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supports and services  
THAT FOSTER self-determination.

# Completing a Guardianship Packet

*A Step-by-step Guide on How to Complete a  
Guardianship Packet*

# Getting Started – Some Things to Know

- **Packets need to be thoroughly completed and should be typed. The only exception to this is the physician's interrogatories.**
- **Guardianship packets become exhibits attached to the petition for guardianship and are filed with the court.**
- **Always consider alternatives, and be prepared to explain why those alternatives are not appropriate, before pursuing full guardianship.**
- **Guardianship packets were last revised in April of 2021. Please make sure you are using the most current version of the packet.**
- **Support Coordinators attend the Guardianship Hearing and testify in court.**

Link to find current packets and forms:

<https://intranet.state.mo.us/dmhonline/general-counsel/guardianship-information/>

# Where do I submit a guardianship request?

As of December 1<sup>st</sup>, 2021 all new DD Regional Office requests for guardianship are to be sent to:

[DDGuardianship@dmh.mo.gov](mailto:DDGuardianship@dmh.mo.gov)

- **The guardianship requests will go to a centralized email address and will be assigned to an Information Specialist from there.**
- **The assigned Information Specialist will handle the guardianship to completion.**



# Page 1 – Information

- **The first page of the guardianship packet includes tips and important information to know when completing a packet.**

\* When completing a packet, it is important to make sure the answer matches the question you are responding to. Read the question and focus the response on that question. Occasionally, responses do not match the questions and have to be redone.

## **Tips for completing the Missouri Department of Mental Health Guardianship Packet (REVISED April 2021)**

- ✓ All forms should be typed. Many of the forms will be attached as an exhibit to the petition for guardianship and filed with the court. Legibility is critical. If for some unavoidable reason the form must be hand written, please make sure that the hand writing is clear and legible.
- The guardianship requests will go to a centralized email address and will be assigned to an Information Specialist from there.  
[DDGuardianship@dmh.mo.gov](mailto:DDGuardianship@dmh.mo.gov)
- ✓ Always consider a limited guardianship. It is critical that you look at each essential requirement (i.e. food, clothing, shelter, safety, medical) and identify whether the individual can meet each need through examples that have been personally observed or assessed. The case manager/social worker will be asked about each of these areas during the hearing and needs to be very familiar with the abilities and limitations of the individual.
- ✓ The doctor's interrogatories need to have been completed within 6 months of the last doctor visit. Be sure the consumer's name is included on the interrogatories, they are signed and dated, notarized, and that the doctor has actually seen the client within the last few months.
- ✓ The case manager's/social worker's statement should be no more than 6 months old.
- ✓ The guardianship coordinator for each facility/office should review the checklist against the packet before submitting to the OGC to make sure everything is included. Please look for obvious errors/omissions such as incorrect consumer name, incomplete forms and interrogatories that are not notarized.
- ✓ If the individual has been found permanently incompetent to proceed on criminal charges, please include a copy of the court order with the packet.
- ✓ When completing the case manager's/social worker's statement, please list up front in the History section the charges for which the individual was found permanently incompetent to proceed.



# Pages 2 and 3 - Checklist

Proposed Ward: \_\_\_\_\_

Case Manager/Social Worker: \_\_\_\_\_

Name and Telephone Number \_\_\_\_\_

Has the client been found Permanently Incompetent to Proceed to Trial? \_\_\_\_\_

## GUARDIANSHIP PACKET CHECKLIST

- \_\_\_\_\_ 1. Doctor's Interrogatories
- \_\_\_\_\_ 2. Case Manager/Social Worker's Guardianship/Conservatorship Stmt
- \_\_\_\_\_ 3. Financial Statement
- \_\_\_\_\_ 4. List of Relatives
- \_\_\_\_\_ 5. List of Steps Taken to Locate Relatives
- \_\_\_\_\_ 6. Information for Family Guardians or Conservators (do not include if proposed guardian is the Public Administrator)
- \_\_\_\_\_ 7. Background Screening for Proposed Guardians and Conservators (do not include if the proposed guardian or conservator is the Public Administrator, or Respondent's parent, adult child, adult sibling)
- \_\_\_\_\_ 7a. Child Abuse and Neglect registry
- \_\_\_\_\_ 7b. Employee Disqualification List for Dept. of Health and Senior Services
- \_\_\_\_\_ 7c. Employee Disqualification List for Dept. of Mental Health
- \_\_\_\_\_ 7d. State Criminal Background Check/Sexual Offender Registry
- \_\_\_\_\_ 8. Credit History Report for Proposed Conservator (do not include if the proposed conservator is the Public Administrator, or Respondent's parent, spouse, adult child, adult sibling)
- \_\_\_\_\_ 9. Consent to Appointment (do not include if proposed guardian is the Public Administrator)
- \_\_\_\_\_ 10. Designation of Resident Agent (include only if proposed guardian resides out-of-state)
- \_\_\_\_\_ 11. Domicile Statement

- \_\_\_\_\_ 12. Information Needed for Confidential Filing Information Sheet
- \_\_\_\_\_ 13. Statement Regarding Proposed Guardian
- \_\_\_\_\_ 14. List of Prospective Witnesses
- \_\_\_\_\_ 15. Copy of Court Order finding client permanently incompetent to proceed (if applicable)
- \_\_\_\_\_ 16. Statement Regarding Pending Criminal Charges
- \_\_\_\_\_ 17. Cover Letter to General Counsel's Office

- **All of the items on the checklist are required to complete the packet.**
- **Any exceptions are noted on the checklist**
- **10 – “Designation of Resident” is only required if the proposed guardian lives out of state.**

# Pages 4 through 7 – Physician’s Interrogatories

The next four pages of the packet are the  
Physician’s Interrogatories:

In the Matter of \_\_\_\_\_ )  
An alleged incapacitated and disabled person, )  
Respondent )

**DEPOSITION OF** \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, \_\_\_\_\_ a Notary  
Public within and for the State of Missouri, personally appeared \_\_\_\_\_  
\_\_\_\_\_, who, after being first duly sworn, testified as follows:

