GUARDIANSHIP FORMS

Instructions for Petition to Determine if Disabled

1. Write the name of the Respondent (person you are filing petition for);
2. Write your name;
3. Write your address;
4. Write your telephone number;
5. Write your relationship to Respondent;
6. Write the name of Respondent (person you are filing petition for) and their date of birth;
7. Write the Respondent's (person you are filing petition for) address and answer sections a and b regarding the address;
8. Provide the information where Respondent is currently located;
9. Answer regarding Respondent's citizenship;
10. & 11. Provide information regarding Respondent's criminal history;
12. List the reasons why you believe the Respondent needs the guardianship (i.e. their disabilities, medical diagnosis);
13. List the value of the Respondent's real property (house(s) and/or land);
14. List the value of the Respondent's personal property;
15. List the amount of the Respondent's yearly income;
16. List the source of the Respondent's income;
17. & 18. Write the name and address of the person having custody of the Respondent (this could be a nursing home, hospital, etc.);
19. & 20. Check if the Respondent has a Durable Power of Attorney and/or Health Care Surrogate. If Respondent has these, write the name and address of the person who is listed as the Respondent's Durable Power of Attorney and/or Health Care Surrogate; and
21. Write the name and address of the Respondent's next of kin (spouse, siblings, or children) – if needed, write additional names and addresses on a separate sheet.

DO NOT SIGN THESE DOCUMENTS. YOU WILL SIGN THEM AT THE COUNTY ATTORNEY'S OFFICE.

AOC-740 Doc. Code: PDD
Rev. 7-18
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Commonwealth of Kentucky
Court of Justice *www.courts.ky.gov*

KRS 387.530; 210.290

PETITION TO DETERMINE IF DISABLED

Case No. _____
Court District
County _____
Division _____

COMMONWEALTH OF KENTUCKY — PETITIONER

VS.

(1) _____ — RESPONDENT

(2) _____ has reasonable grounds or knowledge to lead him/her to believe Respondent appears to be unable to provide for his/her physical health and safety and/or manage his/her financial resources effectively and submits to the Court the following facts upon which he/she supports this belief:

1. Name of Petitioner: (3) _____
   Address: (4) _____
   Telephone Number: (5) _____
   Petitioner's relationship to Respondent: (6) _____
2. **Name of Respondent:** (7) _____
   Respondent's Date of Birth (if known): _____
3. Respondent's Permanent, Full-time Residence: (8) _____
   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
4. Is Respondent currently physically located at his or her permanent address above? ☐Yes ☐No If No, *(check one)*:
   ☐a. Respondent is currently located at: _____
   Address
   ☐b. Respondent's current location is unknown at this time.
5. Is Respondent a citizen or a permanent resident of the United States? ☐Yes ☐No
6. Has 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
7. Has 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
8. The **nature of Respondent's disability** and the facts or reasons supporting the need for determination of disability are:

9. Respondent owns the following estate, including government benefits, insurance entitlements, and anticipated yearly income (state none or unknown):

ESTATE	VALUE
Real Property	$_____ (13)
Personal Property	$_____ (14)
Yearly Income	$_____ (15)

Source of Yearly Income _____ (16)
_____

10. **Name of ☐ Person or ☐ Facility having custody of Respondent:** (17) _____
Address: (18) _____

11. Respondent's ☐ **Durable Power of Attorney** OR ☐ **Health Care Surrogate** is:
Name: (19) _____
Address: (20) _____

12. Respondent's next of kin:
Name: _____
(21) Address: _____
_____
Relationship to Respondent: _____
Name: _____
Address: _____
_____
Relationship to Respondent: _____

WHEREFORE, Petitioner requests the Court inquire into Respondent's ability to care for himself/herself and to manage his/her financial resources. Petitioner attaches an **Application for Appointment of Fiduciary and further requests:**

1. Trial by jury;
2. Counsel to represent the Respondent; and
3. Court appointment of a physician, advanced practice registered nurse, or physician assistant; a psychologist; and a social worker to evaluate Respondent as provided by law unless the evaluation report is filed with this Petition.

_____, 2_____ _____
Date **Signature of Petitioner**

SUBSCRIBED and SWORN to before me this _____ day of _____, 2_____.

My Commission expires:_____.

_____ _____
County, Kentucky Name/Title

To be completed if Petitioner is represented by counsel:

Attorney's Name: _____

Address:

Telephone Number: _____

_____
Attorney Signature

Instructions for Application for Appointment of Fiduciary For Disabled Persons

1. Write the name of Respondent (/Person you are filing petition for);
2. Write your name;
3. Write Guardian / Co-Guardian / Conservator or Co-Conservator;
4. Write your relationship to Respondent;
5. List your qualifications for being appointed Guardian/Conservator for the Respondent;
6. State the reason why you should be appointed as Guardian (ie, Respondent is a sibling, child, or parent)
7. List the value of the Respondent's Real Property (house(s) and/or land);
8. List the value of the Respondent's Personal Property;
9. List the amount of the Respondent's yearly income;
10. List the source of the Respondent's income; and
11. Write your name;
12. Write your address; and
13. Write your telephone number.

DO NOT SIGN THESE DOCUMENTS. YOU WILL SIGN THEM IN FRONT OF THE COUNTY ATTORNEY'S OFFICE.

