

PLEASE CHECK FOR
EMERGENCY GUARDIANSHIP**

GUARDIANSHIP INFORMATION FORM

Petitioner Information:

Name: _____

Address: _____

Phone No.: _____

Relationship to Respondent: _____

Please state your qualifications for appointment of Guardianship:

What will you offer as surety on a bond? _____

Respondent Information:

Name: _____

Permanent Full-Time Address: _____

a. Respondent has resided at this address for the previous ____ years ____ months.

b. Is this address a hospital, treatment facility, correctional facility or long-term care facility? _____ YES _____ NO

****An Emergency Guardianship filing requires a letter from a physician/healthcare provider stating that Emergency Guardianship is necessary and in the best interest of the Respondent****

Is Respondent currently physically located at his or her permanent address above?

_____ YES _____ NO - If NO, please check one of the following:

_____ a. Respondent is currently located at _____

_____ b. Respondent's current location is unknown at this time.

Is the Respondent a citizen or permanent resident of the United States?

_____ YES _____ NO

Has the Respondent been convicted of, pled guilty to, or entered an Alford plea for a felony sex crime as defined in KRS 17.500?

_____ YES _____ NO _____ Unknown

Has the Respondent been convicted of, pled guilty to, or entered an Alford plea for a felony offense that would classify the person as a violent offender under KRS 439.3401?

_____ YES _____ NO _____ Unknown

Please state the nature of the Respondent's disability and the facts or reasons supporting the need for determination of disability:

Respondent's Identifiers:

Sex	Race	DOB	Height	Weight	Eyes	Hair	SSN	DLN	State

The Respondent owns the following estate, (including government benefits, insurance entitlements, and anticipated yearly income.)

<u>ESTATE</u>	<u>VALUE</u>
Real Property	\$ _____
Personal Property	\$ _____
Yearly Income	\$ _____

Source of Yearly Income _____

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Name of _____ Person or _____ Facility having custody of the Respondent:

Address:

Does the Respondent have a _____ Durable Power of Attorney OR _____ Health Care Surrogate?

Name:

Address:

Please list the name and address of the Respondent's next of kin:

Name: _____

Name: _____

Address: _____

Address: _____

Relationship to Respondent: _____

Relationship to Respondent: _____

Name: _____

Name: _____

Address: _____

Address: _____

Please provide the name and address of the Respondent's PCP (Primary Care Physician).

Name:

Address:

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*The Petitioner is the person petitioning/applying for Guardianship for the disabled individual.

*The Respondent is the disabled individual.

*Once this information sheet is completed, please drop off to the Grant County Attorney's Office. The office staff will contact you to schedule an appointment to review and sign the paperwork that will be filed with the Court.

*There is a \$188.00 filing fee made payable to the Grant County Circuit Clerk due at the time of filing.

*The Respondent will be evaluated by their Primary Care Physician and a Psychologist and Social Worker appointed by the Court. (A \$250.00 fee for the Psychologist is due and payable to North Key. Please contact North Key at (859) 578-3200 ext. 3212 regarding payment arrangements.)

*All Guardianship hearings are held on Tuesday afternoons at the Grant County Judicial Center.

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