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Cranbury Office

GUARDIANSHIP QUESTIONNAIRE

Please provide copies of:

- 1. Current IEP
- 2. Most Recent Psychological Evaluation
- 3. Other Recent Evaluations (i.e. Educational, Speech/Language, Psychiatric, Medical)

A. Personal Information regarding person in need of guardianship:

Full Name of Child: _____

Date of Birth: ____/____/____

Social Security Numbre of your Child: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Is Child registered with DDD: Yes No

Is Child Eligible for Social Security Income (SSI): Yes No

Have you applied for SSI: Yes No

Is Child adopted: Yes No

Current Place of Residence: _____ Home _____ Residential _____ School _____

If Child is Residentially Placed: Yes No

Facility Name: _____

Case Managers Name: _____

Street address: _____

City: _____ State _____ Zip: _____

Facility Phone No: ____-____-____

Facility E-mail: _____

Facility Fax No: _____

Has your child ever been institutionalized

a. Where: _____

b. When: _____

B. Financial Information regarding person in need of guardianship:

Amount of monthly SSI received, if eligible for SSI: \$ _____

Property:	Value:

Do you have a Special Needs Trust? Yes No

Do you have a will? Yes No

Bank Name and Money on Deposit, if any:

Bank:	Amount on Deposit:

C. Proposed Guardian(s)

Proposed Guardian #1

Full Name: _____

Street Address: _____

City: _____ State: _____

County: _____ Zip: _____

Home Phone No: _____ Business Phone No: _____

E-mail Address: _____ Fax: _____

Day of Birthday: _____ Social Security number: _____

Relationship to Person in Need of Guardianship: _____

Proposed Guardian #2

Full Name: _____

Street Address: _____

City: _____ State: _____

County: _____ Zip: _____

Home Phone No: _____ Business Phone No: _____

E-mail Address: _____ Fax: _____

Day of Birthday: _____ Social Security number: _____

Relationship to Person in Need of Guardianship: _____

D. Siblings of Person in Need of Guardianship:

	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Name				
D.O.B.	____/____/____	____/____/____	____/____/____	____/____/____
Address				

E. Support for Guardianship

Name of Medical Doctor who will Support Guardianship:

Street Address: _____

City: _____ State: _____

County: _____ Zip: _____

Business Phone No: _____

E-mail Address: _____ Fax: _____

Day of Birthday: _____ Social Security number: _____

Relationship to Person in Need of Guardianship: _____

Name of Second Medical Doctor who will Support Guardianship:

Street Address: _____

City: _____ State: _____

County: _____ Zip: _____

Business Phone No: _____

E-mail Address: _____ Fax: _____

Who Referred you: _____

Submit Form