**INTERROGATORIES**

- Q. Print your name, age and address.  
A. \_\_\_\_\_
- Q. What is your occupation, business or profession?  
A. \_\_\_\_\_
- Q. Are you licensed to practice in the State of Missouri?  
A. \_\_\_\_\_
- Q. If your answer to Interrogatory number 3 above is affirmative, is your license subject to any restrictions imposed by the State of Missouri?  
A. \_\_\_\_\_
- Q. If in your practice you specialize in some particular field, please specify same.  
A. \_\_\_\_\_
- Q. Have you had occasion to examine, observe and treat \_\_\_\_\_?  
A. \_\_\_\_\_

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7. Q. What was the date of such examination, of \_\_\_\_\_ or between what dates has he/she been under your observation?  
A. \_\_\_\_\_

8. Q. Give the neurological and mental diagnoses including the symptomatology which you observed and which you have made, based upon your examination and observation of \_\_\_\_\_  
A. \_\_\_\_\_

9. Q. Please provide detailed facts upon which your diagnostic conclusions are based.  
A. \_\_\_\_\_

10. Q. Do you consider \_\_\_\_\_ to be "incapacitated", that is unable by reason of any physical or mental or cognitive condition to receive and evaluate information or to communicate decisions to such an extent that the person lacks capacity to manage the person's essential requirements for food, clothing, shelter, safety, or medical care such that serious physical injury, illness, or disease is likely to occur were a guardian not appointed for the person?  
A. \_\_\_\_\_

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11. Q. Please describe the cognitive or behavioral deficits upon which your answer to Interrogatory 10 is based. (Include examples of tasks/activities that the individual is unable to perform due to the incapacity)  
A. \_\_\_\_\_

12. Q. Do you consider \_\_\_\_\_ to be "disabled", that is, unable by reason of any physical or mental or cognitive condition, to receive and evaluate information or to communicate decisions to such an extent that the person lacks ability to manage the person's financial resources?  
A. \_\_\_\_\_

13. Q. Please describe the cognitive or behavioral deficits upon which your answer to Interrogatory 12 is based. (Include examples of tasks/activities that the individual is unable to perform due to the disability)  
A. \_\_\_\_\_

14. Q. In your professional opinion, what is the least restrictive environment or alternative for Respondent, that is, what course of action allows the incapacitated person to live, learn, and work with minimum restrictions on the person, and is appropriate for the person considering his or her physical and mental condition and financial means?  
A. \_\_\_\_\_

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15. Q. Do you believe it would be in \_\_\_\_\_'s best interest to appoint a guardian to protect his/her person?  
A. \_\_\_\_\_

16. Q. Do you consider it would be in \_\_\_\_\_'s best interest to appoint a conservator to manage his/her resources?  
A. \_\_\_\_\_

\_\_\_\_\_  
DEPONENT

KNOW ALL MEN BY THESE PRESENTS, that I, the undersigned Notary Public, hereby certify that the above-named deponent was first duly sworn to me to make true answers to the foregoing interrogatories, that said interrogatories were read by me to deponent, that the answers thereto are correctly recorded as hereinabove set forth, that this deposition was subscribed to by the deponent and witness in my presence.

\_\_\_\_\_  
NOTARY PUBLIC

My Commission Expires: \_\_\_\_\_

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Let’s take a closer look at each page of the interrogatories...

# Page 4 – Physician Interrogatories

In the Matter of: )  
 )  
 )  
An alleged incapacitated and disabled person, )  
 )  
Respondent )

**DEPOSITION OF** \_\_\_\_\_

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, \_\_\_\_\_ a Notary Public within and for the State of Missouri, personally appeared \_\_\_\_\_, who, after being first duly sworn, testified as follows:

**INTERROGATORIES**

1. Q. Print your name, age and address.  
A.
2. Q. What is your occupation, business or profession?  
A.
3. Q. Are you licensed to practice in the State of Missouri?  
A.
4. Q. If your answer to Interrogatory number 3 above is affirmative, is your license subject to any restrictions imposed by the State of Missouri?  
A.
5. Q. If in your practice you specialize in some particular field, please specify same.  
A.
6. Q. Have you had occasion to examine, observe and treat \_\_\_\_\_?

- Make sure the professional filling out the interrogatories is qualified. Physician, Psychologist, Psychiatrist, etc.
- Cannot be signed by a Physician's Assistant (P.A.) or a Nurse Practitioner (N.P.) HOWEVER, interrogatories completed by an N.P. or a P.A. can be accepted as long as the physician signs them.
- **Interrogatories MUST be notarized.**
- Interrogatories should be no more than 6 months old when the hearing is held. If the date on the form is nearing 6 months before the packet is submitted, please have the Physician fill out and sign an Affidavit of No Change that is recently notarized.

## Page 5 – Physician Interrogatories

7. Q. What was the date of such examination, of \_\_\_\_\_ or between what dates has he/she been under your observation?

A.

8. Q. Give the **neurological and mental diagnoses** including the symptomatology which you observed and which you have made, based upon your examination and observation of \_\_\_\_\_

A.

9. Q. Please provide **detailed** facts upon which your diagnostic conclusions are based.

A.

10. Q. Do you consider \_\_\_\_\_, to be “incapacitated”, that is unable by reason of any physical or mental or cognitive condition to receive and evaluate information or to communicate decisions to such an extent that the person lacks capacity to manage the person’s essential requirements for food, clothing, shelter, safety, or medical care such that serious physical injury, illness, or disease is likely to occur were a guardian not appointed for the person?

A.

- **Make sure all questions have been answered and that you are able to clearly read the responses.**

- **Number 10 - Should say “Yes” for Guardianship.**





## Page 6 – Physician Interrogatories

11. Q. Please describe the cognitive or behavioral deficits upon which your answer to Interrogatory 10 is based. (Include examples of tasks/activities that the individual is unable to perform due to the incapacity)

A.

12. Q. Do you consider \_\_\_\_\_, to be “disabled”, that is, unable by reason of any physical or mental or cognitive condition, to receive and evaluate information or to communicate decisions to such an extent that the person lacks ability to manage the person’s financial resources?

A.

13. Q. Please describe the cognitive or behavioral deficits upon which your answer to Interrogatory 12 is based. (Include examples of tasks/activities that the individual is unable to perform due to the disability)

A.

14. Q. In your professional opinion, what is the least restrictive environment or alternative for Respondent; that is, what course of action allows the incapacitated person to live, learn, and work with minimum restrictions on the person, and is appropriate for the person considering his or her physical and mental condition and financial means?

A.

- **Number 12** - Should say “Yes” for Conservator.

