Commonwealth of Kentucky
Court of Justice *www.kycourts.net*
KRS 387.530

PETITION TO DETERMINE IF DISABLED

Case No. ____________________

Court ____________________

County ____________________

COMMONWEALTH OF KENTUCKY PETITIONER

VS.

RESPONDENT

____ has reasonable grounds or knowledge to lead him/her to believe Respondent appears to be unable to provide for his/her physical health and safety and/or manage his/her financial resources effectively and submits to the Court the following facts upon which he/she supports this belief:

1. **Name of Petitioner:** ____________________
   Address: ____________________
   ____
   ____
   Telephone Number: ____________________
   Petitioner's relationship to Respondent: ____________________
2. **Name of Respondent:** ____________________
   Address: ____________________
   ____
   ____
   Respondent's Date of Birth (if known): ____________________
3. The **nature of Respondent's disability** and the facts or reasons supporting the need for determination of disability are:
   ____
   ____
   ____
   ____
4. Respondent owns the following estate, including government benefits, insurance entitlements, and anticipated yearly income (state none or unknown):

ESTATE	VALUE
Real Property	$____________
Personal Property	$____________
Yearly Income	$____________
Source of Yearly Income	____________________

   ____

5. **Name of Person having custody of Respondent**: ____________________
   Address: ____________________
   ____
   ____

6. Respondent's ☐ **Durable Power of Attorney** OR ☐ **Health Care Surrogate** is:
   Name: ____________________
   Address: ____________________
   ____
   ____

7. Respondent's next of kin:
   Name: ____________________
   Address: ____________________
   ____
   ____
   Relationship to Respondent: ____________________
   Name: ____________________
   Address: ____________________
   ____
   ____
   Relationship to Respondent: ____________________

WHEREFORE, Petitioner requests the Court inquire into Respondent's ability to care for himself/herself and to manage his/her financial resources. Petitioner attaches an **Application for Appointment of Fiduciary and further requests:**

1. Trial by jury;
2. Counsel to represent the Respondent; and
3. Court appointment of a physician, psychologist and social worker to evaluate Respondent as provided by law unless the evaluation report is filed with this Petition.

Date: ____________________, 2______

____
Signature of Petitioner

Subscribed and before me on____________________, 2_____. My commission expires: ____________________, 2____.

____
Name/Title

To be completed if Applicant is represented by counsel:

Attorney's Name ____________________

Address ____________________
____
____
____

Telephone Number ____________________

____
Attorney Signature

Commonwealth of Kentucky
Court of Justice www.courts.ky.gov

KRS 387.530(2); 387.720; 395.130

APPLICATION FOR APPOINTMENT OF FIDUCIARY FOR DISABLED PERSONS

Case No. ____________________

Court ________ District ________

County ____________________

COMMONWEALTH OF KENTUCKY PETITIONER

VS.

_______________________________________ RESPONDENT

* * * * * * * * * *

1. Comes now ____, Applicant herein,and requests to be appointed as ______________________________ for Respondent.
2. Applicant states his/her relationship to Respondent is ____________________________________.
3. Applicant states his/her qualifications for appointment are as follows: ____________________
____
____
____
4. Applicant offers as surety on his/her bond the following: ______________________________
____
____
5. Respondent owns the following estate, including government benefits, insurance entitlements, and anticipated yearly income (state if none or unknown):

ESTATE	VALUE
Real Property	$____________________
Personal Property	$____________________
Yearly Income	$____________________
Source of yearly Income	$____________________

6. Applicant states that all statements in the foregoing are true.

Applicant's Name: ____

Address: ____
____

Telephone Number: (____) ____________________

Date: ____________________, 2_____. ______________________________
Applicant's Signature

Subscribed and sworn to before me on ______________________________, 2_____. My commission expires ______________________________, 2_____.

