STATE OF INDIANA) IN THE SUPERIOR COURT 2

COUNTY OF JOHNSON) CAUSE NO: 41D02 -_____

IN RE THE GUARDIANSHIP OF:

_____
PROTECTED PERSON/ADULT

PETITION FOR APPOINTMENT OF PERMANENT GUARDIAN FOR INCAPACITATED PERSON

_____your name), Petitioner, says:

1. _____(ward), date of birth _____, who is currently residing at Johnson County, IN, is an incapacitated person and is subject to the jurisdiction of the Court by virtue of being a resident of Johnson County, IN.
2. The alleged incapacitated person's presence at any hearing on this Petition is not required because: _____.
3. The incapacitated person is an individual who is unable to:
   a. ☐ manage his/he property;
   b. ☐ provide self-case,

   because of insanity, mental illness, mental deficiency, physical illness, infirmity, habitual drunkenness, excessive use of drugs, incarceration, confinement, dentition, duress, fraud, undue influence of others on the individual, or other capacity.
4. The property of the incapacitated person is of the approximate value of $_____.
5. There is no Guardian of the Person or Estate of the incapacitated person in any state.
6. The person or institution to be appointed Guardian is:

   Name: _____

   Address: _____
   (City, State, Zip)

   Phone Number: _____ (include area code)

   Relationship: _____
7. The person(s) most closely related by blood or marriage to the incapacitated person is/are:

   Name: _____

   Address: _____
   (City, State, Zip)

   Phone Number: _____ (include area code)

   Relationship: _____

8. The person or Institution (Caregiver) having the care and custody of the incapacitated person is:

Name: _____

Address: _____
(City, State, Zip)

Phone Number: _____ (include area code)

Relationship: _____

9. The person to be appointed Guardian, if not a corporation, is already the Guardian of the following protected person(s): _____.

10. The reason for appointment of a Guardian is to provide care and supervision of the person or property of the incapacitated person, and the interest of the petitioner is such appointment is:

_____

_____

_____

_____
Signature

_____
Date

STATE OF INDIANA) IN THE SUPERIOR COURT 2

COUNTY OF JOHNSON) CAUSE NO: 41D02 -_____

IN RE THE GUARDIANSHIP OF:

_____
PROTECTED PERSON/ADULT

OATH AND ACCEPTANCE OF GUARDIAN

1. I accept appointment as guardian of the
   - ☐ PERSON
   - ☐ ESTATE
   - ☐ PERSON AND ESTATE

   For _____
   Incapacitated person's name

2. I will faithfully discharge the duties of my trust as such Guardian.

I affirm under the penalties for perjury that the foregoing representations are true.

_____
Printed Name

_____
Signature

_____
Date

STATE OF INDIANA)

COUNTY OF JOHNSON)

IN THE SUPERIOR COURT 2

CAUSE NO: 41D02 -_____

IN RE THE GUARDIANSHIP OF:

_____
PROTECTED PERSON/ADULT

CONSENT TO THE APPOINTMENT OF A GUARDIAN BY A RELATIVE OR INDIVIDUAL

I, _____(Your Name), being duly sworn upon his or her oath, says that he/she is an adult and is familiar with the Petition of _____(Petitioner's Name) for the appointment of a guardian over the incapacitated person _____(Your Name) and consents to the appointment of _____(Petitioner's Name) and hereby expressly waives service of summons and notice of hearing on said guardianship petition.

_____
Printed Name

_____
Signature

Sworn to me and subscribed in my presence, a Notary Public in and for the State of _____, County of _____, this ___ day of _____, 20___.

_____
Signature

_____
Expiration Date of Notary

STATE OF INDIANA)
) SS:
COUNTY OF JOHNSON)

IN THE SUPERIOR COURT 2

CAUSE NO: 41D02 -_____

_____
Plaintiff / Petitioner,

v.

_____
Defendant / Respondent.

APPEARANCE

1. My name is: _____

2. I am the
[ ] Initiating (filing) Party [ ] Responding (defending) Party [ ] Intervening Party
in this case, and I am ***not*** represented by a lawyer.

