Youth Guardianship/Conservatorship Referral

PPS Specialist DCF Worker

DCF E-mail address Email

Child Welfare (CW) Agency CW Agency

CW Case Manager (CM) Worker

DCF Phone Phone #

CM Email_Email

CM Phone_Phone #

I. REFERRAL INFORMATION

A. Youth Information

Name (last, first, middle initial) Last Name First Name Middle Initial

Address (facility or resource parent names, state, city, county & zip code) Address County

City State Zip Code

Phone #(s) Home, Cell, Facility, Etc.: Click or tap here to enter text. Phone #s

SSN. xxx-xx-xxxx. Birth date: Date Gender: Choose. Medicaid No. Medicaid #

MCO, Rep, Phone Number

B. Services requested:

☐ Conservatorship ☐ Involuntary ☐ Voluntary

☐ Guardianship ☐ Guardianship & Conservatorship ☐ Successor

Relationship to Youth Background Information Narrative

II. KGP ELIGIBILITY - Must meet **all** requirements

No Family or other individual (willing or appropriate) to serve as Guardian/Conservator

Disabling condition (e.g., MI, I/DD, Aging-related) Circle Condition(s)) Other Conditions: Diagnosis

Financial (Medicaid, SSBG, SSI)

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

A. Family History

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

Relatives, Addresses, Phone #s, Relationship to Ward

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

Family Contact

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

Family Members Contacted

Date of contact(s) Date

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

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

Options Explored

Date of contact(s) Date

Outcome Outcome

B. Health Status, Service and Supports Provider

1. Diagnosis (if known): primary & secondary

Diagnosis

2. Medications Medications

3. Health status Health Status

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

Physician Information

5. Behavior problems/issues

Behavior

6. Special needs including adaptive devices, etc.

C. Services and Supports

1. Other Agencies (e.g. CMHC, CDDO)

Telephone Number:

2. Name of Case Manager/Agency Child CM & Agency

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

1. Income per month – amount and source $Dollar amount

2. Bank account (name, address, type of account) Bank Details

3. Certificate of Deposit (Name & Amount) CD Details

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

5.Date of application for adult disability Date

6.Is there a trust? ☐ Yes ☐ No

7. Has a Credit Check been completed?

IV. ADDITIONAL INFORMATION

What less restrictive interventions have been tried?

Less Restrictive Interventions

Describe results and why intervention was unsuccessful.

Results; Reasons Intervention Unsuccessful

Is there a representative Payee? ☐ Yes ☐ No ☐ Unknown

Name of representative payee: Attorney Name

Address/Telephone: Address / Phone #

V. NOTIFICATION FROM Kansas Guardianship Program (KGP) (COMPLETED BY KGP)

Name (last, first, middle) Name

Address Address

City City State State County County Zip Code Zip

Telephone Number(s) Work Work Phone # Home Home Phone #

Volunteer will contract with KGP? ☐ Yes ☐ No

KGP approval Name Date Date

VI. COURT ACTION (COMPLETED BY KGP)

A. Action (Check One)

☐ Guardian Only ☐ Conservator Only ☐ Guardian & Conservator

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

D. District Court / Case Number: Court Case Number

Distribution: ☐ Kansas Guardianship Program ☐ File

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Kansas

Department for Children and Families

Prevention and Protection Services

Strong Families Make a Strong Kansas