SGW Sussan | Greenwald & Wesler
ADVOCATING FOR THE CHILD WITH SPECIAL NEEDS

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REPLY TO: 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: _____/ _____ / _____ Gender: _____

Social Security Number: _____

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				
Gender				

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