Advocacy, Support and Knowledge
for individuals with developmental disabilities, their families and circles of support

To Whom It May Concern:

Thank you for your interest in the ASK Guardianship program. We are able to offer the legal service at a reduced rate for members of The Arc Jacksonville. Membership to the Arc Jacksonville has other benefits as well which is outlined in the **Join The Arc Jacksonville** attachment and membership form.

Rates for legal services for Arc members will run an average of $400.00 for the attorney plus the court filing fee which varies from county to county. In cases where co-guardianship is desired, please be advised that this fee is charged for each application. (Two guardians = $400 each = $800.00)

Please do not send in a check for legal fees. Your legal fees will be due to the attorney during your first office appointment with them.

If interested in guardianship assistance through ASK at The Arc Jacksonville, please fill out the enclosed application in its entirety. Also enclosed are two Release of Information forms that must be completed as well.

- Please note: **The person needing guardianship signs one and the person becoming the guardian will need to sign one**.

Please return your completed application and membership dues to The Arc Jacksonville if not already a member to the address below. Membership may be completed online at: https://www.arcjacksonville.org/get-involved/membership/

If you have any questions or concerns, please do not hesitate to call us at (904) 358-1200.

A community outreach project of The Arc Jacksonville
1050 N. Davis Street – Jacksonville, Florida 32209
Phone (904) 358-1200 • Fax (904) 358-3800 • arcjacksonville.org
▪ ASK_NEFL_Disability_INFO@yahoogroups.com

The Arc
Jacksonville

Achieve with us.
www.arcjacksonville.org

Annual Membership and Benefits:

- **Individual/Family Membership - $25.00**
    1. Monthly E-Newsletter from The Arc Jacksonville
    2. Access to reduced fee legal guardianship services via the ASK Program
- **Supporter Membership - $50.00**
    1. Monthly E-Newsletter from The Arc Jacksonville
    2. Access to reduced fee legal guardianship services via the ASK Program
    3. $50 supports one day of Adult Day Training (ADT) for one program participant
- **Advocate Membership - $100.00**
    1. Monthly E-Newsletter from The Arc Jacksonville
    2. Access to reduced fee legal guardianship services via the ASK Program
    3. $100 supports one week of transportation for one Arc Jacksonville participant to and from their program

Join The Arc Jacksonville family today and Achieve with us™.

Call for additional information: 904.355.0155

Complete membership application and pay online at arcjacksonville.org/join

Please Print Clearly

Detach form and return

The Arc Jacksonville Annual Membership:

___ Individual/Family $25.00 ___ Supporter $50.00 ___ Advocate $100.00 ___ I wish to give an additional contribution of $__________

Parent/Guardian Representative Name:

Person with disability Name:

Representative's relationship to person with disability: __ Mother __ Father __Sibling __ Other:

Address:

City: State: Zip:

Home Phone: Work Phone:

Cell Phone: Email:

Make checks payable to: The Arc Jacksonville
Mail to: The Arc Jacksonville - Memberships | 1050 North Davis Street | Jacksonville, FL 32209

Information on Person Applying to BECOME Guardian

Date: ________________

Please Answer All Questions

Full Name: ____ **Date of Birth:** ____________________

Street Address: ____ **Home Phone:** ( ) _________________

City, State: ___________________________ **Zip:** _________ **Work Phone:** ( ) _________________

County: __________________________________ **Cell Phone** ( ) _________________

Social Security Number: ________________________ **Driver's License #:** ____________________________

Age: _________ **Marital Status:** _________ **Name of Spouse:** ______________________________________

Email: ____

Race (*Please Circle*): **African American** **White** **Hispanic/Latin** **Native American** **Other** _________

Name of Employer: ____

Are You Paid (*Please Circle*): **Weekly** **Bi-Weekly** **Monthly** **Semi-Monthly**

Your Wages before Deductions: $ ________________________

*** If unemployed, how long:** ___________ **Previous Employer:** ___________________ **Last Salary:** ____________

*** Unemployment Compensation Received? YES NO** **Amount Received: $** __________________

Any other source of income: ____

LIST ALL PERSONS WHO LIVE WITH YOU:

NAME	RELATIONSHIP	AGE
1.		
2.		
3.		
4.		
5.		
6.		

EXPENSES/HOUSEHOLD ASSETS:

Monthly Rent $______________________________

Monthly Mortgage $__________________________

Childcare expenses $ __________________________ per month

Medical expenses not covered by insurance, Medicaid, Medicare $ ____________________ per month

Transportation to & from work $ __________________________________per month

Does anyone in your household pay child support? YES NO

If yes, please list who paid to:

WHO	HOW MUCH	# of Children
________________________________	$__________________________per month	__________________
________________________________	$__________________________per month	__________________

✓ **Does anyone in your household own any of the following?**

Home where you live? YES NO

Other land/home? YES NO Approximate value $______________ Loan Balance $______________