- **Number 14** – Read what is recommended by the physician as the least restrictive environment and consider whether the SC’s response is consistent with the physician’s recommendation.
- *\*\*Example of inconsistent answers: Physician recommends natural home and SC statement recommends residential.*

# Page 7 – Physician Interrogatories

15. Q. Do you believe it would be in \_\_\_\_\_'s best interest to appoint a guardian to protect his/her person?

A.

16. Q. Do you consider it would be in \_\_\_\_\_'s best interest to appoint a conservator to manage his/her resources?

A.

Physician's  
Signature

\_\_\_\_\_  
DEPONENT

KNOW ALL MEN BY THESE PRESENTS, that I, the undersigned Notary Public, hereby certify that the above-named deponent was first duly sworn by me to make true answers to the foregoing interrogatories, that said interrogatories were read by me to deponent, that the answers thereto are correctly recorded as hereinabove set forth, that this deposition was subscribed to by the deponent and witness in my presence.

\_\_\_\_\_  
NOTARY PUBLIC

My Commission Expires:

• **One or both should say "Yes".**

• **Make sure it is notarized.**

*\* Cannot be more than 6 months old.*

# Pages 8 through 11 – Case Manager’s Statement

**The next four pages of the packet is the Case Manager’s Statement.**

**CASE MANAGER/SOCIAL WORKER'S  
GUARDIANSHIP/CONSERVATORSHIP STATEMENT**

Case Manager's/Social Worker's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_

Proposed Ward's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Admission Status: \_\_\_\_\_

- Please list your place of employment and your position.
- Please describe your educational background.
- Please describe your contact with the proposed ward.
- Who currently has custody of the proposed ward?
- Please describe the proposed ward's admission and placement history.

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- Please describe the proposed ward's family and residential (places where proposed ward lived by choice prior to placement) history.
- Please describe the proposed ward's social functioning.
- Do you have a recommendation as to whether the proposed ward is an incapacitated person, that is, unable by reason of any physical or mental or cognitive condition to receive and evaluate information or to communicate decisions to such an extent that the person lacks capacity to manage the person's essential requirements for food, clothing, shelter, safety, or medical care such that serious physical injury, illness, or disease is likely to occur were a guardian not appointed for the person?
- List the specific factual reasons for this opinion. (Please include functional limitations you have personally observed assessed and include examples of tasks/activities that the individual is unable to perform due to the incapacity.)
- Do you have a recommendation as to whether the proposed ward is a disabled person, that is, unable by reason of any physical or mental or cognitive condition, to receive and evaluate information or to communicate decisions to such an extent that if left unsupervised, the person lacks ability to manage the person's financial resources?
- List the specific factual reasons for this opinion. (Please include functional limitations you have personally observed assessed and include examples of tasks/activities that the individual is unable to perform due to the incapacity.)
- What are the placement plans for the proposed ward?
- Is this placement the least restrictive alternative for the proposed ward?

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- Is this a supervised placement? What degree of supervision does the proposed ward require?
- What degree of financial supervision does the proposed ward require?
- Does this placement place the least possible restriction on the proposed ward's personal liberty and exercise of rights and promote the greatest possible inclusion of the person into his or her community, as is appropriate for the person considering his or her physical and mental condition and financial means?
- Is this placement consistent with meeting the proposed ward's essential requirements for health, safety, habilitation, treatment, and recovery and protecting the person from abuse, neglect, and financial exploitation?
- Who are you recommending to serve as guardian of the proposed ward and/or conservator of the proposed ward's estate?
- Has the person listed in number 13 above (unless the person listed is the public administrator) ever been appointed as guardian of the person or conservator of the estate of any other person?  
 If so, please list the names and addresses of such wards or disabled persons.
- Does the proposed ward have a guardian appointed in this or any other state? If so, please provide the name and address of the guardian and the state where the guardianship was obtained.
- Has the proposed ward ever executed a will or power of attorney? If so, please attach a copy of the document.

10

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- Has Respondent expressed interest in retaining the right to vote?
- Has Respondent expressed interest in retaining the right to operate a motor vehicle, should they pass the required exam?
- Has Respondent expressed interest in retaining the right to marry?

The foregoing is made under oath or affirmation and its representations are true and correct to the best knowledge and belief of the undersigned subject to the penalties of making false affidavits or declarations.

\_\_\_\_\_  
Signature

State of Missouri )  
 County of \_\_\_\_\_ ) ss

On \_\_\_\_\_, 2011, the above witness personally appeared before me, and after being duly sworn, stated on oath that the answers written above were the witness's true answer to the questions. I certify that the witness signed and swore to this statement in my presence on the date stated above. In testimony whereof, I have set my hand and official seal at my office in \_\_\_\_\_ County, Missouri, on the date above written.

\_\_\_\_\_  
Notary Public

(SEAL)  
 My Commission Expires: \_\_\_\_\_

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Let's take a closer look at each page in the Case Manager's Statement...



# Page 8 – Case Manager’s Statement

- **If the Support Coordinator (SC) changes prior to packet submission, this does not need to be redone, however, the packet will need to be updated with the current SC and the cover letter should include the current information.**
- **The Case Manager’s Statement cannot be more than 6 months old when the hearing is held. If the dates are nearing 6 months when the packet is submitted, please include a signed and notarized “Affidavit of No Change” to avoid delays.**

**CASE MANAGER’S/SOCIAL WORKER’S  
GUARDIANSHIP/CONSERVATORSHIP STATEMENT**

Case Manger’s/Social Worker’s Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Proposed Ward’s Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Admission Status: \_\_\_\_\_

1. Please list your place of employment and your position.
2. Please describe your educational background.
3. Please describe your contact with the proposed ward.
4. Who currently has custody of the proposed ward?
5. Please describe the proposed ward’s admission and placement history.



# Page 9 – Case Manager’s Statement

6. Please describe the proposed ward’s family and residential (places where proposed ward lived by choice prior to placement) history.

7. Please describe the proposed ward’s social functioning.

8. Do you have a recommendation as to whether the proposed ward is an incapacitated person; that is, unable by reason of any physical or mental or cognitive condition to receive and evaluate information or to communicate decisions to such an extent that the person lacks capacity to manage the person’s essential requirements for food, clothing, shelter, safety, or medical care such that serious physical injury, illness, or disease is likely to occur were a guardian not appointed for the person?

