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## Guardianship Pre-conference Questionnaire

**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 Number 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:**

**Bank: Amount on Deposit:**

**Do you have a Special Needs Trust? Yes ☐ No Do you have a will? Yes ☐ No ☐**

**Bank Name and Money on Deposit, if any:**

**C. Proposed Guardian(s) Proposed Guardian #1 Full Name:**

**_____**

**Street _____**

**City: _____**

**State: _____**

**County: _____**

**Zip: _____**

**Home Phone No: _____**

**Business Phone No:_____**

**E-mail Address: _____ Fax:_____ _____**

**Date of Birth: _____**

**Social Security number: _____**

**Relationship to Person in Need of Guardianship:**

**_____**

**Proposed Guardian #2**

**Full Name: ----------**

**Address:_____**

**_____**

**City: _____ State:_____ ___**

**County: _____ Zip: _____**

**Home Phone No: _____**

**Business Phone No:_____**

**E-mail Address: _____**

**Fax:_____**

**Date of Birth: _____**

**Social Security number: _____**

**Relationship to Person in Need of Guardianship:_____**

**D. Siblings of Person in Need of Guardianship:**

**E. Support for Guardianship Name of Medical Doctor who will Support Guardianship:**

**Sibling**

**Name D.O.B. ____/____/____**

**Address:_____**

**City: _____**

**State:_____**

**County: _____ Zip: _____**

**Business Phone No: _____ E-mail_____**

**Address:_____**

**Fax: _____**

**Date of Birth: _____**

**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:_____**