

To Whom It May Concern:

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

Rates for legal services for Arc members desiring Guardian Advocacy will be \$600.00 for the attorney's services, plus the cost of the court filing fee which varies from county to county. In cases where co-guardian advocacy is desired, please be advised that the fee for the second petitioner is also \$600.00. A separate guardian packet must be completed for each petitioner. (Two guardian advocates would be a fee of \$1200.00 plus court cost if applicable). Stand-by Guardian Advocate paperwork will be completed for the fee of \$300.00. If an individual is seeking Plenary (Full) Guardianship, the fee is higher due to the amount of time and legal services involved, you can expect to pay approximately \$1200.00 each before filing fees. Individuals with intellectual and developmental disabilities (IDD) typically can be served with Guardian Advocacy.

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

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. If they are unable to sign due to limited capacity, simply return the form with the packet.*

Return your completed application by email to dtorres@arcjacksonville.org or fax it to: 904-355-9616 Attn: D. Torres. We are unable to accept individual photos of your documents. You may also mail the completed application with your membership payment by check or money order made out to The Arc Jacksonville at the address below.

Online Membership may be completed at: <https://arcjacksonville.org/family-resources/membership/>

Upon receipt of your completed guardianship documents, your documents will be forwarded to an attorney who will contact you and schedule an appointment. If you have any questions or concerns, please do not hesitate to call the ASK Department 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 ___ Advocate \$100.00

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: _____

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

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 (Check all that apply): African American ☐ White ☐ Hispanic/Latin ☐ Native American ☐ Other _____

Name of Employer: _____

Are You Paid **Please check:** ☐ 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. _____	_____	_____

Information on Person Applying to BECOME Guardian

Highest Level of Education of person(s) applying to become guardian: _____

	Yes	No
Are you currently serving as guardian for another ward?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a disability that would interfere with duties as guardian?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been judicially determined to have committed abuse, abandonment, or neglect against a child as defined by Florida law?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been the subject of a confirmed report of abuse, neglect, or exploitation that has been uncontested or upheld under Florida law?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a judge?	<input type="checkbox"/>	<input type="checkbox"/>
Do you provide substantial services in a business capacity to the proposed ward (are you paid to provide services to the proposed ward)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you in the employ of any person, agency, government, or corporation that provides service to the proposed ward in a professional or business capacity?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever received instruction and training <i>regarding legal guardianship duties and responsibilities</i>	<input type="checkbox"/>	<input type="checkbox"/>
Have you earned other degrees or certifications (<i>example: CNA, MBA, MD, etc.</i>)	<input type="checkbox"/>	<input type="checkbox"/>
Do you possess special educational qualifications (financial, business, or nursing, otherwise) that qualify petitioner to be appointed as guardian	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above, please provide details/explanation _____

SELECT ALL THAT APPLY (note any exceptions or additional information in Other information section)

- ☐ Proposed guardian is the mother or father of the Ward and work closely with the ward's health care providers, teachers and school personnel.
- ☐ The Ward is in the Med Waiver program and the Proposed guardian advocates work closely with the APD Support Coordinator.
- ☐ The proposed ward is on the waiting list for services for the APD Med Waiver program.
- ☐ Proposed guardian regularly attends training(s) provided by the Arc or other entities providing instruction or education on resources for families with individuals with special needs and developmental disabilities.
- ☐ Proposed guardian is a joint account holder on the ward's bank account, which has minimal funds. Petitioners are requesting a waiver of accounting.
- ☐ Proposed guardian advocate(s) is/are professional guardians.
- ☐ Proposed guardian advocate(s) is/are a friend of the family and has assisted in the proposed Ward's care for _____ years/months.
- ☐ Proposed guardian advocate(s) has/have extensive experience assisting individuals with developmental disabilities/special needs.
- ☐ Other: _____

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? NO ☐ YES ☐

If yes, please list who paid to:

WHO	HOWMUCH	# of Children
_____	\$ _____ per month	_____
_____	\$ _____ per month	_____

Does anyone in your household own any of the following?

Home where you live? NO ☐ YES ☐ Approximate value \$ _____ Loan Balance \$ _____

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

Vehicle? YES ☐ NO ☐ Vehicle Make & Year: _____

Checking Account? YES ☐ NO ☐ Balance: \$ _____

Savings Account? YES ☐ NO ☐ Balance: \$ _____

Name of Bank: _____

Other Assets? NO ☐ YES ☐ 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 any SSI benefits? _____

PERSON REQUESTING to become the GUARDIAN/GUARDIAN ADVOCATE:

Relationship to the person needing guardian/guardian advocate: _____

Have you ever been arrested? (check one) Yes ☐ No ☐

Was it a felony? (check one) Yes ☐ No ☐

I state that the information listed is true and correct:

Signature of Applicant

Date

Person NEEDING Guardianship:

- **PERSON NEEDING GUARDIANSHIP:**

Name: _____

Address: _____

County: _____

Social Security #: _____

Phone #: _____

Marital Status: _____

Date of Birth: _____

AGE: _____

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

Primary contact _____ Phone # _____

Comment _____

- **Health Status: Diagnosis/Limitations**

PHYSICAL:

MENTAL:

Has the person executed: ☐ health care directive ☐ power of attorney ☐ living will

☐ do not resuscitate order ☐ None of these

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 INFORMATION:**

o **Name:** _____

o **Address:** _____

o **Phone#:** _____

1. Check all that apply regarding income and potential income/employment:

- ☐ The proposed ward has no income.
- ☐ The proposed ward only receives Social Security income. SSI ☐ SSDI ☐
- ☐ The proposed ward receives SSI and works part-time, which reduces the amount of the SSI award.
- ☐ The proposed ward does not receive any government benefits at this time; however one he or she turns 18, proposed guardian advocates will be applying for benefits, such as SSI (supplemental security income from social security) and will be the representative payee.

2. The proposed ward receives benefits and/or services from/through (select all that apply):

- | | |
|----------------------------------|--|
| <input type="checkbox"/> Mother | Medicaid <input type="checkbox"/> |
| <input type="checkbox"/> Father | Medicaid Waiver <input type="checkbox"/> |
| <input type="checkbox"/> Parents | Agency for Person with Disabilities <input type="checkbox"/> |
| Self | |

Person NEEDING Guardianship

Why is there a need for Guardianship? _____

Please check all that apply to the end of this sentence:

The proposed ward does not have the ability ... (in the context of understanding, protecting and caring for his or her person or property)

- ☐ to make informed decisions about personal and health care and treatment services
- ☐ to judge the consequences of decisions/actions regarding property, including management of property or money or making change
- ☐ to safely live alone
- ☐ to judge the consequences of decisions/actions regarding friendships and social aspects of life
- ☐ to make informed decisions or understand or judge the consequences of contracts or suing or defending a lawsuit
- ☐ to make informed decisions regarding activities related to independent living including
- ☐ to make decisions: about the preparation of meals, about shopping for groceries or personal items
- ☐ to dress or feed himself or herself
- ☐ Other: _____

*If the person **does not** lack any of these abilities –we will discuss whether the person has the understanding to sign a power of attorney and health care designation and whether that would be sufficient to protect them.*

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

NAME	RELATIONSHIP	AGE	ADDRESS	Phone#

Person NEEDING Guardianship

Name	Relationship	Age	Address	Phone #

Medical, mental, or personal care services currently receiving or that need to be provided:

Social experiences and personal services provided or to be provided:

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 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:

(check 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 Applicant

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:

(check 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 Applicant

Date