9. List the specific factual reasons for this opinion. (Please include functional limitations you have personally observed/assessed and include examples of tasks/activities that the individual is unable to perform due to the incapacity)

10. Do you have a recommendation as to whether the proposed ward is a disabled person; that is, unable by reason of any physical or mental or cognitive condition, to receive and evaluate information or to communicate decisions to such an extent that if left unsupervised, the person lacks ability to manage the person’s financial resources?

11. List the specific factual reasons for this opinion. (Please include functional limitations you have personally observed/assessed and include examples of tasks/activities that the individual is unable to perform due to the incapacity.)

12. What are the placement plans for the proposed ward?

13. Is this placement the least restrictive alternative for the proposed ward?

- Answer all questions as thoroughly as possible and provide all relevant, supporting information.  
*\*HINT: This will assist SC later with testifying in court.*

• **Provide as many details as possible to support recommendations.**



# Page 10 – Case Manager’s Statement

• **Avoid brief answers here and explain why.**

• **Provide full name and relationship to the proposed ward.**

• **Note exceptions if proposed guardian is the Public Administrator.**

14. Is this a supervised placement? What degree of supervision does the proposed ward require?

15. What degree of financial supervision does the proposed ward require?

16. Does this placement place the least possible restriction on the proposed ward's personal liberty and exercise of rights and promote the greatest possible inclusion of the person into his or her community, as is appropriate for the person considering his or her physical and mental condition and financial means?

17. Is this placement consistent with meeting the proposed ward's essential requirements for health, safety, habilitation, treatment, and recovery and protecting the person from abuse, neglect, and financial exploitation?

18. Who are you recommending to serve as guardian of the proposed ward and/or conservator of the proposed ward's estate?

19. Has the person listed in number 13 above (unless the person listed is the public administrator) ever been appointed as guardian of the person or conservator of the estate of any other person?

If so, please list the names and addresses of such wards or disabled persons.

20. Does the proposed ward have a guardian appointed in this or any other state? If so, please provide the name and address of the guardian and the state where the guardianship was obtained.

21. Has the proposed ward ever executed a will or power of attorney? If so, please attach a copy of the document.

# Page 11 – Case Manager’s Statement

\* Do not forget to sign the case manager’s statement.

• **Make sure the CM statement is notarized and the date signed is not nearing or past 6 months.**

22. Has Respondent expressed interest in retaining the right to vote?

23. Has Respondent expressed interest in retaining the right to operate a motor vehicle, should they pass the required exam?

24. Has Respondent expressed interest in retaining the right to marry?

The foregoing is made under oath or affirmation and its representations are true and correct to the best knowledge and belief of the undersigned subject to the penalties of making false affidavit or declaration.

*Case Manager's  
Signature*

\_\_\_\_\_  
Signature

State of Missouri )  
County of \_\_\_\_\_ ) *ss*

On \_\_\_\_\_, 201\_, the above witness personally appeared before me, and after being duly sworn, stated on oath that the answers written above were the witness’s true answer to the questions. I certify that the witness signed and swore to this statement in my presence on the date stated above. In testimony whereof, I have set my hand and official seal at my office in \_\_\_\_\_ County, Missouri, on the date above written.

\_\_\_\_\_  
Notary Public

(SEAL)  
My Commission Expires: \_\_\_\_\_



# Page 12 – Financial Statement

- **If you are unsure about anything on this form, you will need to find out.**
- **If it is not applicable, please write N/A or \$0 and do not leave it blank.**

| <u>FINANCIAL STATEMENT</u>     |                 |
|--------------------------------|-----------------|
| <b>PERSONAL PROPERTY:</b>      |                 |
| Checking Accounts              |                 |
| _____                          | Bank \$ _____   |
| _____                          | Bank \$ _____   |
| _____                          | Bank \$ _____   |
| Savings Accounts               |                 |
| _____                          | Bank \$ _____   |
| _____                          | Bank \$ _____   |
| _____                          | Bank \$ _____   |
| Stocks and Bonds               |                 |
| _____                          | Value \$ _____  |
| Vehicle                        |                 |
| _____                          | Value \$ _____  |
| Year, Make and Model           |                 |
| _____                          | Value \$ _____  |
| Year, Make and Model           |                 |
| Other                          |                 |
| _____                          | \$ _____        |
| _____                          | \$ _____        |
| <b>TOTAL PERSONAL PROPERTY</b> | <b>\$ _____</b> |





# Page 13 – Monthly Income

- **Only include income for the individual, not the proposed guardian.**
- **If it is not applicable, please write N/A and do not leave it blank.**

**MONTHLY INCOME:**

Social Security  
Payee \_\_\_\_\_ \$ \_\_\_\_\_

SSI  
Payee \_\_\_\_\_ \$ \_\_\_\_\_

Veterans Administration Benefits \$ \_\_\_\_\_

Pension:  
Source \_\_\_\_\_ \$ \_\_\_\_\_

Interest:  
Source \_\_\_\_\_ \$ \_\_\_\_\_

\*Trust income:  
Source \_\_\_\_\_ \$ \_\_\_\_\_

Other:  
Source \_\_\_\_\_ \$ \_\_\_\_\_

**TOTAL MONTHLY INCOME:**

**REAL PROPERTY:** (List Location and Value, including property outside Missouri)

\_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_

**\*If the client is the grantor, a qualified beneficiary, or a trustee or co-trustee of a trust, please provide the name and address of the presently acting trustees of such trust and the purpose of the trust as well as a copy of the trust.**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

# Page 14 – List of Relatives

| <u>LIST OF RELATIVES</u>                   |                       |
|--|-----------------------|
| <b>PARENTS:</b>                            | Mother:<br>Address:   |
|  | Father:<br>Address:   |
| <b>SPOUSE:</b>                             | Spouse:<br>Address:   |
| <b>ADULT CHILDREN:</b><br>(age 18 or over) | Daughter:<br>Address: |
|  | Age:                  |
|  | Daughter:<br>Address: |
|  | Age:                  |
|  | Son:<br>Address:      |
|  | Age:                  |
| <b>ADULT SIBLINGS:</b>                     | Brother:<br>Address:  |
|  | Age:                  |
|  | Brother:<br>Address:  |
|  | Age:                  |

- You may need to conduct a due and diligent search for family members.
- If there are known, close and suitable family members who are unwilling to become guardian, you will need to have them sign a statement indicating that they are not willing to serve and that they agree to the proposed guardian.
- If you are unable to locate family members or if they refuse to send a written statement, please include a copy of the letter that was sent to the family member with the packet.

# Page 15 – List of Relatives Continued

**OTHER CLOSE RELATIVES:**

Sister:  
Address:

Age:

Sister:  
Address:

Age:

Name:  
Address:

Relationship:

Name:  
Address:

Relationship:

**OTHER ADULTS LIVING W/ INDIVIDUAL:**  
(non DMH clients)

Name:  
Address:

Relationship:

Name:  
Address:

Relationship:

\*\*\*If there is no known spouse, adult child, or parent, then you must include the names and addresses of the siblings and children of deceased siblings of the alleged incapacitated person.

\*\*\*Missouri law prohibits the court from appointing an unrelated third party as guardian or conservator unless there is no relative suitable and willing to serve.

**“Close Relatives” does not mean in close proximity or close in relationship. It means close in bloodline (example: Aunt, Uncle, Grandparent, etc.)**

# Page 16 – List of Steps Taken to Locate Relatives

**LIST OF STEPS TAKEN TO LOCATE RELATIVES**

1. Were you able to locate an address for the proposed ward's mother and father?  
\_\_\_\_\_
2. Were you able to locate an address for all of the proposed ward's brothers and sisters?  
\_\_\_\_\_
3. Were you able to locate an address for all of the proposed ward's children?  
\_\_\_\_\_
4. Were you able to locate an address for the proposed ward's spouse?  
\_\_\_\_\_
5. Were you able to locate any known creditors of the proposed ward?  
\_\_\_\_\_
6. If you answered no to any of the foregoing questions, **you will need to conduct a due and diligent search for these family members.** Please take the following steps and initial on the line after you completed this step.
  - \_\_\_\_\_ I searched the client's entire DMH file;
  - \_\_\_\_\_ I asked family members and the client about the missing person's whereabouts;
  - \_\_\_\_\_ I checked telephone directories and information in the county of the last known address of the missing person;
  - \_\_\_\_\_ I conducted an Internet search for the missing person;
  - \_\_\_\_\_ I sent a certified letter to the last known address of the person.
6. How long has it been since the missing person had any contact with the proposed ward?  
\_\_\_\_\_

\* Please indicate if any questions are inapplicable and do not leave the question blank.

• Here is where SCs document any due and diligent search efforts for family members.





# Pages 17 and 18 – Information for Guardians and Conservators

## INFORMATION FOR GUARDIANS AND CONSERVATORS

To help you perform your duties properly, described below are the general duties and obligation of a guardian and conservator.

1. A guardian or conservator is appointed upon the adjudication of an individual (respondent) as incapacitated (guardian) or disabled (conservator). If you have been appointed guardian, the respondent is known as a "ward." If you have been appointed conservator, the respondent is known as a "protectee." If you have been appointed both guardian and conservator, the respondent is known as both a "ward and protectee."
2. An incapacitated person lacks the legal ability to make medical or psychiatric treatment decisions, or to make placement decisions. An incapacitated person may lack the legal ability to vote, to marry, or to drive an automobile. A disabled person lacks the legal ability to handle his or her own financial resources. If the respondent is adjudicated to be only partially incapacitated or disabled, the extent to which the respondent's rights are limited will be specified by court order. It is the guardian's and conservator's duty to prevent the ward or protectee from exercising only those rights limited or rescinded by adjudication.
3. As guardian, you have the duty to take charge of the person of the ward and to provide for the ward's care, treatment, habilitation, education, support and maintenance; and the powers and duties shall include (a) assuring that the ward resided in the best and least restrictive alternative setting reasonably available; (b) assuring that the ward receives medical care and other services that are needed; (c) promoting and protecting the care, comfort, safety, health, and welfare of the ward; and (d) providing required consents on behalf of the ward. You will be required to file a personal status report annually concerning the care, welfare, and placement of your ward.
4. As conservator, you must take possession of your protectee's property to the extent authorized by the court. The property, income, and bank accounts must be kept separate from your own funds in your name as conservator for the protectee. You must invest the protectee's funds according to law and you are personally liable for imprudent or unauthorized investments. You may apply for an order of continuing support and maintenance authorizing you to spend a budgeted sum each month for the protectee. You will be required to file an annual accounting (called a settlement) showing in detail all receipts and expenditures occurring during the preceding year. Each entry must be explained and each expenditure must be authorized by statute or court order. You may not sell, trade, lease, mortgage, transfer, or discard your protectee's property without court approval, even though the protectee is your child or other relative.

Form 10194a

5. Your authority as guardian and conservator (described in paragraphs 3 and 4 above) may be limited by the order appointing you. **Consult your attorney as to legal limitations resulting from your ward's or protectee's adjudication and as to the extent of your authority.**

6. In the event the ward or protectee dies or you or the ward or protectee move from one address to another, you have a duty to notify the court in writing of such death or new address as soon as possible.
7. You are under a duty, at all times, to act in the best interests of your ward-protectee, and to avoid conflicts of interest that will impair your ability so to act. If you fail to perform any of your duties as guardian or conservator, you are liable to be removed from office and may be held personally liable for any loss or damage sustained by the ward or protectee by reason of your failure.
8. In certain cases, expenses of bond and other costs may be saved by placing funds in restricted deposits and/or securing waiver of filing the annual settlement. Consult your attorney.
9. **Under Missouri law, a conservator who is not a licensed attorney cannot represent the protectee's estate in connection with court proceedings, whether appearing in court or preparing pleadings to be filed with the court.** You must retain an attorney to perform those legal services required of you. On order of the court, the attorney may be compensated for services reasonably necessary from the protectee's estate. If only limited funds or public assistance (SSI) is available, you may qualify for free legal aid.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of proposed Guardian/Conservator


Form 10194a

- Proposed guardian must sign this.
- Do not include if the proposed guardian is the Public Administrator



