CAP Guardianship Intake Form

Description

The Community Assistance Program (CAP) 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 *Guardianship* 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 the Community Assistance Program at 503-345-6732 between 9:00 am and 5:00 pm, Monday through Friday.

Submission Instructions

Please 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, CAP will locate a law firm in your area who will work on this case. CAP 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 CAP.

Guardian Request

Does the client need a temporary guardian?	☐ No	☐ Yes
Has anyone pursued guardianship for the client previously?	☐ No	☐ Yes
Is discharge to a care facility likely?	☐ No	☐ Yes
If yes, list the name of the facility: _____		
Has a person been identified to act as the client's guardian?	☐ No	☐ 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?	☐ No	☐ 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 ☐ E-Mail ☐ 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? ☐No ☐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? ☐No ☐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? ☐No ☐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? ☐No ☐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)		