



In the Superior Court of the State of California
In and for the County of San Joaquin

**CONFIDENTIAL GUARDIANSHIP
QUESTIONNAIRE**

(DECLARATION BY PROPOSED
GUARDIAN(S))

SAN JOAQUIN COUNTY SUPERIOR COURT
315 W. ELM STREET
LODI, CA 95240

FOR COURT USE ONLY

CASE NAME: _____ CASE NUMBER: _____

Is an interpreter needed? No Yes If yes, for whom and in what language:

Instructions to Petitioner(s) / Proposed Guardian(s):

This questionnaire **MUST** be completed with the Petition for Appointment of Guardianship.
If there is not enough room to complete your answer, attach a separate sheet of paper clearly identifying the question.
DO NOT leave any questions blank. State N/A if the question does not apply or "unknown" if you do not know the answer to a question.

This form is required and failure to complete it or to provide attachments may result in delays.

PAGE 1-2 OF THE GUARDIANSHIP QUESTIONNAIRE MUST BE COMPLETED FOR EACH MINOR LISTED ON THE PETITION; MAKE COPIES OF PAGE 1-2 FOR EACH ADDITIONAL CHILD AND ATTACH THEM TO THE QUESTIONNAIRE.

MINOR CHILD(REN) LISTED ON GUARIANSHIP PETITION

ATTACH a copy of the birth certificate for *each* child

Full Legal Name: (As on birth certificate)		Date of Birth:
Pronoun of Preference: <input type="checkbox"/> he/him/his <input type="checkbox"/> she/her/hers <input type="checkbox"/> they/them/theirs		
Person with Whom Residing:		Social Security Number:
Name of School/Daycare:		Grade Level:
Address of School/Daycare:		
Teacher's/Provider's Name:		School/Daycare Phone:
Are there special educational needs? <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>Describe</i>): _____ _____ _____		
Has this child received Regional Center services (past or present)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, answer items a-d below.		
a.	Regional Center(s) they received or are receiving services from:	
b.	Diagnosis:	
c.	Service Coordinator (include name & phone number):	
d.	Has the Minor received any other resources or services for Developmental Disability? <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>Describe</i>): _____ _____ _____	

CONFIDENTIAL GUARDIANSHIP QUESTIONNAIRE

Is this child a member of or do you have reason to believe this child may be eligible for membership in an Indian tribe recognized by the federal government? <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes (<i>Specify tribe</i>):		
Is this child subject to any legal custody orders? <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes		
<u>DOES THE CHILD HAVE:</u>		<u>If Yes</u> , Provide Details
MEDICAL PROBLEMS?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
BEHAVIORAL PROBLEMS?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
DIFFICULTIES IN SCHOOL?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
COUNSELOR?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
SOCIAL WORKER?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
LEGAL GUARDIAN?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
OPEN CPS CASE?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
Will the child's school be changed?	No <input type="checkbox"/> Yes <input type="checkbox"/>	If Yes, Name and address of new school:
Does this child receive any individual or family counseling, therapy, or psychological services? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Is this child prescribed any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list medication(s) and reason for the medication:		
Medication	Reason	

Continued on attachment for this child

Additional children attached

CONFIDENTIAL GUARDIANSHIP QUESTIONNAIRE

PAGES 3-5 OF THE GUARDIANSHIP QUESTIONNAIRE MUST BE COMPLETED BY EACH PETITIONER/PROPOSED GUARDIAN; MAKE COPIES OF PAGES 3-5 FOR EACH ADDITIONAL PETITIONER/PROPOSED GUARDIAN AND ATTACH THEM TO THE QUESTIONNAIRE.

