# C3CAP Guardianship Intake Form

## Description

The C3 Community Assistance Program (C3CAP) facilitates the filing of a guardianship petition, which may include assistance with:

* Locating legal representation
* Payment for legal representation
* Payment of court fees
* Locating a professional guardian
* Payment for non-professional guardians training

## Directions

All requests for Guardianship must be entered into TrackVia using the *Guardianshi*p service to initiate the process.

We understand that you might not have access to the information needed to complete this form in its entirety. However, please ensure that this form is completed to the best of your ability to allow for a responsible and complete court filing, and to support a contested case hearing if necessary.

If at any time you have a question and/or would like an update on this request, please contact C3CAP at 503-345-6732 between 9:00 am and 5:00 pm, Monday through Friday.

|  |
| --- |
| Submission InstructionsPlease ensure that a request for Guardianship has been entered into TrackVia prior to sending this intake form. The progression of this request will be updated in TrackVia and you will be able to check on the status by logging in and accessing the appropriate assistance request. Once the request has been submitted in TrackVia, C3CAP will locate a law firm in your area who will work on this case. C3CAP will communicate to you once a law firm has been identified and will update TrackVia with the law firm's details. You will submit the intake form and corresponding documentation SECURELY to the identified law firm directly. DO NOT SENT THIS INTAKE FORM TO C3CAP. |

## Guardian Request

|  |  |  |
| --- | --- | --- |
| Does the client need a temporary guardian? | ð No | ð Yes |
| Has anyone pursued guardianship for the client previously? | ð No | ð Yes |
| Is discharge to a care facility likely? | ð No | ð Yes |
|  If yes, list the name of the facility: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has a person been identified to act as the client’s guardian? | ð No | ð Yes |

### Nominated Guardian

If a guardian has been identified, please complete the section below.

|  |  |
| --- | --- |
| First Name | Last Name |
|  |  |
| Relationship |
|  |
| Street Address | Apt/Room # | City | State | Zip |
|  |  |  |  |  |
| Phone | Alt. Phone, Fax, Cell, E-Mail (specify) |
|  |  |

|  |  |  |
| --- | --- | --- |
| Is the nominated guardian certified in the state of Oregon? | ð No | ð Yes |
| If the nominated guardian needs training, has the training been scheduled? | * No
 | * Yes
 |
| If yes, with whom? |  |

## Client Information

|  |  |  |
| --- | --- | --- |
| First Name | Middle Name | Last Name |
|  |  |  |
| Date of Birth | Race | Marital Status |
|  |  |  |
| Social Security # | Veterans Affairs # |
|  |  |
| Medical Insurance | Medicaid # |
|  |  |

### Client’s Permanent or Regular Residence

|  |
| --- |
| Facility (if applicable) |
|  |
| Street Address | Apt/Room # | City | State | Zip |
|  |  |  |  |  |
| Mailing Address | Apt/Room # | City | State | Zip |
|  |  |  |  |  |
| Phone # | Alt. Phone, Fax, Cell, E-Mail (specify) |
|  |  |
| Notes Regarding this Location |
|  |

### Client’s Current Location

|  |  |
| --- | --- |
| Facility or Hospital Name (if applicable) | County |
|  |  |
| Street Address | Apt/Room # | City | State | Zip |
|  |  |  |  |  |
| Admit Date | Expected Discharge Date |
|  |  |
| Care Manager | Care Manager’s Phone # |
|  |  |
| Care Manager’s E-mail  | Preferred Contact Method |
|  | ð E-Mail ð Phone  |
| Notes Regarding this Location |
|  |

## Client’s Income and Assets

Please leave fields blank if information is unknown.

### Income

Please record the client’s monthly income, including: Social Security, Supplemental Security Income (SSI), pensions, etc.

|  |  |  |
| --- | --- | --- |
| Source | Contact Information | Amount |
|  |  |  |
| Source | Contact Information | Amount |
|  |  |  |
| Source | Contact Information | Amount |
|  |  |  |

### Assets

Please record bank accounts, Certificates of Deposit, other accounts

|  |  |  |
| --- | --- | --- |
| Bank Name and Branch | Account Number | Balance |
|  |  |  |
| Bank Name and Branch | Account Number | Balance |
|  |  |  |

### Property

Please record real property, personal property (automobiles, jewelry, etc.), insurance policies, stocks, bonds, etc.

|  |  |
| --- | --- |
| Description | Estimated Value |
|  |  |
| Description | Estimated Value |
|  |  |
| Description | Estimated Value |
|  |  |

## Individuals & Agencies Entitled to be Notified

Oregon Law requires that notice be given to certain people, relatives and agencies. Please include all individuals and agencies including: spouse, parents, adult children, co-habitants, nearest relatives, attorneys Department of Veteran’s Affairs, Department of Human Services, etc.

