SOUTH DAKOTA DEPARTMENT OF HUMAN SERVICES
Guardianship/Conservatorship
Establishment Program Application Instructions

This application is to request financial assistance from the department to pay legal costs up to $500 associated with establishing a guardianship and /or conservatorship of a person 18 years and older with a documented developmental disability and who is a resident of South Dakota. Funding for this program is based on a first come first serve basis and the availability of the funding each fiscal year.
*The DHS Establishment Program funds are for first time appointments **only** where there has never been a guardian and/or conservator appointed.*

THE DEPARTMENT WILL NOT ACCEPT ANY APPLICATION SUBMITTED MORE THAN THREE MONTHS PRIOR TO THE INDIVIDUAL'S 18TH BIRTHDAY.

THE APPLICATION MUST BE RECEIVED BY THE DEPARTMENT OF HUMAN SERVICES PRIOR TO THE HEARING FOR APPOINTMENT OF GUARDIANSHIP OR CONSERVATORSHIP TO BE CONSIDERED.

1. Answer all questions that apply.
2. Attach all required documentation.

ATTACH

- A copy of the current psychological or psycho-educational evaluation or school psychological report and multidisciplinary team report and any adaptive behavior test results.
- A copy of the Inventory for Client and Agency Planning (ICAP) summary. ***This is only necessary if one has been completed.***

3. Send completed application and attachments to:

DHS Guardianship Program
Hillsview Plaza, E. Hwy 34
c/o 500 E. Capitol
Pierre, SD 57501-5070

4. If you need assistance with the application, call the DHS Guardianship Program at:

1(800) 265-9684

YOUR APPLICATION WILL BE DENIED IF IT IS INCOMPLETE OR IF YOU DO NOT SEND THE REQUIRED INFORMATION

SOUTH DAKOTA DHS ESTABLISHMENT PROGRAM APPLICATION

TELL US ABOUT THE PERSON THAT NEEDS PROTECTION		
First Name:	Last Name:	
Date of Birth:	Age:	Female ❒ Male ❒
Address:	City:	State, Zip:
Does this person live at home? Yes ❒ No ❒ If no, please select one of the following:		
❒ Independently in the community ❒ Supervised setting ❒ Group home		
TELL US ABOUT THE AGENCY PROVIDING CARE OR SCHOOL THE PERSON ATTENDS		
Community Support Provider or School's Name:		
Address:	City:	State, Zip:
Name of contact person (case manager, teacher, etc.):		
Phone number of contact person:		
TELL US ABOUT THE PERSON(S) WANTING TO BE APPOINTED GUARDIAN OR CONSERVATOR		
First Name:	Last Name:	
Address:	City:	State, Zip:
Phone Number:	Relationship to person needing protection:	
TELL US ABOUT THE ATTORNEY YOU INTEND TO USE (IF KNOWN)		
Attorney's Name:		
Address:	City:	State, Zip:
Phone number:		
Is there an urgent need for this appointment? Yes ❒ No ❒	If yes, why and what are the critical dates?	
Does the person for whom the appointment is needed, currently receive services from the Division of Developmental Disabilities Family Support Program? Yes ❒ No ❒		

Have you attached the following <u>required</u> documents with this application?

- A copy of the current psychological or psycho-educational evaluation or school psychological report and multidisciplinary team report and any adaptive behavior test results.
- (Only if an ICAP has been completed) A copy of the ICAP summary.

Please note! This application will not be considered without documentation of a developmental disability.

I certify that the above information is true and correct to the best of my knowledge	
Signature of person completing this application:	Relationship to person needing protection:
Print Name:	Phone Number: