REQUEST FOR GUARDIANSHIP ESTABLISHMENT FUNDS

OFFICE OF GUARDIANSHIP AND CONSERVATORSHIP
SFN 62718 (07-2026)

*Consumer - individual in need of guardianship or conservatorship.

CONSUMER* DEMOGRAPHIC INFORMATION

Consumer Name	Date Of Birth		Age
Address	City	State	ZIP Code
Medicaid Eligible ◯ No ◯ Yes	Medicaid Number		
Explain			

If consumer is residing out of state or not a resident of North Dakota, consumer is **not eligible** for this program.

CONSUMER PROGRAM ELIGIBILITY

Has consumer previously received Guardianship Establishment Funds? ◯ No ◯ Yes	If yes, provide date received.
Is consumer eligible for Developmental Disabilities Program Management? ◯ No ◯ Yes	

**Incapacitated Person - any adult person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, or chemical dependency to the extent that the person lacks capacity to make or communicate responsible decisions concerning that person's matters of residence, education, medical treatment, legal affairs, vocation, finance, or other matters, or which incapacity endangers the person's health and safety.

Does the consumer meet the definition of incapacitated person** (NDCC 30.1-26-01)? ◯ No ◯ Yes

CONSUMER ANNUAL INCOME

The following poverty thresholds are determined by the number of people in a household and their annual income:

1 = $15,060	2 = $20,440	3 = $25,820	4 = $31,200
5 = $36,580	6 = $41,960	7 = $47,340	8 = $52,720

If more than 8 persons for each additional person, add $5,380.

Does consumer have income at, or below, 100% of the annual federal poverty level and is the consumer Medicaid-eligible? ◯ Yes ◯ No - If no, consumer is **not eligible** for this program.

If funds or assets exceeding 100% of the annual federal poverty level are found during the establishment of the guardianship and the individual is no longer Medicaid eligible, the proposed ward will no longer be eligible for this program and any funds expended must be reimbursed to the Guardianship Establishment Fund, and any funds necessary to pay for the establishment of the guardianship must be paid from the ward's estate.

REFERRAL SOURCE

Name	Agency		
Address	City	State	ZIP Code
Email Address	Telephone Number	Fax Number	

DOCUMENTATION OF INCAPACITY REQUIRED

NOTE: Applications cannot be processed without medical documentation recommending guardianship or supporting the need for guardianship.

Check all that are attached below:

- ☐ Evaluations (Neuropsychological, psychiatric, psychological, chemical dependency)
- ☐ Physician's notes/evaluations recommending guardianship
- ☐ Progress notes for the last six weeks
- ☐ Other (specify)

RECOMMENDED TYPE OF GUARDIANSHIP

Check all that apply below:

☐ Full Guardianship ☐ Limited Guardianship ☐ Emergency Guardianship

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information. NDCC 9-16

Signature	Date

Describe the reason/justification for guardianship including the nature and type of disability and how that disability impacts the individual's decision making. This section should accurately reflect the skills and abilities of the person as well as the deficits and problems. Attach additional sheets and any supporting documentation, if necessary.

LESS RESTRICTIVE ALTERNATIVES TO GUARDIANSHIP TRIED OR CONSIDERED

Identify all alternatives to guardianship that have been tried or considered. Describe why the alternatives are not adequate or appropriate.

Power of Attorney
Healthcare Directives/Advanced Directives
Representative Payee
Informed Healthcare Consent Law
Supported Decision Making
Other (specify)

CONSUMER'S MONTHLY NET INCOME AND BENEFITS

Wages	Supplemental Security Income
Retirement Survivors Disability Insurance	Railroad Retirement
Pension	Other (specify)
Other (specify)	Other (specify)

CONSUMER'S ASSETS

Checking Account	Savings Account
Individual Retirement Account/Keogh Account	Mutual Funds
Savings Bonds	Stocks and Bonds
Vehicles	Personal Property
Real Property	Other (specify)
Other (specify)	Other (specify)
Reason Financial Information Not Included	

PROPOSED GUARDIAN

Proposed Guardian Agreement Necessary for Consideration

Name	Relationship to Proposed Ward		
Agency			
Address	City	State	ZIP Code
Email Address	Telephone Number	Fax Number	
I agree to become guardian of this individual. ◯ Yes (if no signature available, documentation of acceptance is required) ◯ No			

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information. NDCC 9-16

Signature	Date

Complete application must be received and approved before petitioning the court for guardianship.

For State Office Use Only

Date Received	Date Reviewed
Reviewed By	
Status of Application ☐ Approved ☐ Denied ☐ Pending Additional Information ☐ Withdrawn	Date
Reason for Denial	
Date Referral Source Notified of Application Status	
Notes	

Mail Completed Form to:
Office of Guardianship and Conservatorship
600 E Boulevard Ave
Bismarck, ND 58505

701-328-3010
Fax: (701)328-0306
Email Completed Form: ogc@nd.gov