



FOND DU LAC COUNTY ADRC & DCP
INFORMATION SHEET FOR GUARDIANSHIP
AND/OR PROTECTIVE PLACEMENT

1. Name of person completing referral: _____

2. Name, date of birth, phone number, residence & address of the proposed ward:

First name: _____

Middle initial: _____

Last name: _____

Date of birth: _____

Address: _____

3. Name and address of person or institution having care and custody of the proposed ward: _____

Address of person or facility: _____

Telephone number: _____

a) Effective date of ward's arrival @ facility, if not residing at personal residence or home: _____

Name, relationship and current address of spouse, parents, relatives and phone number of all other persons believed to be interested:

<u>Name</u>	<u>Address</u>	<u>Relationship</u>	<u>Phone number</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Type of guardianship needed: (✓) all that apply:

- | | |
|--------------------------------|--|
| _____ guardianship of person | _____ temporary guardianship of person |
| _____ guardianship of property | _____ temporary guardianship of property |
| _____ protective placement | _____ successor guardianship |
| | _____ stand-by guardianship |

5. Name, address and phone number of proposed guardian:

Name of proposed guardian: _____

Address: _____

Telephone Number: _____ Relationship: _____

Email Address: _____

6. Name, address and phone number of stand-by guardian:

Name of proposed guardian: _____

Address: _____

Telephone Number: _____ Relationship: _____

Email Address: _____

7. Name, address and phone number of SUCCESSOR guardian:

Name of proposed guardian: _____

Address: _____

Telephone Number: _____ Relationship: _____

Email Address: _____

8. Do any alternate decision making documents exist?

_____ None

_____ Power of Attorney-Health Care & Financial
Activated? Yes No

_____ Power of Attorney-Health Care Only
Activated? Yes No

_____ Power of Attorney-Financial Only
Activated? Yes No

_____ Representative Payee

_____ Supported Decision-Making Agreement

_____ Conservatorship

_____ Other: _____

Email address for any power of attorneys: _____

Attachments Needed:

- Examining Physician's or Psychologist's Report
Assessing for incompetency (WI form GN-3130)
- Financial Information/Declaration of Income and Assets
Form completed in full
- Copies of any alternate decision making documents
Listed in #8

For developmentally disabled, degenerative brain disorder, other like incapacity referrals please call ADRC at 920-929-3466 and fax completed referral form and other necessary attachments to fax # (920) 929-3470.

For serious and persistent mental illness or alcohol/drug related referrals please call DCP at 920-929-3500 and fax completed referral form and other necessary attachments to fax # (920) 929-3129.

For office use only:

Petitioner name: _____

Notes: _____

FINANCIAL INFORMATION/DECLARATION OF INCOME AND ASSETS

INCOME: (GROSS MONTHLY)		ASSETS			
	CLIENT	SPOUSE	CLIENT	SPOUSE	JOINT
1) WAGES OR SALARY	\$	\$	\$	\$	\$
2) NET INCOME FROM SELF EMPLOYMENT	\$	\$	\$	\$	\$
3) SOCIAL SECURITY	\$	\$	\$	\$	\$
4) SSI/SSI-E	\$	\$	\$	\$	\$
5) VETERANS PENSIONS	\$	\$	\$	\$	\$
6) PENSION/ANNUITIES	\$	\$	\$	\$	\$
7) INTEREST INCOME	\$	\$	\$	\$	\$
8) ESTATE/TRUST INCOME	\$	\$	\$	\$	\$
9) NET "RENTAL INCOME"	\$	\$	\$	\$	\$
10) WORKMAN'S COMP	\$	\$	\$	\$	\$
11) UNEMPLOYMENT COMP	\$	\$	\$	\$	\$
12) ALIMONY/SPOUSAL SUP/ CHILD SUPPORT	\$	\$	\$	\$	\$
13) OTHER	\$	\$	\$	\$	\$
JOINT TOTAL INCOME \$			JOINT TOTAL ASSETS \$		
DO YOU HAVE?					
A MARKER	YES	NO	VAULT TRUST AMT \$		
CASKET TRUST AMT	\$		LOCATION:		
BURIAL PLOT	YES	NO	NAME OF FUNERAL HOME		
IRREVOCABLE BURIAL TRUST AMT \$					
HAS THE CLIENT OR THEIR SPOUSE GIVEN AWAY ANY PROPERTY (SUCH AS LAND, STOCKS, BONDS, CASH, ETC) IN THE LAST SIXTY SIXTY (60) MONTHS INCLUDING TRANSFER OF PROPERTY TO CHILDREN, RELATIVES, OR OTHER PERSONS? YES _____ NO _____					
NAME OF PERSON COMPLETING THIS FORM _____					
RELATIONSHIP TO CLIENT _____					



SIGNATURE

DATE