AOC- 745 Doc. Code: AAF Rev. 7-18 Page 1 of 2 Commonwealth of Kentucky Court of Justice *www.courts.ky.gov* KRS 387.530(2); 387.720; 395.130; 210.290	**APPLICATION FOR APPOINTMENT OF FIDUCIARY FOR DISABLED PERSONS**	Case No. _____ Court District County _____ Division _____

COMMONWEALTH OF KENTUCKY PETITIONER

VS.

(1) _____ RESPONDENT

* * * * * * * * * * * * *

1. Comes now (2) _____, Applicant herein, and requests to be appointed as (3) _____ for Respondent.
2. Applicant states his/her relationship to Respondent is (4) _____.
3. Applicant states his/her qualifications for appointment are as follows:

(5) _____

_____

_____

4. Applicant offers as surety on his/her bond the following:

(6) _____

_____

5. Respondent owns the following estate, including government benefits, insurance entitlements, and anticipated yearly income (state if none or unknown):

ESTATE	VALUE
Real Property	$ (7)
Personal Property	$ (8)
Yearly Income	$ (9)

Source of Yearly Income

(10) _____

6. If Applicant is the Cabinet for Health and Family Services, please attach, or provide the Court prior to the final hearing in this matter, a report indicating the average caseload of each field social worker.
7. Applicant states that all statements in the foregoing are true.

Applicant's Name: (11) _____

Address: (12) _____

_____

Telephone Number: (13) _____

_____, _____ _____

Date **Applicant's Signature**

SUBSCRIBED and SWORN to before me this _____ day of _____, 2_____.

My Commission expires:_____.

_____ _____

County, Kentucky Name/Title

WAIVER OF NOTICE AND REQUEST FOR APPOINTMENT OF FIDUCIARY

The undersigned hereby waive notice of hearing and the right to appointment and request the Court to make the appointment herein applied for:

_____	_____
_____	_____
_____	_____
_____	_____

To be completed if Applicant is represented by counsel:

Attorney's Name: _____

Address: _____

_____

_____

Telephone Number: _____

_____, _____ _____

Date **Attorney Signature**

Instructions for Report of Interdisciplinary Evaluation Team

Take this form to Respondent's doctor for completion. Once they have completed and signed the form, return to Tina Hodges at the County Attorney's Office.

AOC-765 Doc. Code: RIET Rev. 7-18 Page 1 of 3 Commonwealth of Kentucky Court of Justice *www.courts.ky.gov* KRS 387.540; 387.510	**REPORT OF INTERDISCIPLINARY EVALUATION TEAM**	Case No. _____ Court District County Hart Division _____

COMMONWEALTH OF KENTUCKY)
PETITIONER)
)
VS.)
)
_____)
RESPONDENT

* * * * * * * * * * * * *

☐ I, ☐ We, the undersigned, hereby report to the court as follows:

1. That the nature and extent of the Respondent's disabilities may be described as follows:

_____

_____

_____

_____

2. That the evaluations ordered regarding the Respondent are current and were performed and signed by the following individuals:

Evaluation: **Name** **Title** **Date Performed**

Intellectual: _____

Physical: _____

Educational: _____

Adaptive Behavior: _____

Social Skills: _____

3. That guardianship (management of "personal affairs" as defined in KRS 387.510):

☐ Is needed for the following reason:

_____

_____

_____

☐ Is not needed for the following reason:

_____

_____

_____

4. That the recommendation(s) of the type, scope, and duration of guardianship for the Respondent is/are as follows:

_____

_____

_____

_____

5. That conservatorship (management of financial resources):

☐ Is needed for the following reason:

_____

_____

_____

☐ Is not needed for the following reason:

_____

_____

_____

6. That the recommendation(s) of the type, scope, and duration of conservatorship for the Respondent is/are as follows:

_____

_____

_____

_____

7. That the social, educational, medical, and rehabilitative services currently being provided to the Respondent are as follows:

_____

_____

_____

_____

8. That appropriate alternatives to guardianship/conservatorship:

☐ Are available *(explain)*:

_____

_____

_____

☐ Are not available *(explain)*:

_____

_____

_____

9. That the recommendations and reasons as to the most appropriate treatment or rehabilitation plan and living arrangement for the Respondent are as follows:

_____

_____

_____

_____

10. That for the Respondent to attend the hearing on the Petition filed herein:

☐ Would subject him/her to serious risk of harm for the following reason(s): _____

_____.

☐ Would not subject him/her to serious risk of harm.

11. That appended hereto is a list of all medications currently being given to the Respondent on a continuous basis, the dosage of the medication, and a description of its impact upon the Respondent's mental and physical condition and behavior.

12. That any dissenting opinions or other comments are as follows:

_____

_____

_____

_____

_____
Date

_____
Signature of *(check one)*:
❑ Licensed Physician
❑ Advanced Practice Registered Nurse
❑ Physician Assistant

_____
Signature of Licensed/Certified Psychologist under KRS Chapter 319

_____
Signature of *(check one)*:
❑ Licensed/Certified Social Worker
❑ Employee of the Cabinet for Health and Family Services who is qualified under KRS 335.080(1)(a), (b), and (c) and KRS 335.090(1)(a), (b), and (c)

_____
Signature of Other

_____
Name of Facility or Agency

_____

_____
Address

_____
Telephone Number