



Advocacy, Support and Knowledge

for individuals with developmental disabilities, their families and circles of support



To Whom It May Concern:

Thank you for your interest in the ASK Guardianship program. We are able to offer the legal service at a reduced rate for members of The Arc Jacksonville. Membership to the Arc Jacksonville has other benefits as well which is outlined in the **Join The Arc Jacksonville** attachment and membership form.

Rates for legal services for Arc members will run an average of \$400.00 for the attorney plus the court filing fee which varies from county to county. In cases where co-guardianship is desired, please be advised that this fee is charged for each application. (Two guardians = \$400 each = \$800.00)

Please do not send in a check for legal fees. Your legal fees will be due to the attorney during your first office appointment with them.

If interested in guardianship assistance through ASK at The Arc Jacksonville, please fill out the enclosed application in its entirety. Also enclosed are two Release of Information forms that must be completed as well.

- Please note: The person needing guardianship signs one and the person becoming the guardian will need to sign one.

Please return your completed application by email to dtorres@arcjacksonville.org. You may also mail the application with your membership dues to The Arc Jacksonville at the address below. Membership may be completed online at: <https://arcjacksonville.org/family-resources/membership/>

Upon receipt of your guardianship documents, a supplemental questionnaire will be sent to you for the specific attorney you will be working with.

If you have any questions or concerns, please do not hesitate to call us at (904) 358-1200.

A community outreach project of The Arc Jacksonville
1050 N. Davis Street - Jacksonville, Florida 32209
Phone (904) 358-1200 • Fax (904) 358-3800 • arcjacksonville.org

Annual Membership and Benefits:

Individual/Family Membership – \$25.00

- Monthly E-Newsletter from The Arc Jacksonville
- Access to reduced fee legal guardianship services via the ASK Program

Supporter Membership – \$50.00

- Monthly E-Newsletter from The Arc Jacksonville
- Access to reduced fee legal guardianship services via the ASK Program
- \$50 supports one day of Adult Day Training (ADT) for one program participant

Advocate Membership – \$100.00

- Monthly E-Newsletter from The Arc Jacksonville
- Access to reduced fee legal guardianship services via the ASK Program
- \$100 supports one week of transportation for one Arc Jacksonville participant to and from their program

Complete membership application and pay online at arcjacksonville.org/membership

Detach form and return (Please Print Clearly)

The Arc Jacksonville Annual Membership:

Individual/Family \$25.00 Supporter \$50.00 \$100.00 Advocate

I wish to make an additional donation of \$_____

Parent/Guardian Representative Name: _____

Person with disability name: _____

Representative's relationship to person with disability: Mother Father Sibling Other: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

Make checks payable to: The Arc Jacksonville

Mail to: The Arc Jacksonville | Attn: Membership | 1050 North Davis Street | Jacksonville, FL 32209

Downtown: 1050 North Davis Street | Jacksonville, Florida 32209 | Phone 904-355-0155 | Fax 904-355-9616
Westside: 4401 Wesconnett Blvd. | Jacksonville, Florida 32210 | Phone 904-573-2805 | Fax 904-573-2156

Information on Person Applying to BECOME Guardian

Date: _____

Please Answer All Questions

Full Name: _____ Date of Birth: _____

Street Address: _____ Home Phone: () _____

City, State: _____ Zip: _____ Work Phone: () _____

County: _____ Cell Phone () _____

Social Security Number: _____ Driver's License #: _____

Age: _____ Marital Status: _____ Name of Spouse: _____

Email: _____

Race (Please Circle): African American White Hispanic/Latin Native American Other _____

Name of Employer: _____

Are You Paid (Please Circle): Weekly Bi-Weekly Monthly Semi-Monthly

Your Wages before Deductions: \$ _____

* If unemployed, how long: _____ Previous Employer: _____ Last Salary: _____

* Unemployment Compensation Received? YES NO Amount Received: \$ _____

Any other source of income: _____

LIST ALL PERSONS WHO LIVE WITH YOU:

	<u>NAME</u>	<u>RELATIONSHIP</u>	<u>AGE</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Information on Person Applying to BECOME Guardian

EXPENSES/HOUSEHOLD ASSETS:

Monthly Rent \$ _____

Monthly Mortgage \$ _____

Childcare expenses \$ _____ per month

Medical expenses not covered by insurance, Medicaid, Medicare \$ _____ per month

Transportation to & from work \$ _____ per month

Does anyone in your household pay child support? YES NO

If yes, please list who paid to:

WHO	HOW MUCH	# of Children
_____	\$ _____ per month	_____
_____	\$ _____ per month	_____

✓ **Does anyone in your household own any of the following?**

Home where you live? YES NO

Other land/home? YES NO Approximate value \$ _____ Loan Balance \$ _____

Vehicle? YES NO Approximate value \$ _____ Loan Balance \$ _____

Vehicle Make & Year: _____

Checking Account? YES NO Balance: \$ _____

Savings Account? YES NO Balance: \$ _____

Name of Bank: _____

Other Assets? YES NO Value: \$ _____

Information on Person Applying to BECOME Guardian

➤ DO YOU OR ANYONE IN YOUR HOUSEHOLD RECEIVE?

