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New Jersey Judiciary

**Adult Guardianship
Case Information Statement**

Use for initial Chancery Division Probate Part Pleadings under *Rule 4:5-1*
Pleading will be rejected for filing, under *Rule 1:5-6(c)*, if information is not
completed or signature is not affixed

**For Chambers or Surrogate's
Office Use Only**

Date Filed:

Docket Number:

Chambers:

Surrogate's Office:

Plaintiff

Name (last, first, middle initial)

Address: Street

City

State

Zip

Age

Telephone

Relationship to AIP

Alleged Incapacitated Person (AIP):

Name (last, first, middle initial)

Address: Street

City

State

Zip

Date of Birth

Social Security Number

Case Type☐ Title 30 (DDD)☐ Title 3B (DD)☐ Title 3B (All Others)

Is the Plaintiff the proposed guardian?

☐ Yes☐ No

Are any other person(s) proposed guardian(s)?

☐ Yes☐ No**All person(s) proposed as guardian(s):** (Attach additional sheets if necessary to list all proposed guardian(s))

Name (last, first, middle initial)

Address: Street

City

State

Zip

Age

Telephone

Relationship to AIP

Name (last, first, middle initial)

Address: Street

City

State

Zip

Age

Telephone

Relationship to AIP

Other person(s) or entities to be noticed: (Attach additional sheets if necessary to list all parties to be noticed, including DDD Administrator and County Adjuster, if applicable)

Name (last, first, middle initial)

Address: Street

City

State

Zip

Age

Telephone

Relationship to AIP

Name (last, first, middle initial)

Address: Street

City

State

Zip

Age

Telephone

Relationship to AIP

Does any party need an interpreter?

☐ Yes☐ No

If yes, for whom and for what language?

Does any party need an accommodation for a disability? If yes, please identify the party and requested accommodation

☐ Yes☐ No

I certify that I have completed this form to the best of my knowledge and ability, and will supplement this form as may be necessary should additional information become available. I further certify that, except as required on this page, confidential personal identifiers have been redacted from documents now submitted to the court, and will be redacted from all documents submitted in the future in accordance with *Rule 1:38-7(b)*.

X

Date

X

Attorney/Plaintiff Signature

FORM B

Filing Attorney Information or Pro Se Litigant:

Name _____
NJ Attorney ID Number _____
Law Firm/Agency Name _____
Address _____

Telephone Number _____

In the Matter of,

_____,
Name of Alleged Incapacitated Person (AIP)
an Alleged Incapacitated Person

Superior Court of New Jersey
Chancery Division - Probate Part
County _____
Docket Number _____

Civil Action

Verified Complaint to Appoint Guardian(s) of the Person and Estate (Property)

I, _____, by way of verified complaint, say:

I am _____ years of age. I reside at _____, County of _____, and State of _____. I have domicile (permanent/legal residence) at _____. My relationship to the alleged incapacitated person (AIP) is _____. My interest in this action is the welfare of the alleged incapacitated person.

I am (check one)

☐ the only individual bringing this action for guardianship; **OR**

☐ one of two or more individuals bringing this action for guardianship. Below is the name, age, present residence, and permanent/legal residence (domicile) of the other applicant(s).

;;, ,

;;, ,

1. The name, age, present address, permanent/legal residence (domicile), and marital status of the alleged incapacitated person are as follows:

Name _____ Age _____
Present Address _____
How long at this address? _____ Marital Status _____
Permanent/Legal Residence (Domicile) _____

Spouse's information, if married:

Name _____ Age _____
Present Address _____
Permanent/Legal Residence (Domicile) _____

If applicable:

☐ Not Applicable

The alleged incapacitated person _____, has been determined eligible for services from the New Jersey Division of Developmental Disabilities (DDD).

If applicable:

☐ Not Applicable

The alleged incapacitated person has been receiving services from the DDD since _____.
Currently, these services consist of:

3. The alleged incapacitated person, _____, has been diagnosed as having _____, as set forth by the attached affidavit or certification of _____, (Physician or Psychologist). Because of this condition, _____ lacks sufficient capacity to govern him/herself to the extent set forth below.
4. The functional capacity of the alleged incapacitated person is further detailed by **one** of the following documents, attached to this complaint: (check one)
- ☐ A copy of the Individualized Education Program (IEP) for the alleged incapacitated person; **OR**
- ☐ An affidavit or certification from the chief executive officer, medical director, or other officer having administrative control over the DDD program from which the alleged incapacitated person is receiving services; **OR**
- ☐ An affidavit or certification from a designee of the DDD having personal knowledge of the functional capacity of the AIP; **OR**
- ☐ A second affidavit or certification of a physician or psychologist; **OR**
- ☐ An affidavit or certification from a licensed care professional having personal knowledge of the functional capacity of the alleged incapacitated person.
5. The names, addresses, relationships and ages of the persons most closely related to the alleged incapacitated person (parents, children, siblings) are as follows:

Name	Address	Relationship to AIP	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If applicable:

☐ Not Applicable

The name and address of the person or institution having the care and custody of the alleged incapacitated person is as follows:

If applicable:

☐ Not Applicable

If the alleged incapacitated person has lived in an institution, the date(s) of any commitment or confinement and by what authority committed or confined, are as follows:

Institution

Period(s) of Residence

_____	_____
_____	_____
_____	_____

If applicable:

☐ Not Applicable

The name(s) and address(es) of any person(s) named as an attorney-in-fact in any power of attorney, and/or any person named as health care representative in any health care directive, and/or any person acting as trustee under a trust for the benefit of the alleged incapacitated person, are as follows:

Name

Role (Attorney-In-Fact, Health Care Representative, Trustee)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

6. The name(s), address(es), relationship to the alleged incapacitated person, age and telephone number of the proposed guardian(s) are as follows: (attach additional pages as necessary).

Name _____

Address _____

Relationship _____ Age _____ Telephone No. _____

Name _____

Address _____

Relationship _____ Age _____ Telephone No. _____

Name _____

Address _____

Relationship _____ Age _____ Telephone No. _____

7. Information about the real and personal property and income of the alleged incapacitated person is set forth in the attached Certification of Assets.

8. Guardianship of the person and estate is requested at this time. (check one)

☐ I request that the court appoint the Office of the Public Defender Division of Mental Health Advocacy, *pro bono* (without cost), to represent the alleged incapacitated person. I understand that the guardianship hearing may be scheduled on a later date if the Office of the Public Defender Division of Mental Health Advocacy is appointed as counsel.

OR

☐ I request that the court appoint a private attorney, potentially for cost, to represent the alleged incapacitated person. I understand that if the assets of the alleged incapacitated person are insufficient to cover the fee charged by the court-appointed attorney, then the court may order that I pay that fee.

9. Request for Guardianship of the Person (check one)

Option 1:

☐ **Request for General (Full) Guardianship of the Person**

The condition of _____ renders him/her without the necessary cognitive capacity to govern himself/herself in **all** areas (including medical, legal, residential, educational, and vocational). _____ requires a general (full) guardian of the person.

WHEREFORE, the plaintiff(s) demand(s) judgment pursuant to *N.J.S.A. 30:4-165.7*, declaring _____ to be suffering from a chronic functional impairment that renders him/her incapable of governing himself/herself in all areas, and appointing _____ as **general (full) guardian(s) of the person** of _____.

OR

Option 2:

☐ **Request for Limited Guardianship of the Person**

The condition of _____ renders him/her without the necessary cognitive capacity to govern himself/herself in **some** areas. However, _____ retains the necessary cognitive capacity to make some decisions regarding his/her person and requires a limited guardian.

Specifically, _____ retains the capacity to make decisions regarding the following areas: (check all that apply)

- ☐ medical decision making ☐ legal decision making ☐ vocational decision making
☐ residential decision making ☐ educational decision making
☐ other (voting, driving, etc.) _____

WHEREFORE, the plaintiff(s) demand(s) judgment pursuant to *N.J.S.A. 30:4-165.7*, declaring _____ to be suffering from a chronic functional impairment that renders him/her incapable of governing himself/herself in some areas, and appointing _____ as **limited guardian(s) of the person** of _____.

X

Date

X

Signature

X

Print Name

10. Request for Guardianship of the Estate (check one)

Option 1:

☐ **Request for General (Full) Guardianship of the Estate (Property)**

The condition of _____ renders him/her without the necessary cognitive capacity to manage his/her affairs in **all** areas. _____ requires a general (full) guardian of the estate.

WHEREFORE, the plaintiff(s) demand(s) judgment pursuant to *N.J.S.A. 30:4-165.7*, declaring _____ to be suffering from a chronic functional impairment that renders him/her incapable of managing his/her affairs in all areas, and appointing _____ as **general (full) guardian(s) of the estate** of _____.

