



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 to person in need of guardianship:

Full Name of person in need of guardianship:

Date of Birth: ____ / ____ / ____ Gender: _____

Social Security Number of person in need of guardianship: _____

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

Does the person in need of guardianship require full or limited guardianship?:

Full Limited

If limited, in what areas can they manage their own affairs?:

What is the diagnosis of the person in need of guardianship?:

Is the person in need of guardianship registered with DDD? Yes No

Is the person in need of guardianship eligible for Social Security Income (SSI):

Yes No

Has the person in need of guardianship applied for SSI? Yes No

Is the person in need of guardianship adopted? Yes No

Current place of residence? Home Residential School

If the person in need of guardianship is residentially placed:

Facility Name: _____

Case Managers Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

MAIN OFFICE

1249 S. River Road, Suite 104
Cranbury, NJ 08512
(609) 409-3500 (P); (609) 409-3505 (F)
www.sgwlawfirm.com

Revmont Park
1161 Broad Street, Suite 215
Shrewsbury, NJ 07702
(732) 483-6300 (P); (F) 732-676-7636

140 E. Ridgewood Avenue
Suite 415, South Tower
Paramus, NJ 07652

Facility Phone No: _____ - _____ - _____

Facility E-Mail: _____

Facility Fax No: _____

Has the person in need of guardianship ever been institutionalized?: Yes No

If so, Where?: _____ 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

Does the person in need of guardianship have financial or healthcare powers of attorney?: Yes No

C. Proposed Guardian(s)

Proposed Guardian #1

Full Name: _____

Street Address: _____

City: _____ State: _____

Country: _____ Zip: _____

Home Phone No: _____ Business Phone No: _____
 E-Mail Address: _____ Fax: _____
 Date of Birth: ____ - ____ - ____ Social Security No: _____
 Relationship to person in need of guardianship: _____

Proposed Guardian #2

Full Name: _____
 Street Address: _____
 City: _____ State: _____
 Country: _____ Zip: _____
 Home Phone No: _____ Business Phone No: _____
 E-Mail Address: _____ Fax: _____
 Date of Birth: ____ - ____ - ____ Social Security No: _____
 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. Children of Person in Need of Guardianship:

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

E. Support for Guardianship:

Is person in need of guardianship married? Yes No

Acknowledgment

I understand that in order to proceed with the guardianship I must provide two physician certifications, or a certification by one physician and one DDD case worker familiar with the person in need of guardianship. (Only if the person is receiving services from DDD). I understand that SGW is required to file these certifications within a specific time frame after they are completed.

Yes I Understand