3. This case is a: [ ] Small Claim [ ] Dissolution [ ] Other: _____

4. Are there any other cases involving the same children or adults? [ ] Yes [ ] No
Case Number(s): _____

_____

Signature: _____

Printed Name: _____

Address*: _____

City*: _____ State* _____ ZIP*: _____

Phone*: _____

Email*: _____

* = *It is your responsibility to notify the Court immediately if this information changes.*

JOHNSON COUNTY PROBATE FORM NO. 1

APPLICATION FOR APPOINTMENT OF PERSONAL REPRESENTATIVE

(COMPLETE ONE FORM FOR EACH PERSONAL REPRESENTATIVE)

CONTACT INFORMATION:

Case No.: **41 _____ - _____ - _____ - _____**

Name: _____

Address: _____

_____

Length of Residence: _____

Phone number: **(_____) _____ - _____**

BACKGROUND / EXPERIENCE:

Highest degree received *(including institution and year degree received)*: _____

_____

Employer: _____

Address: _____

_____

Length of employment: _____

Past experience with financial management *(including investing and checkbook management)*:

_____

_____

Do you have any prior felony convictions in the State of Indiana or under the law of any other State or Territory of the United States? Yes ____ No _____

AFFIRMATIONS AND VERIFICATION:

I AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT. I AFFIRM THAT I HAVE ATTAINED THE AGE OF MAJORITY. I AM NOT INCAPACITATED FOR A REASON OTHER THAN PHYSICAL MATTERS.

I FURTHER AFFIRM THAT I HAVE PROVIDED MY ATTORNEY MY DATE OF BIRTH AND SOCIAL SECURITY NUMBER.

AS A CONDITION OF APPOINTMENT OF THE PERSONAL REPRESENTATIVE, I HEREBY WAIVE THE PRIVILEGE ASSOCIATED WITH THIS INFORMATION AND AUTHORIZE MY ATTORNEY TO DISCLOSE THIS INFORMATION TO THE COURT, UPON COURT ORDER IN THE EVENT OF MY FAILURE TO RENDER AN ACCOUNT AS REQUIRED BY LAW OR OTHER DETERMINATION OF BREACH OF FIDUCIARY DUTY.

Dated: ____ / ____ / _____ _____

Signature

☐ **Proposed Order of Appointment and Letters enclosed.**

STATE OF INDIANA)
)SS:
COUNTY OF JOHNSON)

IN THE SUPERIOR COURT 2

CAUSE NO: 41D02 - _____

IN RE: THE GUARDIANSHIP OF:

_____

ORDER ON FEE WAIVER

The Petitioner's Motion for Fee Waiver is:

_____ **GRANTED,**

It is therefore **ORDERED** that the Petitioner may file this case:

_____ without the pre-payment of any filing fees, costs, security, bond or other expenses; or

_____ upon the pre-payment of $_____ which is a portion of the filing fee set by statute. Such sum must be paid by the Petition to the Clerk within the next twenty (20) days. The Court will determine whether any or additional costs are to be paid at a preliminary or final hearing in this case.

OR

_____ **DENIED**

SIGNED THIS _____ DAY OF _____, 20_____.

_____
PETER NUGENT, JUDGE
JOHNSON SUPERIOR COURT 2

Distribution:

_____
Petitioner(s)

_____
Mailing address

_____
Town, State and Zip Code

_____
Telephone number

_____
Email

STATE OF INDIANA)
)SS:
COUNTY OF JOHNSON)

IN THE SUPERIOR COURT 2

CAUSE NO: 41D02 -_____

IN RE: THE GUARDIANSHIP OF:

_____

VERIFIED MOTION FOR FEE WAIVER

Petitioner, _____, now states:

1. I have filed a court action against someone or someone has filed a court action against me and I believe that I have a case with merit.

2. I cannot pay any of the filing fees, costs, security, bond or other expenses of this action because I do not have sufficient income or resources.

3. I live with _____

4. Our family's income is $_____ per month (total from line #31 below).

(Income received each month, before taxes)

Wages ($_____ per hour x _____ hours per month)	_____
Unemployment Compensation	_____
AFDC/TANF Benefits	_____
SSI/SSD Benefits	_____
Child Support	_____
Other (please describe): _____ +	_____
Total=	_____

5. We have $_____ in the bank.

6. Our expenses total $_____ per month: (total from line #47 below)

(Expenses spent each month)

Housing (Rent, Contract, or Mortgage)	_____
Utilities (Gas, Electric, Water, Phone, Etc.)	
Food	_____
Child Care	_____
Medical Bills	_____
Transportation	_____
Insurance (car, medical and/or property)	_____
Child Support	_____
Other (please specify)	_____
Total=	_____

I request that this Court waive all costs of this action and allow me to proceed without the payment of any filing fees or other costs.

I affirm under penalties of perjury that the foregoing representations are true.