Vehicle? YES NO Approximate value $______________ Loan Balance $______________

Vehicle Make & Year: ____

Checking Account? YES NO Balance: $__________________________________

Savings Account? YES NO Balance: $__________________________________

Name of Bank: ____

Other Assets? YES NO Value: $__________________________________

➢ **DO YOU OR ANYONE IN YOUR HOUSEHOLD RECEIVE?**

	Who Receives?	Amount?	How Often?
WELFARE	______________________	$_______________	____________
SOCIAL SECURITY	______________________	$_______________	____________
* SSI	______________________	$_______________	____________
VETERAN BENEFITS	______________________	$_______________	____________
PENSION/RETIREMENT	______________________	$_______________	____________
UNEMPLOYMENT COMPENSATION	______________________	$_______________	____________
WORKER'S COMPENSATION	______________________	$_______________	____________
CHILD SUPPORT OR ALIMONY	______________________	$_______________	____________
OTHER INCOME OR SUPPORT	______________________	$_______________	____________
FOOD STAMPS RECEIVED	______________________	$_______________	

*** Who is the payee for the SSI benefits?**____

I state that the information listed is true and correct:

____
Signature of Applicant

Please give three references who are not related to you and who you have known for at least 5 years:

1. **Name:**____

   Address:____
   (street address) (city) (state) (zip code)

   Phone Number: ____

2. **Name:**____

   Address:____
   (street address) (city) (state) (zip code)

   Phone Number: ____

3. **Name:**____

   Address:____
   (street address) (city) (state) (zip code)

   Phone Number: ____

ADULT GUARDIANSHIP CHECKLIST

- **PERSON REQUESTING to become the GUARDIAN:**

Name: ____

Relationship to person needing guardianship: ________________________________

Have you ever been arrested *(circle one)*: **YES NO**

Was it a felony: *(circle one)*: **YES NO**

- **PERSON NEEDING GUARDIANSHIP:**

Name: ____

Address: ____

____ **County:** ________

Phone #: ____

Social Security #: __________________________ **Marital Status:** ______________

Date of Birth: ____________________________ **AGE:** ______________

Race (*Please Circle*): **African American White Hispanic/Latin Native American Other** ________

- **HEALTH STATUS:**

PHYSICAL:____

____

MENTAL:____

____

PERSON NEEDING GUARDIANSHIP:

- **Adjudicated Incompetent? YES NO**

When? _________________ Where? ____

Court Papers? YES NO * If YES, please describe below or make copies:

____

____

- **MEDICARE coverage: YES NO**
- **MEDICAID coverage: YES NO**
- **DOCTOR INFORMAION:**
  - **Name:____**
  - **Address:_______________________________________**
  - **____**
  - **Phone #: ______________________________________**

IDENTIFY ALL SOURCES OF INCOME AND MONTHLY AMOUNTS:

Source	Amount
_____________________________	$_____________________
_____________________________	$_____________________
_____________________________	$_____________________

Who is the payee for SSI benefits?____

Why is there a need for Guardianship? ____

____

PERSON NEEDING GUARDIANSHIP:

Please List Immediate Relatives (parents, siblings, children, etc…):

NAME	RELATIONSHIP	AGE	ADDRESS	PHONE #

NAME	RELATIONSHIP	AGE	ADDRESS	PHONE #

COMMENTS:____

ASK at Arc Jacksonville
1050 North Davis Street
Jacksonville, Florida 32209
904.358.1200 phone
904.358.3800 fax

AUTHORIZATION FOR RELEASE OF INFORMATION

Name:____ **DOB:**______________
(*Name of Individual Applying to be Guardian)*

Name(s)/Agency(s) and address of where ASK is to obtain or release records/information:

Attorney for purpose of obtaining Guardianship/Guardianship Advocate.____
____

I,____________________________________, authorize ASK to:

(circle all that apply) Obtain Release Exchange

The following information: written verbal other (specify)____________

___X___ Educational Records/Information
___X___ Psychological Records/Information
___X___ Medical Records/Information
______ Other_______________________

For the purpose of: Guardianship/Guardianship Advocacy

This authorization shall remain valid for one-year from the date signed or until such time as I withdraw my consent.

________________________________ ________________
Signature of Applicant Date

ASK at Arc Jacksonville
1050 North Davis Street
Jacksonville, Florida 32209
904.358.1200 phone
904.358.3800 fax

AUTHORIZATION FOR RELEASE OF INFORMATION

Name:____ DOB:______________
(*Name of Individual Needing a Guardian*)

Name(s)/Agency(s) and address of where ASK is to obtain or release records/information:

Attorney for purpose of obtaining Guardianship/Guardianship Advocate.____
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I,____________________________________, authorize ASK to:

(circle all that apply) Obtain Release Exchange

The following information: written verbal other (specify)____________

___X___ Educational Records/Information
___X___ Psychological Records/Information
___X___ Medical Records/Information
______ Other________________________

For the purpose of: Guardianship/Guardianship Advocacy

This authorization shall remain valid for one-year from the date signed or until such time as I withdraw my consent.

____ ____________
Signature of Individual needing Guardianship Date