# Page 19 – Background Screening Form

Double Click on Caregiver Background Screening Form below to open in PDF

|  |   |       |          |
|--|---|-------|----------|
|  STATE OF MISSOURI<br><b>CAREGIVER BACKGROUND SCREENING</b>   | AGENCY USE  |       |          |
|  | <b>BLOCK I - TO BE COMPLETED BY THE REQUESTOR</b><br><b>SECTION A: TYPE OF SCREENING (Check as many as applicable)</b><br><input type="checkbox"/> 1. Child Abuse or Neglect File (No charge, Notary req)<br><input type="checkbox"/> 2. Family Foster Care Licensing (No charge)<br><input type="checkbox"/> 3. Department of Health and Senior Services Employee Disqualified List (No charge)<br><input type="checkbox"/> 4. Department of Mental Health Disqualified Registry (No charge)<br><input type="checkbox"/> 5. Child Day Care Licensing (No charge)<br><input type="checkbox"/> 6. State Criminal Background Check/Sexual Offender Registry - Name Search (\$13.00) |       |          |
| <b>SECTION B: REQUESTOR INFORMATION</b><br>Responses generated as a result of this form are confidential. Any person disclosing the information in violation of 43.540, 589.400 RSMo. and/or 210.150 RSMo. is guilty of a class A misdemeanor. |   |       |          |
| REQUESTOR'S NAME   | REQUESTOR'S TELEPHONE   |       |          |
| REQUESTOR'S ADDRESS  | CITY  | STATE | ZIP CODE |
| SIGNATURE OF REQUESTOR (REQUIRED IN INK)   | DATE  |       |          |

|  |   |                |                                       |                        |       |
|--|---|----------------|---------------------------------------|------------------------|-------|
| <b>BLOCK II - TO BE COMPLETED BY THE CAREGIVER</b><br><b>SECTION C: IDENTIFYING DATA FOR BACKGROUND SCREENING</b><br>CAREGIVER NAME (LAST, FIRST, M.I., JR., OR, III)  |   |                |                                       | SOCIAL SECURITY NUMBER |       |
| MARITAL STATUS   | DATE OF BIRTH (MM/DD/YY)                                      | STATE OF BIRTH | SEX                                   | AGE                    |       |
| ALIAS NAME(S)  | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |                |                                       |                        |       |
| <b>ADDRESSES FOR THE LAST 3 YEARS</b>  |   |                |                                       |                        |       |
| STREET   | CITY  | STATE          | STREET                                | CITY                   | STATE |
| <b>SECTION D: AUTHORIZATION TO RELEASE BACKGROUND CHECK INFORMATION</b><br>The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission to obtain any and all information needed to process this request, to make the information available to the requestor and to use the information as permitted by law. |   |                |                                       |                        |       |
| SIGNATURE OF CAREGIVER (MUST BE SIGNED IN PRESENCE OF A NOTARY PUBLIC (REQUIRED IN INK))   |   |                |                                       | DATE                   |       |
| <b>SECTION E: NOTARY INFORMATION (Required for screening type 1. See Section A above)</b><br>NOTARY PUBLIC (EMBOSSER OR BLACK INK RUBBER STAMP SEAL)   |   |                |                                       |                        |       |
| STATE  | COUNTY (OR CITY OF ST. LOUIS)                                 |                |                                       |                        |       |
| SUBSCRIBED AND SWORN BEFORE ME, THIS   | DAY OF  | YEAR           | USE RUBBER STAMP IN CLEAR AREA BELOW. |                        |       |
| NOTARY PUBLIC SIGNATURE  | MY COMMISSION EXPIRES   |                |                                       |                        |       |
| NOTARY PUBLIC NAME (TYPED OR PRINTED)  |   |                |                                       |                        |       |

|  |  |
|--|--|
| <b>BLOCK III - REQUESTOR MUST PROVIDE RETURN ADDRESS BELOW</b><br>(REQUIRED) |  |
| _____<br>_____<br>_____<br>_____   | ← ATTN (REQUESTOR'S NAME)<br>← ADDRESS 1<br>← ADDRESS 2 (IF APPLICABLE)<br>← CITY, STATE, ZIP CODE |

- Do not include if the proposed guardian or conservator is the Public Administrator, or Respondent's parent, adult child or adult sibling.

# Page 20 – Background Screening Instructions

**MISSOURI'S CAREGIVER BACKGROUND SCREENING SERVICE  
INSTRUCTIONS**

This service allows the public to receive background information on people who provide daycare or healthcare services to children, the elderly and persons with disabilities.

The State, through various departments, offers several resources to screen caregivers:

1. Child abuse/neglect records, maintained by the Division of Family Services (573) 751-2330
2. Family Foster Care Licensing records, maintained by the Health and Senior Services (573) 522-2449
3. The Employee Disqualification List, maintained by the Health and Senior Services (573) 522-2449
4. The Disqualified Registry, maintained by the Department of Mental Health (573) 751-8567
5. Child Daycare Licensing, maintained by the Department of Health (573) 751-2450
6. State criminal background checks, sexual offender registry, conducted by the Missouri State Highway Patrol (573) 526-6153

The Caregiver Background Screening Request form allows the public to obtain information from these databases through a single request. The form must be completed and signed by both the requestor and the caregiver. The requestor will receive separate responses from [each database](#) that is selected.

1. Once completed, send the form to the appropriate address below.
2. If you have a question about a particular response, please call the agency that sent you the response at the phone number [above](#).

For purposes of this form, the requestor is the person who wishes to obtain background information on a potential caregiver. The caregiver is the person being screened for the purposes of potential employment as a daycare or healthcare service provider.

**BLOCK I (To be completed by the requestor, or person obtaining information)**

**Section A: Type of Screening**

Section A contains the resources available to screen potential caregivers. The requestor must indicate the resources to be included in the background screening. All screenings, except for the state criminal background check, are free of charge. Requests for state criminal background checks must be accompanied by a check for \$13 payable to the Missouri State Highway Patrol. In addition, screenings for option 1, the child abuse or neglect file, require a notary public to witness the caregiver's signed authorization to release information (See Section D and E). All other screenings are considered open information under state statute and do not require a notary's verification.

**Section B: Requestor's Information**

The requestor must complete Section B.

**BLOCK II (To be completed by the caregiver, or person being screened)**

**Section C: Identifying Data for Background Screening**

The caregiver, or person being screened for potential employment, must complete Section C. This section consists of identifying information that is needed to conduct background screenings.

**Section D: Authorization to Release Background Check Information**

The caregiver must sign Section D to authorize the State to conduct the screening and to provide the information to the requestor. The caregiver must sign Section D in the presence of a notary public if screening 1 is selected.

**Section E: Notary Information**

A notary public must complete Section E after witnessing the caregiver's signed authorization for release of information in Section D.

**BLOCK III (To be completed by the requestor, or person obtaining information)**

The requestor must complete Block III by providing return address information.