_____

Signature

_____

Print your name

_____

Mailing address

_____

Town, State and Zip Code

STATE OF INDIANA)
) SS:
COUNTY OF JOHNSON)

IN THE SUPERIOR COURT 2

CAUSE NO: 41D02 -_____

IN THE MATTER OF)
THE GUARDIANSHIP OF)
)
_____)

PHYSICIAN'S REPORT

1. General Information

Name _____

Phone (_____) _____

Office Address _____
_____

What is your License/Certification? _____

What is your area of specialty? _____

I last examined the Person on: _____, 20____

The Person is under my continuing treatment.
□ YES, since _____, 20____
□ NO

2. Evaluation of the Person's Physical Condition

Physical Diagnosis: _____
_____
_____

Severity: □ Mild □ Moderate □ Severe
Prognosis: □ Continuing □ Degenerative □ Recovering □ Relapsing

Treatment/Medical History/Additional Comments (attach additional pages, if necessary):
_____
_____ _____
_____ _____

3. Evaluation of the Person's Mental Functioning

The Person is oriented to the following (check all that apply):

□ Person □ Time □ Place □ Situation

Do you have concerns about the Person's functioning in the following areas? (check all that apply)

YES	NO	UNKNOWN	FUNCTION
			Short-term memory
			Long-term memory
			Immediate recall
			Understanding and communicating (verbally or otherwise)
			Recognizing familiar objects and persons
			Solving problems
			Reasoning logically
			Grasping abstract aspects of his or her situation
			Interpreting idiomatic expressions or proverbs
			Breaking down complex tasks into simple steps and carrying them out

Mental Diagnosis: _____

_____

Severity: □ Mild □ Moderate □ Severe

Prognosis: □ Continuing □ Degenerative □ Recovering □ Relapsing

Treatment/Medical History/Additional Comments:

_____

_____

4. Medication Information

□ YES □ NO Is the Person currently taking medication related to Person's physical or mental functioning as reported in sections 2 and 3? If "YES," please list:

_____

_____

Additional Comments: _____

_____

_____

_____

5. Decision-Making

Is the Person able to make decisions regarding the following?

YES	WITH SUPPORT	NO	UNKNOWN	ACTION/DECISION
				Make complex business, managerial, and/or financial decisions.
				Manage a personal bank account. If "YES," or "WITH SUPPORT," should amount deposited in any such bank account be limited? □ YES □ NO
				Pay his or her own bills.
				Safely operate a motor vehicle.
				Make decisions regarding marriage.
				Determine the Person's own residence.
				Live alone.
				Obtain food.
				Administer own medications daily.
				Attend to basic activities of daily living (ADLs) (e.g., bathing, grooming, dressing, walking, and/or toileting) with/out services.
				Attend to instrumental activities of daily living (e.g., shopping, cooking, traveling, and/or cleaning).
				Make appropriate judgments that will protect them personally, physically, and/or financially.
				Consent to medical and dental treatment.
				Consent to psychological and/or psychiatric treatment.

Additional Comments:

_____
_____
_____
_____
_____
_____

“Incapacitated person” means an individual who:
(1) cannot be located upon reasonable inquiry;
(2) is unable:
(A) to manage in whole or in part the individual's property;
(B) to provide self-care; **or**
(C) both;
because of insanity, mental illness, mental deficiency, physical illness, infirmity, habitual drunkenness, excessive use of drugs, incarceration, confinement, detention, duress, fraud, undue influence of others on the individual, or other incapacity; or
(3) has a developmental disability (as defined in IC § 12-7-2-61).

Ind. Code § 29-3-1-7.5

(a) **"Less restrictive alternatives"** means an approach to meeting a person's needs that restricts fewer rights of the person than would the appointment of the guardian.
(b) “**Less restrictive alternatives”** may include, but are not limited to, the following:
(1) A supported decision making agreement (as defined in IC § 29-3-14-2).
(2) Appropriate technological assistance.
(3) The appointment of a representative payee.
(4) The appointment of a health care representative (as defined in IC § 16-36-1-2).
(5) The creation of a power of attorney (as defined in IC § 30-5-2-7).

Ind. Code § 29-3-1-7.8

6. Evaluation of Less Restrictive Alternatives

According to the definition in Ind. Code § 29-3-1-7.8 and based upon your last examination and observations of the Person, in your opinion, the following less restrictive alternatives could be considered or implemented:

YES	NO	UN-KNOWN	LESS RESTRICTIVE ALTERNATIVE
			Supported decision making agreement
			Appropriate technological assistance
			Representative payee
			Health care representative
			Power of attorney
			Other_____

7. Evaluation of Capacity

According to the definition in Ind. Code § 29-3-1-7.5 and based upon your last examination and observations of the Person, in your opinion, the Person is:

□ Not incapacitated
□ Not incapacitated with use of the following less restrictive alternative:
_____
_____
_____
□ Partially incapacitated
□ Personal OR □ Financial
□ Totally incapacitated

Additional Comments:
_____
_____
_____
_____

8. Recommendation of Living Arrangement

In your opinion, what is the least restrictive living arrangement that you consider appropriate for the Person?