Include all, even uninvolved. Please attach more pages as necessary.

### Individual or Agency

|  |  |
| --- | --- |
| First Name | Last Name |
|  |  |
| Relationship | Contacted? |
|  | ð No ð Yes |
| Street Address | Apt/Room # | City | State | Zip |
|  |  |  |  |  |
| Phone | Alt. Phone, Fax, Cell, E-Mail (specify) |
|  |  |

### Individual or Agency

|  |  |
| --- | --- |
| First Name | Last Name |
|  |  |
| Relationship | Contacted? |
|  | ð No ð Yes |
| Street Address | Apt/Room # | City | State | Zip |
|  |  |  |  |  |
| Phone | Alt. Phone, Fax, Cell, E-Mail (specify) |
|  |  |

### Individual or Agency

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| --- | --- |
| First Name | Last Name |
|  |  |
| Relationship | Contacted? |
|  | ð No ð Yes |
| Street Address | Apt/Room # | City | State | Zip |
|  |  |  |  |  |
| Phone | Alt. Phone, Fax, Cell, E-Mail (specify) |
|  |  |

### Individual or Agency

|  |  |
| --- | --- |
| First Name | Last Name |
|  |  |
| Relationship | Contacted? |
|  | ð No ð Yes |
| Street Address | Apt/Room # | City | State | Zip |
|  |  |  |  |  |
| Phone | Alt. Phone, Fax, Cell, E-Mail (specify) |
|  |  |

## Documentation

### Licensed Healthcare Professionals Who Have Treated or Evaluated

#### Healthcare Professional # 1

|  |  |
| --- | --- |
| First Name | Last Name |
|  |  |
| Title/Specialty | Facility or Hospital Name |
|  |  |
| Street Address | Apt/Room # | City | State | Zip |
|  |  |  |  |  |
| Phone | Alt. Phone, Fax, Cell, E-Mail (specify) |
|  |  |

#### Healthcare Professional # 2

|  |  |
| --- | --- |
| First Name | Last Name |
|  |  |
| Title/Specialty | Facility or Hospital Name |
|  |  |
| Street Address | Apt/Room # | City | State | Zip |
|  |  |  |  |  |
| Phone | Alt. Phone, Fax, Cell, E-Mail (specify) |
|  |  |

### Professional Letter Check List Incapacity Narrative

Attach the licensed professional’s letter. As appropriate, confirm each item below is addressed via check mark.

* Ability to Evaluate Information / Communication: Provide evidence (examples) of the client’s inability to receive and evaluate information, and communicate decisions
* Health Care: Provide evidence (examples) of the client’s inability to provide for their health care.
* Food / Shelter: Provide evidence (examples) of the client’s inability to provide for food, nutrition, and shelter for themselves.
* Clothing / Hygiene: Provide evidence (examples) of the client’s inability to adequately provide for their clothing and/or personal hygiene
* Safety / Other care: Provide evidence (examples) that the person does not adequately provide for his/her safety and/or other care, without which serious physical injury is likely to occur.
* Management of Financial Resources: Provide evidence (examples) of the client’s inability to manage their financial resources effectively.
* Other Relevant Information: Please record any other factual details regarding the client’s incapacity that are not recorded in the previous questions.
* Description of other less restrictive alternatives to guardianship that were considered (Health Care Representative, available community resources, etc.).

### Persons Having Direct Knowledge of Incapacities

Please include the contact information for any individuals (case managers, social workers, nurses, physicians, family members, others) who have direct knowledge of incapacities as outlined above. These individuals may be interviewed by the court visitor and/or called before the court. Please attach more pages as necessary.

#### Person with Direct Knowledge

|  |  |
| --- | --- |
| Name | Title |
|  |  |
| Relationship | Agency |
|  |  |
| Street Address | Apt/Room # | City | State | Zip |
|  |  |  |  |  |
| Phone | Alt. Phone, Fax, Cell, E-Mail (specify) |
|  |  |

#### Person with Direct Knowledge

|  |  |
| --- | --- |
| Name | Title |
|  |  |
| Relationship | Agency |
|  |  |
| Street Address | Apt/Room # | City | State | Zip |
|  |  |  |  |  |
| Phone | Alt. Phone, Fax, Cell, E-Mail (specify) |
|  |  |

#### Person with Direct Knowledge

|  |  |
| --- | --- |
| Name | Title |
|  |  |
| Relationship | Agency |
|  |  |
| Street Address | Apt/Room # | City | State | Zip |
|  |  |  |  |  |
| Phone | Alt. Phone, Fax, Cell, E-Mail (specify) |
|  |  |