

Youth Guardianship/Conservatorship Referral

PPS Specialist _____

DCF Region and
County _____

Date sent to KGP _____

DCF E-mail address _____

Child Welfare (CW) Agency _____

CW Case Manager (CM) _____

DCF Phone _____

CM Email _____

CM 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. Birth date: Gender: Medicaid No.

MCO, Rep, Phone Number _____

Current Location and Address _____

Current Home Address _____

Address History for the last 5 years _____

B. Services requested: (Chose those that apply)

- Conservatorship Involuntary Voluntary
- Guardianship Guardianship & Conservatorship Successor
- Temporary Limited Full
- Substitute Protective Arrangement
- Emergency

Relationship to Youth Background Information

The reason a guardianship is necessary:

The nature and extent of the respondent's alleged need:

Description of why a protective arrangement has or has not been considered or implemented:

Why is a protective arrangement insufficient to meet the respondent's alleged need?

Description of why a limited guardianship/conservatorship has or has not been considered:

Why is a limited guardianship/conservatorship insufficient to meet the respondent's alleged need?

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) Condition(s) Other Conditions: _____

Financial (Medicaid, SSBG, SSI)

APS referral

III. PROPOSED RESPONDENT (R) SUMMARY OF FACTS

A. Family History

1. Names of relatives, their addresses and relationship to proposed respondent

2. Describe contact, if any, proposed respondent 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 _____

Spouse _____

Adult Roommate (The adult respondent has shared household responsibilities for more than 6 months in the 12-month period immediately before filing) _____

Parents _____

Sibling _____

Adult primarily responsible for the care of respondent if different from above. _____

Person nominated as guardian by the respondent _____

Person nominated as guardian by the respondent's parents or spouse in a will or other signed record _____

Any person known to have routinely assisted the respondent with decision making during the six months immediately before the filing _____

B. Health Status, Service and Supports Provider

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

2. Functional Impact of the diagnosis _____

3. Medications _____

4. Health status _____

5. Name and address of physician, include primary physician and specialists and frequency of appointments, if known
Name: _____
Address: _____
Phone: _____

Name: _____
Address: _____
Phone: _____

6. Behavior problems/issues _____

7. Special needs including adaptive devices, etc. _____

C. Services and Supports

1. Other Agencies (e.g. CMHC, CDDO)	Telephone Number:
_____	_____
Services provided:	_____
_____	_____

2. Does the respondent need an interpreter, translator or other form of support to communicate? _____

3. Name of Case Manager/Agency _____

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

1. Income per month – amount and source _____

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

3. Certificate of Deposit (Name & Amount) _____

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

5. Date of application for adult disability _____

6. Is there a trust? Yes No

7. Has a Credit Check been completed? _____

8. Any Resources (*e.g.: savings accounts, trusts, certificates of deposit, stocks, bonds, funeral plans, ABLE or Arcare accounts etc.*) _____

IV. ADDITIONAL INFORMATION

What least restrictive interventions have been tried? _____

Describe results and why intervention(s) were unsuccessful. _____

Explain reasonable efforts attempted _____

Is there a representative Payee? Yes No Unknown

Name of representative payee: _____

Address/Telephone: _____

Is there an Advanced Directive? Yes No Unknown

Is there a Durable Power of Attorney for Healthcare? 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 will? Yes No Unknown

Is there a Guardian Ad Litem? Yes No Unknown

Is there a trustee or custodian of a trust or custodianship of which the respondent is a beneficiary? Yes No Unknown

Any fiduciary appointed by the Department of Veterans Affairs? Yes No Unknown

Is there a curator appointed under K.S.A 73-507? Yes No Unknown

Is there a supported decision maker? Yes No Unknown

Name and address of any person with whom the petitioner seeks to limit the respondent's contact:

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

Name (last, first, middle)

Address

City _____ State _____ County _____ Zip Code _____

Telephone Number(s) Work _____ Home _____

Date of Birth _____ Age _____

Place of Employment _____ Gender _____

Relationship to the respondent _____ Potential Conflict of Interest _____

Reason the respondent should be selected _____

Volunteer will contract with KGP? Yes No

KGP approval _____ Date _____

VI. 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: _____

Distribution: Kansas Guardianship Program File

This form has been staffed with DCF legal and is approved for referral to the Kansas Guardianship Program.

Yes

No

Date Staffed _____