Fill out the form as completely and accurately as possible. Accurate information on the form is essential for a quality background check.

**SCREENINGS 1, 2, 3, 5 AND 6 SHOULD BE SENT TO:**

Missouri State Highway Patrol  
Criminal Justice Information Services Division  
P.O. Box 9500  
Jefferson City, MO 65102

**SCREENING 4 SHOULD BE SENT TO:**

Department of Mental Health  
Central Office  
1706 East Elm  
Jefferson City, MO 65101  
Fax - (573) 526-4561

MO 300-1590 (9-16)

 April 2021

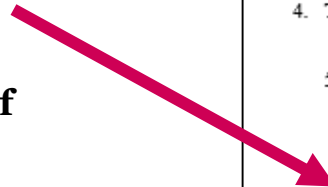
**\* Detailed instructions on how to complete a background screening.**

- **Do not include if the proposed guardian or conservator is the Public Administrator, or Respondent's parent, adult child or adult sibling.**



# Page 21 – Consent to Appointment

- **Proposed guardian must list three people, who do not live with them, that will know their whereabouts.**
- **Do not include if the proposed guardian is the Public Administrator.**



IN RE \_\_\_\_\_ NO. \_\_\_\_\_

**CONSENT TO APPOINTMENT**

The undersigned, \_\_\_\_\_, hereby consents to serve as guardian and/or conservator of the above named respondent if appointed by the court and in support thereof states:

1. The undersigned has never pled guilty to nor been convicted of a misdemeanor or felony.
2. The undersigned spouse is \_\_\_\_\_.
3. The undersigned resides at: \_\_\_\_\_  
Telephone No. \_\_\_\_\_
4. The name and address of undersigned's employer is: \_\_\_\_\_  
\_\_\_\_\_. Telephone No. \_\_\_\_\_
5. The following three listed persons (who are not members of your household, and of each reside at a different address) will know the whereabouts of the undersigned:  
Name: \_\_\_\_\_ Telephone No. \_\_\_\_\_  
Address: \_\_\_\_\_  
Name: \_\_\_\_\_ Telephone No. \_\_\_\_\_  
Address: \_\_\_\_\_  
Name: \_\_\_\_\_ Telephone No. \_\_\_\_\_  
Address: \_\_\_\_\_
6. The last four digits of the undersigned's Social Security Number are: \_\_\_\_\_.
7. The undersigned has read and understands the Information for Guardians and Conservators as set out on Form 10194a, and acknowledges receipt of a copy thereof.

The undersigned swears that the matters set forth are true and correct to the best knowledge and belief of the undersigned, subject to the penalties of making a false affidavit or declaration.

Dated: \_\_\_\_\_

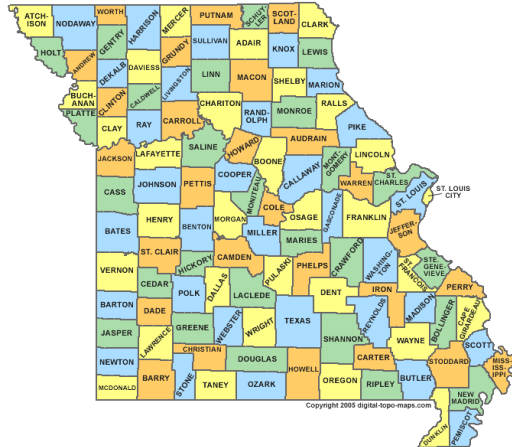
\_\_\_\_\_  
(Signature)

Form 10194



# Page 22 – Designation of Agent

**\* This form is ONLY applicable if the proposed guardian lives outside of Missouri.**



**DESIGNATION OF AGENT FOR SERVICE OF PROCESS  
AND RECEIPT OF NOTICE**

Come(s) now \_\_\_\_\_, a non-resident of the State of Missouri, and designates the following resident of the State of Missouri as Agent for the service of all process on and the receipt of notice by such non-resident, and further states that the following is the name, address and signature of the Agent:

\_\_\_\_\_  
Name of Agent

\_\_\_\_\_  
Residence

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
Signature of Agent

The foregoing is made under oath or affirmation and its representations are true and correct to the best knowledge and belief of the undersigned, subject to the penalties of making a false affidavit or declaration.

Dated this \_\_\_\_ day of \_\_\_\_\_, 20\_\_

\_\_\_\_\_  
Signature of Non-Resident

# Pages 23, 24 and 25 – Domicile Statement

The next three pages of the packet is the Domicile Statement.

**DOMICILE STATEMENT**

Name of Client/patient: \_\_\_\_\_

Where does the client currently reside?

Street \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_

Length of time at this address: \_\_\_\_\_

With whom does s/he reside (including any cotenants or codepositors)? \_\_\_\_\_

Is this a placement or natural home? \_\_\_\_\_

**Prior to this residence, where did the client reside? \*\*\*You must include the prior residences, up to three, for the three years prior to filing for guardianship. If unknown, you must explain what you did to try to identify and locate prior residences. When listing addresses, please include those addresses where the client lived by choice. Explain client's significant connection to county, where client lived, by choice such as years lived at address, years attended school in county, work history in county, relatives still live in county. (DO NOT list correctional institutions, hospitals or DMH inpatient facilities).**

Street \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_

Dates and length of time at this address: \_\_\_\_\_

With whom did s/he reside? \_\_\_\_\_

Was this a placement or natural home? \_\_\_\_\_

If unknown, what efforts were made to locate prior residence? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Street \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_

Dates and length of time at this address: \_\_\_\_\_

With whom did s/he reside? \_\_\_\_\_

Was this a placement or natural home? \_\_\_\_\_

If unknown, what efforts were made to locate prior residence? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Street \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_

Dates and length of time at this address: \_\_\_\_\_

With whom did s/he reside? \_\_\_\_\_

Was this a placement or natural home? \_\_\_\_\_

If unknown, what efforts were made to locate prior residence? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Where was the patient born? \_\_\_\_\_

County (if born in Missouri): \_\_\_\_\_

State (if born outside of Missouri): \_\_\_\_\_

Where did the patient attend school: \_\_\_\_\_

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4. Does the patient own property in this or any other county in Missouri?  
 Yes  No

If yes, briefly describe the property and state the location of the property.  
\_\_\_\_\_  
\_\_\_\_\_

5. Does the patient own property in any other state?  
 Yes  No

If yes, briefly describe the property and the location of the property.  
\_\_\_\_\_  
\_\_\_\_\_

6. Date when (s)he first entered the mental health system either as an inpatient or a placement made by the department: \_\_\_\_\_

a. Age at the time: \_\_\_\_\_

b. Complete address at that time: \_\_\_\_\_  
\_\_\_\_\_

c. Length of time at this address: \_\_\_\_\_

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The Domicile Statement is information on where the client currently resides, as well prior residences for up to three years.  
Let's look closer at page 25...