PETITIONER / PROPOSED GUARDIAN

Full Legal Name:		AKA or Maiden Name:	
Pronoun of Preference: <input type="checkbox"/> he/him/his <input type="checkbox"/> she/her/hers <input type="checkbox"/> they/them/theirs			
Legal Relationship to Child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent <input type="checkbox"/> Other:			
Age:	Date of Birth:	Place of Birth:	
Social Security Number:		Driver's License No.:	Currently valid: <input type="checkbox"/> No <input type="checkbox"/> Yes
Home Phone:		Business Telephone:	
Cell Phone:		e-mail address:	
Current Address:		From: _____ – to PRESENT	
City:		State:	Zip:
Are you currently <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Living Together			
If married or living together, Name of Spouse/Partner:		How long have you been married/living together?	
Date of Birth of Spouse/Partner:			
LIST PREVIOUS ADDRESSES FOR THE PAST 5 YEARS			<input type="checkbox"/> Continued on Attachment
From: _____ To: _____		From: _____ To: _____	
Previous Street Address _____		Previous Street Address _____	
City _____ State _____ Zip Code _____		City _____ State _____ Zip Code _____	
From: _____ To: _____		From: _____ To: _____	
Previous Street Address _____		Previous Street Address _____	
City _____ State _____ Zip Code _____		City _____ State _____ Zip Code _____	
CURRENT EMPLOYMENT		Your Position and/or Job Title:	
Name of Company: _____		_____	
Address: _____		_____	
City _____ State _____ Zip Code _____		Telephone: _____	
Length at this job:	Days/Hours you work:	Gross Salary/Monthly: \$	
Other Income <input type="checkbox"/> TANF <input type="checkbox"/> Social Security <input type="checkbox"/> Unemployment		Amount \$ _____	
<input type="checkbox"/> Child Support <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Other _____		Received from: _____	

CONFIDENTIAL GUARDIANSHIP QUESTIONNAIRE

CRIMINAL RECORDS

Please note that a complete criminal background will be conducted. Disclose any arrests, even if the charges were later dismissed.

Have charges ever been filed against you for crimes other than a minor traffic violation? No Yes If yes, please specify:

	<u>Charge(s)</u>	<u>City/State</u>	<u>Date</u>	<u>Disposition</u> <small>(pending, dismissed, convicted)</small>
1.				
2.				
3.				

Continued on attachment

Are you on Probation? No Yes If yes, provide information below:

Probation Officer:

Phone Number:

Are you on Parole? No Yes If yes, provide information below:

Parole Agent:

Phone Number:

Do you have any restraining orders or ever been a party to a request for a restraining order?

No Yes If Yes, Explain: _____

Have you ever had contact with a Child Protective Service Agency?

No Yes If Yes, which county? _____

Give Detail: _____

Have you or anyone living in your home ever been accused of or convicted for child abuse or child molestation? No Yes

If Yes, Explain: _____

MEDICAL HISTORY

Your health is Good Fair Poor

If fair or poor, please explain: _____

Are you currently taking any medications? No Yes

If yes, complete the following:

Continued on attachment

Name	Amount	Reason	How Often Taken

Have you ever had a substance abuse problem with any of the following?
 Alcohol No Yes Drugs No Yes

If yes, to any of the above, please explain:

If you have received psychiatric treatment or counseling, please complete the section below. Continued on attachment

Name of Doctor/Hospital	Address of Doctor/Hospital	Date Last Treated	Diagnosis

FINANCIAL INFORMATION

Your Monthly Net Income(s)(All Sources): \$ Monthly Expenses: \$

INCOME: Please list source(s) of income and amount(s):

	<u>Income Source</u>	<u>Amount</u>
1.		
2.		
3.		

The home you live in is: owned rented Please **ATTACH** proof of residence, e.g. rental agreement.

Monthly Rent or Mortgage: \$ Value (if own): \$

Approximate Size: Sq. ft. Number of Bedrooms: Number of Bathrooms:

OTHER ASSETS: Please list other major assets or real property and the value:

	<u>Asset</u>	<u>Value</u>
1.		
2.		
3.		

