KIPS Investigation ID: KIPS ID

Adult Guardianship/Conservatorship Referral/Notification

DCF Service Center	Town	DCF Region	Choose an item.	Send copy to:
County	County			State of Kansas Guardianship Program 3248 Kimball Ave. Manhattan, KS 66503-0353 Telephone 785-587-8555
Date Sent to KGP	Date			
Worker	Name			
Email Address	Email			
Telephone Number	Telephone Numbers			

I. REFERRAL INFORMATION (completed by DCF)

A. Client Information

Name (last, first, middle initial) Name

Address (facility, state, city, county & zip code) Address

Telephone (home, cell, facility, etc.) Telephone Number(s)

Soc. Sec. No: SSN Birth Date: DOB Gender: Choose an item. Medicaid No. #

MCO, Rep, Phone #______________________

B. Services Requested

☐ Conservatorship ☐ Involuntary ☐ Voluntary
☐ Guardianship
☐ Guardianship & Conservatorship ☐ Successor ☐ Temporary

C. Prospective Guardian/Conservator

Prospect available? ☐ Yes ☐ No *(If yes, complete name, address & phone below)*

Name (last, first, middle initial) Name

Address (street and number) Address

City City State State County County Zip Code Zip

Telephone Number(s) (work, home, cell) Telephone Number(s)

II. NOTIFICATION FROM KGP (completed by KGP)

Name (last, first, middle initial) Name

Address (street and number) Address

City City State State County County Zip Code Zip

Telephone Number(s) (work, home, cell) ________________

Volunteer will contract with KGP? ☐ Yes ☐ No

KGP Approval ________________ Date Date

III. COURT ACTION (completed by KGP)

A. Action (check one)

☐ Guardian Only ☐ Conservator Only ☐ Guardian & Conservator

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

D. District Court Case Number Case Number

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

☐ No Family (willing or appropriate)
☐ Disabling Condition (e.g.: MI, I/DD, Aging-Related)
☐ Financially Vulnerable (Medicaid, SSBG, SSI)
☐ APS Referral

V. DESCRIBE CURRENT CRISIS OR ISSUES

Current/previous ANE investigation? ☐ Yes ☐ No Date of investigation(s): Date

Describe outcome of investigation(s): Outcome

VI. ADDITIONAL INFORMATION

What less restrictive interventions have been tried? Interventions

Interventions

Describe results and why intervention was unsuccessful. Results

Is there an Advance Directive?	☐	Yes	☐	No	☐	Unknown
Is there a Durable Power of Attorney for Health Care?	☐	Yes	☐	No	☐	Unknown
Is there a Durable Power of Attorney for Finances?	☐	Yes	☐	No	☐	Unknown
Is there currently a Power of Attorney?	☐	Yes	☐	No	☐	Unknown
Is there a S.S.A Representative Payee?	☐	Yes	☐	No	☐	Unknown

Name of attorney in fact / agent:
Address & Telephone:
Is there a will? ☐ Yes ☐ No ☐ Unknown

VII. PROPOSED WARD/CONSERVATEE SUMMARY OF FACTS

A. Family History

1. Names of nearest relative, their addresses, and their relationship to the proposed ward/conservatee:

Name	Relationship	Address / Telephone
Name	Relationship	Address/Telephone
Name	Relationship	Address/Telephone
Name	Relationship	Address/Telephone
Name	Relationship	Address/Telephone

2. Describe contact, if any, proposed w/c has with immediate or extended family member(s)? Contact
3. Names of family members contacted by the social worker: Names

Date of contact(s): Dates
Reason family member unable to serve as guardian/conservator: Reason

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

B. Health Status

1. Diagnosis: Diagnosis
2. Medications: Medications
3. Health Status Health Status
4. Physician(s):

Name: Name
Contact Info: Contact Information
Condition(s): Conditions

Name: Name
Contact Info: Contact Information
Condition(s): Conditions

5. Behavior problems/issues: Issues

6. Special needs (adaptive devices, etc): Special Needs

C. Services and Supports

Agency/Advocate:	Agency/Advocate	Telephone Number:	Telephone Number
Services Provided: Services			
Agency/Advocate:	Agency/Advocate	Telephone Number:	Telephone Number
Services Provided: Service Provided			
Rep Payee:		Telephone Number:	Telephone Number

How was the intervention unsuccessful?

Describe

Financial Information

Income

D.

1. *Type*			
		monthly	
Type	*Amount*	*Frequency*	*Location*
Resources (savings accounts, trusts, certificates of deposit, stocks, bonds, etc)	*Amount*	*Frequency*	*Location*

2. *Type*		
Type	*Value*	*Location*

Debts	*Value*	*Location*
3. *Type*		
Type	*Balance*	*Location*
Real Estate	*Balance*	*Location*
4. *Type*		
Type	*Value*	*Location*
Other Property	*Value*	*Location*
5. *Type*		
Type	*Value*	*Location*
Insurance (term/whole life, renters, housing, auto, etc.)	*Value*	*Location*
Type		
6.		

Type	*Cash Value*	*Agency*	*Beneficiary (name and relationship to proposed W/C)*
Type	*Cash Value*	*Agency*	*Beneficiary (name and relationship to proposed W/C)*
	Cash Value	*Agency*	*Beneficiary (name and relationship to proposed W/C)*
Is there anything which requires sale?			

If yes, what needs to be sold?

A. ☐ Yes ☐ No ☐ Unknown

Is there joint ownership on any property?

If yes, what property and who co-owns such property?

B. ☐ Yes ☐ No ☐ Unknown

Distribution:

DCF Administration Building, 555 S. Kansas, TOPEKA, KS 66603-3444

Voice 785-296-4653 Fax 785-368-8159 www.dcf.ks.gov