____
Name/Title

Case No. ______________________________

WAIVER OF NOTICE AND REQUEST FOR APPOINTMENT OF FIDUCIARY

The undersigned hereby waive notice of hearing and the right to appointment and request the Court to make the appointment herein applied for:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

To be completed if Applicant is represented by counsel:

Attorney's Name: ______________________________

Address: ______________________________

____

____

Telephone Number: (____) ______________________

____
Attorney Signature

AOC-747 Doc. Code: PEF Rev. 7-03 04/28/2016 09:43 am Page 1 of 2 Ver. 1.01 Commonwealth of Kentucky Court of Justice *www.kycourts.net* KRS 387.740; 387.720; 395.130	 **PETITION / APPLICATION FOR EMERGENCY APPOINTMENT OF FIDUCIARY FOR DISABLED PERSONS**	Case No. ______________ Court District County ______________

COMMONWEALTH OF KENTUCKY ex rel

______________________________ PETITIONER

VS.

______________________________ RESPONDENT

1. Comes Petitioner and requests appointment as **emergency limited** ☐ **guardian** OR ☐ **conservator** for Respondent for the purpose of: ______________________________

____

____

____

____

2. Petitioner states his/her relationship to Respondent is: ______________________________
and his/her qualifications for appointment are: ______________________________

____

____

____

3. Petitioner offers as surety on his/her bond the following: ______________________________

____

____

4. Respondent is __________ years of age and resides at:

____

____

____

5. The person or facility having custody of the Respondent is *(name and address)*:

____

____

____

____

6. A petition for a Determination of Disability was filed on ________________, 2______.

7. Respondent's ☐ **Durable Power of Attorney** OR ☐ **Health Care Surrogate** is:
Name: ______________________________
Address: ______________________________

____

____

8. Affidavit(s) are attached setting forth facts, including any danger alleged as imminent, and reasons necessitating such appointment.

9. Respondent's next of kin is/are:

Name: ______________________________

Address: ______________________________

____

____

Relationship: ______________________________

Name: ______________________________

Address: ______________________________

____

____

Relationship: ______________________________

WHEREFORE, Petitioner respectfully **requests** that a **hearing be held** within one (1) week of the filing of this Application.

Petitioner's Name: ______________________________

Address: ______________________________

____

____

Telephone Number: ____________________ **Social Security No.** ____________________

Date: ____________________ ______________________________

Petitioner's Signature

Subscribed and sworn to before me this _____ day of ____________________, 2_____. My Commission expires: ____________________, 2______.

____

Name/Title

WAIVER OF NOTICE AND REQUEST FOR APPOINTMENT OF FIDUCIARY

The undersigned hereby waive notice of hearing and the right to appointment and request the Court to make the appointment herein requested.

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

To be completed if Petitioner is represented by counsel:

Petitioner's Attorney: ______________________________

Address: ______________________________

____

____

Telephone No. ____________________ ______________________________

Attorney's Signature

Distribution: ☐ Petitioner/Attorney ☐ County Attorney ☐ Respondent/Attorney

AOC- 034 Doc. Code: PIDMD Rev. 6-11 Page 1 of 1 Commonwealth of Kentucky Court of Justice *www.courts.ky.gov*	 **PERSONAL IDENTIFIER DATA SHEET** **(Mental Health / Disability / Incompetency)**	Case No. ____________ Court ____________ County ____________

****For use in actions brought or proceedings conducted pursuant to KRS Chapters 202A (Involuntary hospitalization of the mentally ill); 202B (Involuntary mental retardation admission); 222.430 et seq. (Involuntary treatment for alcohol and other drug abuse); 387.500 et seq. (Guardianship and conservatorship for disabled persons); 504 (Responsibility, incompetency/insanity/mental illness); and, 645 (Involuntary hospitalization of the mentally ill child).

TO THE PETITIONER IN A MENTAL HEALTH OR DISABILITY PROCEEDING

TO THE DEFENDANT OR HIS/HER ATTORNEY IN A CHAPTER 504 PROCEEDING

The Court requires that you provide the following information about the Respondent/Defendant in this case:

RESPONDENT/DEFENDANT: Please Print ____________
First Middle Last

Also known as: ____________

Street address: ____________

Mailing address: ____________

Respondent's/Defendant's Identifiers:

Sex	Race	Date of Birth	Height	Weight	Eyes	Hair	Social Security #	Drivers License #	State

I understand that the information requested herein is intended to be entered into the official court record of this matter, and that its accuracy is of the utmost importance. The information I have provided above is true and accurate to the best of my knowledge and belief.

____________, 2______
Date

____
(Signature)

____
(Printed Name)

Original: Court file