

SOUTH DAKOTA DEPARTMENT OF HUMAN SERVICES

Long Term Services & Supports Guardianship Establishment Program Application

This application is to request financial assistance from the department to pay legal costs up to \$1500 associated with establishing a permanent guardianship of a person 18 years and older with a documented need for a guardian and who is a resident of South Dakota.

DHS will not consider any application that is not complete and received at least two weeks before any hearing on a petition for appointment of guardian.

In order for the application to be complete, you must:

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

ATTACH



A copy of the current psychological evaluation.



A copy of the primary care physician's documentation showing the cognitive impairment that supports the need for guardian.

Send completed application and attachments to:

DHS Guardianship Program
Hillview Plaza
3800 E. Hwy 34, c/o 500 E. Capitol Ave.
Pierre, SD 57501

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

1(800) 265-9684 / (605) 773-5990

**YOUR APPLICATION WILL BE DENIED IF YOU DO NOT SEND THE
REQUIRED INFORMATION**

SOUTH DAKOTA DHS/LTSS ESTABLISHMENT PROGRAM APPLICATION

TELL US ABOUT THE PERSON THAT NEEDS PROTECTION			
First Name:		Last Name:	
Date of Birth:	Age:	Female <input type="checkbox"/>	Male <input type="checkbox"/>
Address:		City:	State, Zip:
Does this person live at home? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please select one of the following:			
<input type="checkbox"/> Independently in the community <input type="checkbox"/> Supervised setting <input type="checkbox"/> Group home			
TELL US ABOUT THE AGENCY PROVIDING CARE			
Agency Information:			
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			
Attorney's Name:			
Address:		City:	State, Zip:
Phone number:			
Is there an urgent need for this appointment? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 Long-Term Services and Supports? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<p style="text-align: center;">Have you attached the following required documents with this application?</p> <ul style="list-style-type: none"> A copy of the current psychological evaluation. A copy of the primary care physician's documentation showing cognitive impairment that supports the need for guardian. 			
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:	