debts, if any, exist? _____

3. Real estate (legal description and street address) _____

4. Who owns the property? _____

Joint tenancy with anyone? _____

Titles/deeds? _____

5. Is someone else living on/in property? Yes No If yes, what is their relationship to the proposed w/c? _____

6. Are property taxes current? Yes No

7. Is there anything which requires management, sale, eviction or legal action on behalf of the proposed w/c? _____

8. Personal Property (Are there personal belongings/collections or collectable of value? If so, provide general description of items.) _____

Is there anything which requires sale? _____

Is there joint ownership on any personal property? _____

9. Funeral trust(s) _____

Name and address of funeral home and banking institution _____

Is there a life insurance policy(ies)? Yes No

Name of Beneficiary _____

Relationship to proposed W/C _____

Cash Value _____

Have you verified financial information with Economic & Employment Assistance? Yes

Name of EES Case Manager _____ Telephone number: _____

Date of Verification _____

Distribution: Kansas Guardianship Program File