OR

Option 2:

☐ **Request for Limited Guardianship of the Estate (Property)**

The condition of _____ renders him/her without the necessary cognitive capacity to manage his/her affairs in **some** areas. However,

_____ retains the necessary cognitive capacity to make some decisions regarding his/her estate and requires a limited guardian of the estate.

Specifically, _____ retains the capacity to make decisions regarding the following areas: (describe)

WHEREFORE, the plaintiff(s) demand(s) judgment pursuant to *N.J.S.A. 30:4-165.7*, declaring _____ to be suffering from a chronic functional impairment that renders him/her incapable of managing his/her affairs in some areas, and appointing

_____ as **limited guardian(s) of the estate** of

_____.

X

Date

X

Signature

X

Print Name

Verification

I/We _____ hereby certify and say:

1. I/We am/are the plaintiff(s).
2. The contents of the Verified Complaint for Guardianship are true to the best of my/our knowledge.

X

Date

Signature

Print Name

X

Date

Signature

Print Name

Form C

Filing Attorney Information or Pro Se Litigant:

Name _____
NJ Attorney ID Number _____
Law Firm/Agency Name _____
Address _____

Telephone Number _____

In the Matter of,

_____,
Name of Alleged Incapacitated Person (AIP)
an Alleged Incapacitated Person

Superior Court of New Jersey
Chancery Division - Probate Part
County _____
Docket Number _____

Civil Action Certification of Assets

I, _____, of full age, hereby certify as follows:

This certification is made by me in support of an application for a declaration of incapacity for
_____. (Check one)

☐ The alleged incapacitated person, _____, possesses no property, or possesses only Social Security benefits, a **State-funded Personal Needs Allowance**, and/or funds held in trust for his/her benefit. (**Note:** If you select this option, check "None" Schedules A-F below. If the alleged incapacitated person possesses Social Security benefits, describe them in Schedule G; if not, check "None.")

OR

☐ The following schedules contain a complete and accurate statement and valuation of all real and personal property and income of _____, based upon my diligent inquiry.

Schedule A: Real Property

☐ None ☐ Unknown

All interests in real property including real property held in common or jointly with other(s) and, if held jointly, describe the interest.

#	Description: Address (include county and state)	Municipal Tax Assessed Value	Market Value
1.		\$	\$
2.		\$	\$
Total Schedule A			\$ 0.00

Schedule B: Stocks, Bonds, Mutual Funds, Securities and Investment Accounts

☐ None ☐ Unknown

Include all interests in stocks, bonds, mutual funds, securities and investment accounts including interests held in common or jointly with other(s) or in trust, and, if held jointly, describe the interest.

#	Description (include name of financial institution, account type, number of shares or last four digits of account and date value fixed)	Face Value	Market Value
1.		\$	\$
2.		\$	\$
Total Schedule B			\$ 0.00

Schedule C: Money on Hand
☐ None ☐ Unknown

Checking and savings accounts and certificates of deposit in banks and notes or other indebtedness due the alleged incapacitated person.

#	Description (include name of financial institution, account type, last four digits of account and date value fixed)	Value
1.		\$
2.		\$
Total Schedule C		\$ 0.00

Schedule D: Pensions, retirement accounts
☐ None ☐ Unknown

IRA's, 401(k), annuities, profit sharing plans, etc. Include last four digits of account.

#	Description (include name of financial institution, account type, last four digits of account and date value fixed)	Value
1.		\$
2.		\$
Total Schedule D		\$ 0.00

Schedule E: Miscellaneous Personal Property
☐ None ☐ Unknown

Tangible personal property, motor vehicles, recreation vehicles, employment bonus or award, interest in a partnership or unincorporated business, articles or collections have either artistic or intrinsic value, etc.

#	Description	Value
1.		\$
2.		\$
Total Schedule E		\$ 0.00

Schedule F: Liabilities/Encumbrances
☐ None ☐ Unknown

If any asset listed in this certification has a secured associated debt, such as a mortgage or a car loan, indicate below. List all other debts.

#	Description	Encumbrance Amount
1.		\$
2.		\$
Total Schedule F		\$ 0.00

Schedule G: Sources of Monthly Income
☐ None ☐ Unknown

#	Description	Value
1.		\$
2.		\$
Total Schedule G		\$ 0.00

I hereby certify and say that the foregoing statements made by me are true to the best of my knowledge, and that I will supplement this form as may be necessary should additional information become available. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

X

Date

X

Signature
X

Print Name