# Page 25 – Domicile Statement

4. Does the patient own property in this or any other county in Missouri?  
 Yes       No

If yes, briefly describe the property and state the location of the property.

---

---

5. Does the patient own property in any other state?  
 Yes       No

If yes, briefly describe the property and the location of the property.

---

---

6. Date when (s)he first entered the mental health system either as an inpatient or a placement made by the department: \_\_\_\_\_

a. Age at the time: \_\_\_\_\_

b. Complete address at that time: \_\_\_\_\_

---

c. Length of time at this address: \_\_\_\_\_



• **Make sure you answer number 6, 6a, 6b, and 6c.**  
Do not leave any of these blank.

# Page 26 – Information Needed for Confidential Filing

**INFORMATION NEEDED FOR CONFIDENTIAL FILING INFORMATION SHEET**

1. Proposed Ward's Full Name:  

|       |        |      |
|-------|--------|------|
|       |        |      |
| First | Middle | Last |
2. Proposed Ward's Social Security Number:  

*Entire SSN*
3. Proposed Guardian's Name:  

|       |        |      |
|-------|--------|------|
|       |        |      |
| First | Middle | Last |
4. Proposed Guardian's Social Security Number (not needed for Public Administrator):  

*Entire SSN*
5. Proposed Guardian's Date of Birth (not needed for Public Administrator):
6. Proposed Guardian's Full Address (not needed for Public Administrator):
7. Proposed Guardian's Telephone Number (not needed for Public Administrator):

**• Make sure you put their entire social security number.**

**\* Note exceptions for the Public Administrator.**

# Pages 27 and 28 – Statement Regarding Proposed Guardian

## STATEMENT REGARDING PROPOSED GUARDIAN

1. Who did you consider to serve as guardian and/or conservator?

|       |                        |
|-------|------------------------|
| _____ | _____                  |
| Name  | Relationship to Client |
| _____ | _____                  |
| Name  | Relationship to Client |
| _____ | _____                  |
| Name  | Relationship to Client |
| _____ | _____                  |
| Name  | Relationship to Client |
| _____ | _____                  |
| Name  | Relationship to Client |

2. Who are you recommending serve as guardian and/or conservator?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Why are you recommending this person?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Does this person understand the client's disability as well as all of his/her needs, including medical and placement needs?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Have you explained the duties of guardianship to this person, including acting in the best interest of the ward and filing an annual status report with the court?

\_\_\_\_\_

6. If you are not recommending a family member to serve as guardian/conservator, please explain in detail below the reasons you are not recommending a family member serve as guardian/conservator?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

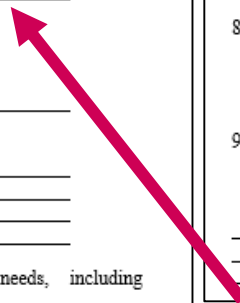
7. If you are not recommending the public administrator or the client's spouse, parent, adult child, or adult sibling as guardian/conservator, has the recommended guardian/conservator submitted themselves for the required background screening(s)? (Results must be submitted to the court at least 10 days prior to the appointment hearing date)

8. If you are not recommending the public administrator or the client's spouse, parent, adult child, or adult sibling as conservator, has the recommended conservator submitted themselves for a credit history report? (Results must be submitted to the court at least 10 days prior to the appointment hearing date)

9. Has the client ever nominated a person to make decisions on his behalf in a will or a Power of Attorney? If so, please provide that person's name and address as well as a copy of the will or power of attorney.

\_\_\_\_\_

\_\_\_\_\_



- **Make sure that ALL the adults that are listed on the “List of Relatives” are also included on this form.**



# Page 29 – List of Prospective Witnesses

## LIST OF PROSPECTIVE WITNESSES

\_\_\_\_\_  
Name (Physician or Licensed  
Psychologist)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip Code

\_\_\_\_\_  
Name (Social Worker or Service  
Coordinator)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip Code

\_\_\_\_\_  
Name (Proposed Guardian)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip Code

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip Code

# Pages 30 and 31 – Statement Regarding Pending Criminal Charges

**Statement Regarding Pending Criminal Charges**

Proposed Ward: \_\_\_\_\_

Proposed Ward's Date of Birth: \_\_\_\_\_

**1.** Are there currently any criminal charges pending against the client? \_\_\_\_\_

If so, please complete the following:

A. Charge Pending: \_\_\_\_\_

B. Court Where Pending: \_\_\_\_\_

C. Cause Number: \_\_\_\_\_

D. Brief description of the alleged conduct that is the basis for the charge.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E. Has the person been found by the court to be permanently incompetent to proceed on the pending charge? \_\_\_\_\_

If so, please attach a copy of the court order.

If this is the only charge pending, please go to question 2.

If there are other pending charges, please complete the following:

A. Charge Pending: \_\_\_\_\_

B. Court Where Pending: \_\_\_\_\_

C. Cause Number: \_\_\_\_\_

D. Brief description of the alleged conduct that is the basis for the charge.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**If no charges – Answer “No” and move on to question 2.**

\_\_\_\_\_

E. Has the person been found by the court to be permanently incompetent to proceed on the pending charge? \_\_\_\_\_

If so, please attach a copy of the court order.

F. Has the person been found not guilty by reason of mental disease or defect excluding responsibility under Chapter 552, ~~RSMo?~~

If so, please attach a copy of the court order.

If other charges are pending, please attach a separate sheet and include the information requested above.

**2.** Does the client have any other criminal history of which you are aware?

If so, briefly describe his or her criminal history:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Revised April 2021 31



Improving lives THROUGH  
supports and services  
THAT FOSTER self-determination.

*Information brought to you by:*

# Information Specialists

[DDGuardianship@dmh.mo.gov](mailto:DDGuardianship@dmh.mo.gov)

**Department of Mental Health  
Division of Developmental Disabilities**





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THAT FOSTER self-determination.