	Who Receives?	Amount?	How Often?
WELFARE	_____	\$ _____	_____
SOCIAL SECURITY	_____	\$ _____	_____
* SSI	_____	\$ _____	_____
VETERAN BENEFITS	_____	\$ _____	_____
PENSION/RETIREMENT	_____	\$ _____	_____
UNEMPLOYMENT COMPENSATION	_____	\$ _____	_____
WORKER'S COMPENSATION	_____	\$ _____	_____
CHILD SUPPORT OR ALIMONY	_____	\$ _____	_____
OTHER INCOME OR SUPPORT	_____	\$ _____	_____
FOOD STAMPS RECEIVED	_____	\$ _____	_____

*** Who is the payee for the SSI benefits?** _____

I state that the information listed is true and correct:

Signature of Applicant

Information on Person Applying to BECOME Guardian

Please give three references who are not related to you and who you have known for at least 5 years:

1. **Name:** _____

Address: _____
(street address) (city) (state) (zip code)

Phone Number: _____

2. **Name:** _____

Address: _____
(street address) (city) (state) (zip code)

Phone Number: _____

3. **Name:** _____

Address: _____
(street address) (city) (state) (zip code)

Phone Number: _____

ADULT GUARDIANSHIP CHECKLIST

- **PERSON REQUESTING to become the GUARDIAN:**

Name: _____

Relationship to person needing guardianship: _____

Have you ever been arrested (*circle one*): YES NO

Was it a felony: (*circle one*): YES NO

- **PERSON NEEDING GUARDIANSHIP:**

Name: _____

Address: _____

_____ County: _____

Phone #: _____

Social Security #: _____

Marital Status: _____

Date of Birth: _____

AGE: _____

Race (*Please Circle*): African American White Hispanic/Latin Native American Other _____

- **HEALTH STATUS:**

PHYSICAL: _____

MENTAL: _____

PERSON NEEDING GUARDIANSHIP:

- **Adjudicated Incompetent? YES NO**

When? _____ **Where?** _____

Court Papers? YES NO * If YES, please describe below or make copies:

- **MEDICARE coverage: YES NO**

- **MEDICAID coverage: YES NO**

- **DOCTOR INFORMAIION:**

- **Name:** _____

- **Address:** _____

- _____

- **Phone #:** _____

IDENTIFY ALL SOURCES OF INCOME AND MONTHLY AMOUNTS:

Source	Amount
_____	\$ _____
_____	\$ _____
_____	\$ _____

Who is the payee for SSI benefits? _____

Why is there a need for Guardianship? _____

PERSON NEEDING GUARDIANSHIP:

Please List Immediate Relatives (parents, siblings, children, etc...):

NAME	RELATIONSHIP	AGE	ADDRESS	PHONE #

NAME	RELATIONSHIP	AGE	ADDRESS	PHONE #

COMMENTS: _____

ASK at Arc Jacksonville
1050 North Davis Street
Jacksonville, Florida 32209
904.358.1200 phone
904.358.3800 fax

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ **DOB:** _____
(Name of Individual Needing a Guardian)

Name(s)/Agency(s) and address of where ASK is to obtain or release records/information:

Attorney for purpose of obtaining Guardianship/Guardianship Advocate.

I, _____, authorize ASK to:

(circle all that apply) Obtain Release Exchange

The following information: written verbal other (specify) _____

- Educational Records/Information
- Psychological Records/Information
- Medical Records/Information
- Other _____

For the purpose of: Guardianship/Guardianship Advocacy

This authorization shall remain valid for one-year from the date signed or until such time as I withdraw my consent.

Signature of Individual needing Guardianship

Date

ASK at Arc Jacksonville
1050 North Davis Street
Jacksonville, Florida 32209
904.358.1200 phone
904.358.3800 fax

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ DOB: _____
(Name of Individual Applying to be Guardian)

Name(s)/Agency(s) and address of where ASK is to obtain or release records/information:

Attorney for purpose of obtaining Guardianship/Guardianship Advocate.

I, _____, authorize ASK to:

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- Medical Records/Information
- Other _____

For the purpose of: Guardianship/Guardianship Advocacy

This authorization shall remain valid for one-year from the date signed or until such time as I withdraw my consent.

Signature of Applicant

Date