

Filing Attorney Information or Pro Se Litigant:

Name _____

NJ Attorney ID Number _____

Law Firm/Agency Name _____

Address _____

Telephone Number _____

In the Matter of,

_____,
Name of Alleged Incapacitated Person (AIP)

an Alleged Incapacitated Person

Superior Court of New Jersey
Chancery Division - Probate Part

County _____

Docket Number _____

Civil Action

**Verified Complaint to Appoint
Guardian(s) of the Person**

I, _____, by way of verified complaint, say:

I am _____ years of age. I reside at _____, County of _____, and State of _____. I have domicile (permanent/legal residence) at _____. My relationship to the alleged incapacitated person (AIP) is _____. My interest in this action is the welfare of the alleged incapacitated person.

I am (check one)

☐ the only individual bringing this action for guardianship; **OR**

☐ one of two or more individuals bringing this action for guardianship. Below is the name, age, present residence, and permanent/legal residence (domicile) of the other applicant(s).

1. The name, age, present address, permanent/legal residence (domicile), and marital status of the alleged incapacitated person are as follows:

Name _____ Age _____

Present Address _____

How long at this address? _____ Marital Status _____

Permanent/Legal Residence (Domicile) _____

Spouse's information, if married:

Name _____ Age _____

Present Address _____

Permanent/Legal Residence (Domicile) _____

If applicable:

☐ Not Applicable

The alleged incapacitated person _____, has been determined eligible for services from the New Jersey Division of Developmental Disabilities (DDD).

If applicable:

☐ Not Applicable

The alleged incapacitated person has been receiving services from the DDD since _____.
Currently, these services consist of:

3. The alleged incapacitated person, _____, has been diagnosed as having _____, as set forth by the attached affidavit or certification of _____, (Physician or Psychologist). Because of this condition, _____ lacks sufficient capacity to govern him/herself to the extent set forth below.
4. The functional capacity of the alleged incapacitated person is further detailed by **one** of the following documents, attached to this complaint: (check one)
- ☐ A copy of the Individualized Education Program (IEP) for the alleged incapacitated person; **OR**
- ☐ An affidavit or certification from the chief executive officer, medical director, or other officer having administrative control over the DDD program from which the alleged incapacitated person is receiving services; **OR**
- ☐ An affidavit or certification from a designee of the DDD having personal knowledge of the functional capacity of the AIP; **OR**
- ☐ A second affidavit or certification of a physician or psychologist; **OR**
- ☐ An affidavit or certification from a licensed care professional having personal knowledge of the functional capacity of the alleged incapacitated person.
5. The names, addresses, relationships and ages of the persons most closely related to the alleged incapacitated person (parents, children, siblings) are as follows:

Name	Address	Relationship to AIP	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If applicable:

☐ Not Applicable

The name and address of the person or institution having the care and custody of the alleged incapacitated person is as follows:

If applicable:

☐ Not Applicable

If the alleged incapacitated person has lived in an institution, the date(s) of any commitment or confinement and by what authority committed or confined, are as follows:

Institution

Period(s) of Residence

_____	_____
_____	_____
_____	_____

If applicable:

☐ Not Applicable

The name(s) and address(es) of any person(s) named as an attorney-in-fact in any power of attorney, and/or any person named as health care representative in any health care directive, and/or any person acting as trustee under a trust for the benefit of the alleged incapacitated person, are as follows:

Name

Role (Attorney-In-Fact, Health Care Representative, Trustee)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

6. The name(s), address(es), relationship to the alleged incapacitated person, age and telephone number of the proposed guardian(s) are as follows: (attach additional pages as necessary).

Name _____

Address _____

Relationship _____ Age _____ Telephone No. _____

Name _____

Address _____

Relationship _____ Age _____ Telephone No. _____

Name _____

Address _____

Relationship _____ Age _____ Telephone No. _____

7. Information about the real and personal property and income of the alleged incapacitated person is set forth in the attached Certification of Assets.

8. Guardianship of the person only is requested at this time. (check one)

☐ I request that the court appoint the Office of the Public Defender Division of Mental Health Advocacy, *pro bono* (without cost), to represent the alleged incapacitated person. I understand that the guardianship hearing may be scheduled on a later date if the Office of the Public Defender Division of Mental Health Advocacy is appointed as counsel.

OR

☐ I request that the court appoint a private attorney, potentially for cost, to represent the alleged incapacitated person. I understand that if the assets of the alleged incapacitated person are insufficient to cover the fee charged by the court-appointed attorney, then the court may order that I pay that fee.

9. Request for Guardianship of the Person (check one)

Option 1:

☐ **Request for General (Full) Guardianship of the Person**

The condition of _____ renders him/her without the necessary cognitive capacity to govern himself/herself in **all** areas (including medical, legal, residential, educational, and vocational). _____ requires a general (full) guardian of the person.

WHEREFORE, the plaintiff(s) demand(s) judgment pursuant to *N.J.S.A. 30:4-165.7*, declaring _____ to be suffering from a chronic functional impairment that renders him/her incapable of governing himself/herself in all areas, and appointing _____ as **general (full) guardian(s) of the person** of _____.

OR

Option 2:

☐ **Request for Limited Guardianship of the Person**

The condition of _____ renders him/her without the necessary cognitive capacity to govern himself/herself in **some** areas. However, _____ retains the necessary cognitive capacity to make some decisions regarding his/her person and requires a limited guardian.

Specifically, _____ retains the capacity to make decisions regarding the following areas: (check all that apply)

- | | | |
|--|--|---|
| ☐ medical decision making | ☐ legal decision making | ☐ financial decision making |
| ☐ residential decision making | ☐ educational decision making | ☐ vocational decision making |
| ☐ other (voting, driving, etc.) _____ | | |

WHEREFORE, the plaintiff(s) demand(s) judgment pursuant to *N.J.S.A. 30:4-165.7*, declaring _____ to be suffering from a chronic functional impairment that renders him/her incapable of governing himself/herself in some areas, and appointing _____ as **limited guardian(s) of the person** of _____.

Date

Signature

Print Name

Verification

I/We _____ hereby certify and say:

1. I/We am/are the plaintiff(s).
2. The contents of the Verified Complaint for Guardianship are true to the best of my/our knowledge.

Date

Signature

Print Name

Date

Signature

Print Name