□ At home/at home with services
□ Community based residence
□ Facility based residence
□ Hospital based residence

Additional Comments:
_____
_____

9. Ability to Attend Court Hearing

□ YES There is no significant threat to the Person's health and/or safety that would prevent them from attending the court hearing.

□ NO There is a significant threat to the Person's health and/or safety that would prevent them from attending the court hearing.

10. Additional Information of Benefit to the Court

Please provide any additional information that would benefit the court (attach additional pages, if necessary).
_____
_____
_____

11. Additional Professional Evaluations

If the descriptions of the Person's condition or skills is based on evaluations or assistance by other professionals, please provide the names and contact information of those professionals who are able to provide additional information or evaluations.

Professional's Name_____ Phone (_____)_____

Office Address or E-mail _____

Professional's Name_____ Phone (_____) _____

Office Address or E-mail _____

I affirm under the penalties for perjury that the foregoing representations are true.

_____ _____

Signature Date

_____

Name Printed

_____

Guardianship Information Sheet

Choose One* (☐ Individual ☐ Estate ☐ Estate and Individual)

Choose One* (☐ Minor ☐ Adult) **Choose One***(☐ Temporary ☐ Permanent)

Related Cases (List any cases in which the Protected Person is a party, e.g., CHINS)

_____ _____ _____

Petitioner **Relationship to Protected Person*** _____

Last:* _____ **Suffix:**_____ **First:*** _____ **Middle:**_____

DOB:_____ **Gender:*** _____ **Race:*** _____ **Hispanic?: Yes/No**

Address:* _____

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

Email Address:* _____

Attorney Name:_____ **Bar Number:**_____ **App. Filed Date:** _____

Protected Person **Estimated Value $**_____

Last:* _____ **Suffix:**_____ **First:*** _____ **Middle:**_____

DOB:* _____ **Gender:*** _____ **Race:*** _____ **Hispanic?: Yes/No**

Eye Color:_____ **Hair Color:**_____ **Height:**_____ **Weight:**_____ **lbs**

Scars, Marks, and Tattoos: _____

Address:* _____

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

Email Address:* _____

Attorney Name:_____ **Bar Number:**_____ **App. Filed Date:** _____

Guardian Ad Litem Full Name:_____

Interpreter required? Yes/No **Language:** _____

Guardian ☐ **Check if same as petitioner** ☐ **Certified (Only check if Federal or State Certified)**

Last:* _____ **Suffix:**_____ **First:*** _____ **Middle:**_____

DOB:_____ **Gender:*** _____ **Race:*** _____ **Hispanic?: Yes/No**

Address:* _____

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

Email Address:* _____

Attorney Name:_____ **Bar Number:**_____ **App. Filed Date:** _____

Guardian Institution

Name:* _____

Address:* _____

Phone:_____ **Fax:**_____ **Agent Name:**_____

Close Relative (Entitled to Notice) **Relationship to Protected Person** _____

Last:* _____ **Suffix:**_____ **First:*** _____ **Middle:**_____

Gender:* _____ **Race:*** _____ **Hispanic?: Yes/No**

Mailing Address:* _____

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

Email Address:* _____

Guardianship Information Sheet

(Additional)

Petitioner **Relationship to Protected Person** _____

Last:*_____ Suffix:_____ First:*_____ Middle:_____

DOB:_____ Gender:*_____ Race:*_____ Hispanic?: Yes/No

Address:*_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____

Attorney Name:_____ Bar Number:_____ App. Filed Date: _____

Guardian ☐ Check if same as petitioner ☐ Certified (Only check if Federal or State Certified)

Last:*_____ Suffix:_____ First:*_____ Middle:_____

DOB:_____ Gender:*_____ Race:*_____ Hispanic?: Yes/No

Address:*_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____

Attorney Name:_____ Bar Number:_____ App. Filed Date: _____

Close Relative (Entitled to Notice) **Relationship to Protected Person** _____

Last:*_____ Suffix:_____ First:*_____ Middle:_____

Gender:*_____ Race:*_____ Hispanic?: Yes/No

Mailing Address:*_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____

Interested Party

Last:*_____ Suffix:_____ First:*_____ Middle:_____

Gender:*_____ Race:*_____ Hispanic?: Yes/No

Address:*_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____

Interested Party

Last:*_____ Suffix:_____ First:*_____ Middle:_____

Gender:*_____ Race:*_____ Hispanic?: Yes/No

Address:*_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____