Is medical insurance available to the Minor? No Yes

If Yes, name of Insurer:

Do you receive public assistance? No Yes

If Yes, amount: \$

Do you pay or receive child support (for your own children, if any)? No Yes

If Yes, Paying: \$ Receiving: \$

Continued on attachment

HOUSEHOLD COMPOSITION

NAMES OF ANY OTHER ADULTS, 18 YEARS OR OLDER, LIVING IN THE HOME

1. Full Legal Name:			AKA or Maiden Name:
Sex:	Age:	Date of Birth:	Place of Birth:
Social Security Number:			Driver's License No.:
Home Phone:			Business Telephone:
Cell Phone:			E-mail Address:
Relationship to Petitioner:			Relationship to Child(ren):
2. Full Legal Name:			AKA or Maiden Name:
Sex:	Age:	Date of Birth:	Place of Birth:
Social Security Number:			Driver's License No.:
Home Phone:			Business Telephone:
Cell Phone:			E-mail Address:
Relationship to Petitioner:			Relationship to Child(ren):
3. Full Legal Name:			AKA or Maiden Name:
Sex:	Age:	Date of Birth:	Place of Birth:
Social Security Number:			Driver's License No.:
Home Phone:			Business Telephone:
Cell Phone:			E-mail Address:
Relationship to Petitioner:			Relationship to Child(ren):
4. Full Legal Name:			AKA or Maiden Name:
Sex:	Age:	Date of Birth:	Place of Birth:
Social Security Number:			Driver's License No.:
Home Phone:			Business Telephone:
Cell Phone:			E-mail Address:
Relationship to Petitioner:			Relationship to Child(ren):

Continued on attachment

NAMES OF ANY OTHER CHILDREN, UNDER 18, LIVING IN YOUR HOME

Name	Relation	DOB	School or Daycare

Continued on attachment

IF THERE ARE ADDITIONAL PARENTS OF THE CHILD(REN) LISTED IN THE PETITION FOR GUARDIANSHIP, MAKE COPIES OF PAGE 7 OF THE GUARDIANSHIP QUESTIONNAIRE AND ATTACH THE ADDITIONAL PAGES TO THE QUESTIONNAIRE

PARENTS OF MINOR(S)

If a parent is deceased, please check “deceased” for that person’s and include death of death (DOD).

ATTACH a copy of the death certificate or obituary.

1. Full Legal Name: <input type="checkbox"/> Deceased, DOD:		AKA or Maiden Name:	
Age:	Date of Birth:	Place of Birth:	
Social Security Number:		Driver’s License No.:	Currently valid: <input type="checkbox"/> No <input type="checkbox"/> Yes
Home Phone:		Business Telephone:	
Cell Phone:		e-mail address:	
Current Address:			
City:		State:	Zip:
Last Date of Contact With Child(ren):			
2. Full Legal Name: <input type="checkbox"/> Deceased, DOD:		AKA or Maiden Name:	
Age:	Date of Birth:	Place of Birth:	
Social Security Number:		Driver’s License No.:	Currently valid: <input type="checkbox"/> No <input type="checkbox"/> Yes
Home Phone:		Business Telephone:	
Cell Phone:		e-mail address:	
Current Address:			
City:		State:	Zip:
Last Date of Contact With Child(ren):			

OTHER CHILDREN OF PARENTS

Name	Age	Birth date	Name(s) of Parent(s)

Continued on attachment

PROPOSED VISITATION
Provide specific details (days and times)

For Father:	
For Father's Parents:	
For Mother:	
For Mother's Parents:	
For the Brothers & Sisters of the minor(s):	

Before filing your documents with the court, confirm that you have attached all required documents to this packet

(Each Proposed Guardian must sign the acknowledgement under penalty of perjury.)

I declare under penalty of perjury under the laws of the State of California that all of the information I have submitted in this Guardianship Questionnaire is true and correct.

Date:

Type or print name

Signature of Proposed Guardian

Date:

Type or print name

Signature of Proposed Guardian

Note: If another person filed out this document for you, that person must also sign the acknowledgement under penalty of perjury.

Date:

Type or print name

Signature