

**Kin-GAP MUTUAL AGREEMENT FOR 18 YEAR OLDS**

CASE NAME

BIRTH DATE

CASE NUMBER

I request that the \_\_\_\_\_ County Welfare Department/Probation Department or \_\_\_\_\_ Tribe  
(circle appropriate public agency)

maintain my Kin-GAP payment until the completion of my education/training by age 19.

Recognizing my responsibility, I agree to:

1. Assist the responsible public agency in determining my financial need and eligibility while receiving a Kin-GAP payment.
2. Keep the responsible public agency informed of my progress with my education/training program.
3. Give reasonable notice if I leave my guardian's home for more than a temporary absence.

SIGNATURE OF Kin-GAP YOUTH

Kin-GAP YOUTH'S ELIGIBILITY WORKER

ADDRESS

ADDRESS

TELEPHONE

ALTERNATIVE TELEPHONE

TELEPHONE

( )

( )

( )

DATE

DATE

**STATEMENT OF FACTS SUPPORTING ELIGIBILITY FOR KINSHIP GUARDIANSHIP ASSISTANCE PAYMENT (Kin-GAP) PROGRAM:** *The legal guardian should complete in ink all questions to the left of the heavy black line with information about the child for whom they are the legal guardian. If there are multiple children, one form per child should be completed. Please complete, sign and date this form within two weeks, attaching extra sheets if necessary. Failure to complete and return this form within two weeks (14 days) of the date it was mailed will cause interruption, termination or delay in your receipt of the benefit.*

① Child Name \_\_\_\_\_ ②  Male  Female

③ Address \_\_\_\_\_

④ Birth date \_\_\_\_\_ ⑤ Birthplace \_\_\_\_\_

⑥ Social Security # \_\_\_\_\_ Applied For?  Yes  No

⑦ Citizen of U.S.?  Yes  No ⑧ Alien Status: \_\_\_\_\_

⑨ Does the child have medical insurance other than Medi-Cal?  Yes  No

If yes, list policy number, company name, and name of policy: \_\_\_\_\_

⑩ Does the child have real or personal property?  Yes  No

If yes, list property type (land, cash, auto, motorcycle, life insurance, trust fund, bank account, bond, etc.) and its value: \_\_\_\_\_

⑪ Does the child have income?  Yes  No  Unknown\*  
If yes, list amounts below. If application pending, check associated box.

INCOME TYPE	AMOUNT	PENDING
Social Security	\$	
Child Support	\$	
Railroad Retirement	\$	
SSI/SSP	\$	
Veteran's Benefits	\$	
Salary/Wages	\$	
Other (specify)	\$	
Total Amount/Month	\$	

\*If unknown, please explain: \_\_\_\_\_

⑫ Does the child have siblings placed with you?  Yes  No  
If yes, list the names and DOB.

NAME OF SIBLING	DATE OF BIRTH

⑬ Is the child's mother or father deceased?  Yes  No

⑭ Has the child's parents been receiving Social security or VA benefits?  Yes  No  
If yes, explain and list amount if known: \_\_\_\_\_

⑮ If the youth is age 16 or older, does the youth want a referral to the ILP Program?  Yes  No

⑯ Does the child reside in your home?  Yes  No  
If no, do you provide any support for the above-named child?  Yes  No

⑰ Does this youth have a child(ren) of his/her own residing in your home?  Yes  No

⑱ Do you have a shared responsibility plan about the care of the child with the minor parent?  Yes  No

⑲ Do you have guardianship of the child which was granted by a California juvenile court?  Yes  No

**ELIGIBILITY WORKER ONLY**

APPLICATION  
 REASSESSMENT

CASE NAME \_\_\_\_\_

CASE NUMBER \_\_\_\_\_

**VERIFICATION**

AGE \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

CITIZENSHIP/ALIEN STATUS \_\_\_\_\_

DHS 6155

CHILD'S PROPERTY \_\_\_\_\_

DOES THE CHILD HAVE SIBLINGS PLACED WITH THE GUARDIAN? \_\_\_\_\_

DID THE CHILD RESIDE FOR AT LEAST SIX CONSECUTIVE MONTHS IN THE APPROVED HOME OF THE PROSPECTIVE RELATIVE GUARDIAN? \_\_\_\_\_

**SPECIAL NEEDS CHILDREN INFORMATION**

20 Does this child have special needs, i.e., health and/or behavior problems?  Yes  No  
 If yes, I am requesting an assessment of the child's special needs to determine if the specialized care increment meets the needs of this child.

**COMPLETE BELOW FOR CHILDREN 18 AND OLDER**

21 Expected graduation/completion before the 19th birthday?  Yes  No  
 22 Do you request an assessment for continued payment over the age of 18 because the youth has a mental or physical handicap? If yes, describe condition:  Yes  No  
 23 Was guardianship ordered in a juvenile court after the youth's 16th birthday?  Yes  No

If yes, is youth participating in one of the following activities (Note: this provision does not apply until January 2, 2012):

- Completing secondary education (e.g., high school) or a program leading to an equivalent credential (e.g., taking classes in preparation for a general equivalency diploma exam).
- Enrolled in an institution which provides post-secondary (e.g., university or college) or vocational education (e.g., trade school).
- Participating in a program or activity designed to promote, or remove barriers to employment (e.g., enrolled in Job Corps or attending classes on resume writing and interview skills).
- Employed for at least 80 hours per month.
- Is incapable of doing any of the previously described educational or employment activities due to a documented medical condition.
- None of the above.

LEGAL GUARDIAN:

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT.

SIGNATURE OF LEGAL GUARDIAN

COUNTY WHERE SIGNED

DATE

SIGNATURE OF ELIGIBILITY WORKER

DATE

SIGNATURE OF ELIGIBILITY WORKER SUPERVISOR

DATE

**VERIFICATION**

ILP

VERIFICATION BY SCHOOL

YES

SCHOOL ATTENDANCE GRADUATION

GUARDIANSHIP VERIFIED

CHILD SUPPORT REFERRAL  
 BEST INTEREST DETERMINATION  
 NOT TO REFER

NOT ELIGIBLE

ELIGIBLE

FEDERAL

NONFEDERAL

OTHER

**RELEASE OF INFORMATION**

You and any member of your family for whom you are applying for aid must give us a Social Security Number(s) (SSN). The SSN(s) are needed to determine your eligibility. Failure to cooperate may result in denial or discontinuance of aid. Authority: **Welfare and Institutions Code, Section 11268.**

**PERSONAL INFORMATION NOTICE**

Pursuant to the Federal Privacy Act (P.L. 93-679) and the information Practices Act of 1977 (Civil Code Sections 1798, et. seq.), notice is hereby given for the request of personal information by this form. The requested personal information is voluntary. The principal purpose of the voluntary information is to facilitate the processing of this form. The failure to provide all or any part of the requested information may delay processing of this form. No disclosure of personal information will be made unless permissible under Article 6, Section 1798.17 of the IPA of 1977. Each individual has the right upon request and proper identification, to inspect all personal information in any record maintained on the individual by an identifying particular. Direct any inquiries on information maintenance to your IPA Forms Officer.

# Kin-GAP MUTUAL AGREEMENT FOR NONMINOR FORMER DEPENDENTS

CASE NAME
BIRTH DATE
CASE NUMBER

I request that the \_\_\_\_\_ Child Welfare Services/Probation Department or  
(circle appropriate public agency)  
\_\_\_\_\_ Tribe maintain my extended Kin-GAP payment.

Recognizing my responsibility, I agree to:

1. Assist the responsible public agency in determining my financial need and eligibility while receiving a Kin-GAP payment.
2. Update/notify the responsible public agency and relative guardian if there are any changes in my circumstances or living arrangements.

Select criteria below:

3.  I am over 18 years old and have a documented physical or mental disability that warrants continuation of Kin-GAP assistance until I am 21 years old pursuant to Welfare and Institutions Code (W&IC) sections 11363(c)(2) and 11386(g)(2).
4.  I meet at least one of the five participating criteria as set forth in W&IC section 11403(b). I am (check all that apply):
  - Completing high school or an equivalency program.
  - Enrolled or enrolling in a post-secondary or vocational school.
  - Participating in a program or activity that promotes or removes barriers to employment.
  - Employed at least 80 hours per month.
  - Incapable of participating in 1-4 above, due to a documented physical or mental condition.
5. Keep the responsible public agency informed of my progress with my education/training program

SIGNATURE OF Kin-GAP YOUTH/AUTHORIZED REPRESENTATIVE		Kin-GAP YOUTH'S ELIGIBILITY WORKER
ADDRESS		ADDRESS
HOME TELEPHONE	ALTERNATE TELEPHONE	OFFICE TELEPHONE
DATE		DATE

# AGENCY-RELATIVE GUARDIANSHIP DISCLOSURE

ONE COPY TO: Relative Caregiver  
Child's Social Services Record  
Child's Eligibility Record

**NOTE:** THIS DISCLOSURE MUST BE COMPLETED PRIOR TO A RELATIVE BECOMING LEGAL GUARDIAN

NAME OF CHILD:		CAREGIVER'S NAME:
DATE PLACED WITH THIS RELATIVE:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

**Initial Here:**

\_\_\_\_\_ I understand that I am not required to change custodial status from relative caregiver to legal guardian. However, if I decide to become a legal guardian, court dependency may be dismissed.

\_\_\_\_\_ I have been provided a Guardianship Pamphlet.

**1. AFDC-Foster Care to Kin-GAP  
Initial Here:**

\_\_\_\_\_ I understand that by becoming a relative legal guardian of \_\_\_\_\_:

- The child's payment will change from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ per month.
- When the child reaches age 18 years, the child must complete the Kin-GAP Mutual Agreement for 18 year olds to continue to receive Kin-GAP payments until they reach the age of 19 years or completes their secondary education or vocational training prior to 19 years.
- The child may be eligible for continued benefits up to age 21 years if the child has a mental or physical disability. If you start to receive Kin-GAP benefits before the child's 16th birthday and the child does not have such a disability, the child will not be eligible for the up-to-age 21 extension of benefits that comes into effect as of January 1, 2012.
- The child will no longer be eligible to receive an AFDC-Foster Care payment.
- The child's siblings are eligible for Kin-GAP if they live in the same household.
- The child will be eligible to receive a clothing allowance and the state supplemental clothing allowance.
- The child may be eligible to receive a specialized care increment if already in receipt of a specialized care increment or may receive a specialized care increment if the needs of the child change in the future. Note: the amount of the specialized care increment may be increased or decreased based on changes to the child's special needs.
- If the child is a consumer of California regional center services, he/she will be eligible for a dual agency rate and may be eligible for a supplemental rate.
- Non-referral to child support may continue if the social worker determines it is in the best interest of the child. If not, the parent may have to pay child support to the agency.
- The child remains eligible for Independent Living Program services when the child attains age 16 and such services are requested by you the caregiver or the child. However the youth will not be eligible for the Chafee Educational/Training Voucher unless the youth remains in foster care until age 16 prior to the transfer to Kin-GAP.
- The Infant Supplement and the \$200 Shared Responsibility Plan increment may be payable in Kin-GAP.
- If I move to another county, the Kin-GAP rate paid to me will be based on the host county's rate, or the rate of the county which had court-ordered jurisdiction over the legal guardianship if it is determined that the host county rate cannot be paid.

- If I move out of state, the Kin-GAP payment may continue. In addition, if I remain eligible for a Kin-GAP payment, after moving out of state, I will be eligible for Medicaid based on that state's Medicaid program.
- If the child is eligible for Kin-GAP, he/she will also be eligible for Medi-Cal.
- The child's Kin-GAP and Medi-Cal eligibility may be impacted if resources exceed \$10,000 or residence is out of state.
- Any income, which the youth has earned as part of their transitional independent living plan, is exempt.
- The child will not be eligible for the Transitional Housing Program or the Transitional Housing Program Plus.

**2. AFDC-FC to CalWORKs**  
Initial Here:

\_\_\_\_\_ I understand that by becoming a relative legal guardian of \_\_\_\_\_:

- The child's payment will change from \$\_\_\_\_\_ to \$\_\_\_\_\_ per month.
- The child will not receive an AFDC-Foster Care payment.
- The child will not receive a clothing allowance or a specialized care increment.
- The child will not be eligible for the Transitional Housing Program.

**3. CalWORKs to Kin-GAP**  
Initial Here:

\_\_\_\_\_ I understand that by becoming a relative legal guardian of \_\_\_\_\_:

- The child's payment will change from \$\_\_\_\_\_ to \$\_\_\_\_\_ per month.
- The child's siblings are eligible for Kin-GAP if they live in the same household.
- The child cannot get both CalWORKs and Kin-GAP payments.
- The child will no longer be eligible to receive Cal-Learn benefits.
- The child will no longer be eligible to receive CalWORKs child care services.
- The child will be eligible to receive a clothing allowance and may be eligible to receive a specialized care increment if the needs of the child change in the future. Note: the amount of the specialized care increment may be increased or decreased based on changes to the child's special needs.
- If the child is a consumer of California regional center services, he/she will be eligible for a dual agency rate and may be eligible for a supplemental rate.
- Non-referral to child support may continue if the social worker determines it is in the best interest of the child. If not, the parent may have to pay child support to the agency.
- The child remains eligible for Independent Living Program services when the child attains age 16 and such services are requested by you the caregiver or the child. However, the youth will not be eligible for the Chafee Educational/Training Voucher unless the youth remains in foster care until age 16 prior to the transfer to Kin-GAP.

- When the child reaches age 18 years, the child must complete the Kin-GAP Mutual Agreement for 18 year olds to continue to receive Kin-GAP payments until they reach the age of 19 years or completes their secondary education or vocational training prior to 19 years.
- The child may be eligible for continued benefits up to age 21 years if the child has a mental or physical disability. If you start to receive Kin-GAP benefits before the child's 16th birthday and the child does not have such a disability, the child will not be eligible for the up-to-age 21 extension of benefits that comes into effect as of January 1, 2012.
- The Infant Supplemental and the \$200 Shared Responsibility Plan increment may be payable in Kin-GAP.
- If I move to another county, the Kin-GAP rate paid to me will be based on the host county's rate, or the rate of the county which had court-ordered jurisdiction over the legal guardianship if it is determined that the host county rate cannot be paid.
- If I move out of state, the Kin-GAP payment may continue. In addition, if I remain eligible for a Kin-GAP payment, after moving out of state, I may be eligible for Medicaid based on that state's Medicaid program.
- If the child is eligible for Kin-GAP, he/she will also be eligible for Medi-Cal.
- The child's Kin-Gap and Medi-Cal eligibility may be impacted if resources exceed \$10,000 or residence is out of state.
- Any income, which the youth has earned as part of their transitional independent living plan, is exempt.
- The child will not be eligible for the Transitional Housing Program or the Transitional Housing Program Plus.
- If the relative caregiver is on CalWORKs and is caring for one or more foster children and all children in the assistance unit move to Kin-GAP, the caregiver may continue to remain eligible for a CalWORKs grant as a family of one.

**4. Remain CalWORKs**  
Initial Here:

\_\_\_\_\_ I understand that by becoming a relative legal guardian of \_\_\_\_\_:

- The child will not receive an AFDC-Foster Care or Kin-GAP payment.
- The child will remain eligible to CalWORKs.

**Services**

If you become guardian of this child and the court dependency is terminated:

**Initial Here:**

\_\_\_\_\_ I understand that I may receive assistance from the county child welfare agency if it is necessary to terminate guardianship or to appoint a co-guardian for the child.

\_\_\_\_\_ I understand that I may renegotiate the payment if my circumstances or the needs of the child change;

\_\_\_\_\_ I understand that the child and I will no longer be assigned a social worker;

\_\_\_\_\_ I understand that the child and I will no longer be required to go to court;

\_\_\_\_\_ I understand that the child will no longer have a court appointed attorney;

\_\_\_\_\_ I understand that I am not prevented from adopting this child at any time in the future;

\_\_\_\_\_ I understand that I may still contact the county if I need assistance at \_\_\_\_\_;

\_\_\_\_\_ Other: \_\_\_\_\_

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**Some Important Kin-GAP Information**

These are some of the important things you should know about Kin-GAP:

**Initial Here:**

\_\_\_\_\_ I understand that every two years I will be required to complete a review of the child's circumstances with the county. I understand that I must report within 5 days any changes which may affect the child's eligibility for the program.

\_\_\_\_\_ I understand that if I move to another county/state, my payment will be based on the host county's/state's rate, or the rate of the county/state which had court-ordered jurisdiction over the legal guardianship if it is determined that the host county/state rate cannot be paid.

\_\_\_\_\_ I understand that any specialized care increment that I receive may change based on the child's health or behavioral needs.

I have read the above and understand all of the legal guardianship options that are available to me (adoption, legal guardianship, long-term foster care). After considering all the options, I have voluntarily chosen legal guardianship with the associated payment noted above.

I have chose option #        1        2        3        4        (*Circle one*)

SIGNATURE OF SOCIAL WORKER: 		SIGNATURE OF RELATIVE LEGAL GUARDIAN: 	
TITLE/AGENCY:			
ADDRESS:		ADDRESS:	
TELEPHONE NUMBER (    )	DATE:	TELEPHONE NUMBER (    )	DATE:

**RELEASE OF INFORMATION**

You and any member of your family for whom you are applying for aid must give us a Social Security Number(s) (SSN). The SSN(s) are needed to determine your eligibility. Failure to provide SSN may result in denial or discontinuance of aid. Authority: **Welfare and Institutions Code, Section 11268.**

**KINSHIP GUARDIANSHIP ASSISTANCE PAYMENT (KIN-GAP) PROGRAM AGREEMENT AMENDMENT**

*This form amends and supplements the SOC 369 to memorialize the terms, conditions, rights, responsibilities, and agreements reached between the county child welfare agency, probation department or Title IV-E agreement tribe and the relative guardian.*

**NOTICE:** This agreement describes the guardianship assistance benefit that you will receive. If you agree, please sign the agreement and return it to the responsible public agency. If you disagree, please contact the responsible public agency. If you and the agency cannot reach an agreement, you will receive a Notice of Action which explains how to request a state hearing to resolve the matter.

I/We, \_\_\_\_\_ and \_\_\_\_\_, have  
(NAME OF LEGAL GUARDIAN) (NAME OF LEGAL GUARDIAN)  
 entered into an agreement with the \_\_\_\_\_ for a  
(NAME OF RESPONSIBLE PUBLIC AGENCY)

(check one)  federally eligible;

state eligible

Kinship Guardianship Assistance Payment (Kin-GAP) for \_\_\_\_\_  
(NAME OF CHILD)

This Kin-GAP Agreement will continue until it is modified or terminated in accordance with its terms.

This is (check one)  an initial agreement

an amendment to the agreement dated \_\_\_\_\_  
(DATE OF INITIAL AGREEMENT)

1. A Kin-GAP benefit of \$ \_\_\_\_\_ per month is authorized to begin \_\_\_\_\_  
(BEGINNING DATE OF PAYMENT)

The child's needs must be reassessed at least every two years. The next scheduled reassessment is

\_\_\_\_\_  
(REASSESSMENT DATE)

2. Unless the benefit is ending because of age, \_\_\_\_\_ will send a Statement of Facts  
(RESPONSIBLE PUBLIC AGENCY)

Supporting Eligibility for Kinship Guardianship Assistance Payment (Kin-GAP) Program (KG 2 form), at least 60 days before the next reassessment date. I/We shall complete the KG 2 and return it within 14 days to

\_\_\_\_\_  
(RESPONSIBLE PUBLIC AGENCY)

I/We understand that failure to complete and return this form in a timely manner may result in an interruption, delay or termination in the receipt of the benefit.

3. If applicable, any specialized care increment (SCI) that the child receives may change as the needs of the child change.
4. A child receiving Kin-GAP shall be eligible for an age-related increase after his or her 5th, 9th, 12th and 15th birthdays. (In Marin County, the age-related increase occurs after his or her 5th, 7th, 12th, 13th and 15th birthdays.)
5. The Kin-GAP benefit may not exceed the age-related, state-approved foster family home care rate, and any applicable state-approved SCI, that would have been paid if the child had remained in foster care.
6. The Kin-GAP payment that the child receives may change if other income is received by or on behalf of the child.
7. A child receiving Kin-GAP benefits may retain cash and other assets subject to limitations established by law.
8. A child receiving Kin-GAP shall be eligible for a clothing allowance in accordance with state law and as established by the county of legal responsibility.

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9. For a youth eligible for a Kin-GAP benefit who is a teen parent and has a child living in the same home, the rate may include a two hundred dollar (\$200) monthly payment made to the relative caregiver in a whole family foster home.
10. If a child is living with a teen parent who is eligible for Kin-GAP benefits, the rate paid to the relative guardian on behalf of the teen parent shall include the "infant supplement" which is an additional benefit for the care and supervision of the child.
11. Payments on behalf of a child who is a recipient of Kin-GAP benefits and who is also a consumer of a California regional center services shall be based on the dual agency rates established by the State Department of Social Services.
12. Continuation of the Kin-GAP benefit depends upon my/our responsibility for the support of the child and on the child's continued receipt of my/our support.
13. I/We agree to inform the agency immediately if any of the following occurs:
- Our address changes.
  - The youth is no longer residing in the family home.
  - I/We are no longer providing any type of support to the youth.
  - I/We are no longer responsible for the support of the youth.
  - Guardianship is terminated and/or dependency is reinstated.
  - The child begins to receive earned or unearned income (i.e., Social Security, SSI/SSP, other).
- Failure to report these changes may result in an overpayment which may be recovered by a one-time charge or a reduction in current and future Kin-GAP benefits.
14. I/We understand that \_\_\_\_\_ will remain eligible to receive a Kin-GAP benefit from the State of California regardless of where I/we reside.  
(NAME OF CHILD)
15. I/We understand that under the terms of this agreement the child is eligible for medical services under Medi-Cal, California's Medicaid program. It is understood that if we move to another state we will need to apply for Medicaid in that state. I/We are aware that medical coverage and social services may vary in other states.
16. I/We understand that the child will not be eligible to receive a Kin-GAP payment after reaching the age of 18 years unless he or she is in school and is expected to graduate by the age of 19 years.
17. Effective January 1, 2012, a former dependent child or ward of the juvenile court who is eligible for the Kin-GAP program and who attained 16 years of age before originally entering the Kin-GAP program shall continue to receive aid up to 19 years of age; effective January 1, 2013, up to 20 years of age; and, effective January 1, 2014, up to 21 years of age [the extension of benefits for those between 20 and 21 years of age shall be contingent upon appropriation by the California Legislature], as long as one or more of the following conditions exist:
- (1) The individual is completing secondary education or a program leading to an equivalent credential.
  - (2) The individual is enrolled in an institution which provides postsecondary or vocational education.
  - (3) The individual is participating in a program or activity designed to promote or remove barriers to employment.
  - (4) The individual is employed for at least 80 hours per month.
  - (5) The individual is incapable of doing any of the activities described in (1) to (4), inclusive, due to a medical condition, and that incapability is supported by regularly updated information in the case plan of the individual.
18. Kin-GAP benefits shall continue to age 21 if the youth has a physical or mental disability that warrants the continuation of assistance.

Pursuant to Welfare and Institutions Code Section 1403(c), relative guardians who receive Kin-GAP payments are responsible for reporting to the responsible public agency when the nonminor former dependent no longer satisfies at least one of the five conditions described above.

19. I/We understand that under the terms of this agreement the child is eligible for services which include assistance in the filing of a petition to appoint a co-guardian or a successor guardian for the child to have dependency jurisdiction returned, or to terminate guardianship.

20. I/We will not be charged or have to pay any fees or costs to establish guardianship.

21. Once the youth attains the age of 16, he or she may request and receive independent living program services.

22. The youth, who was in foster care between the ages of 16 - 18 while under the care and custody of the juvenile court, is eligible to apply for a Chaffee Education and Training Voucher.

23. I/We acknowledge that a copy of this written agreement has been received.

24. I/We understand that reimbursement can be made for reasonable and verified nonrecurring expenses incurred from obtaining legal guardianship to the extent the expenses don't exceed \$2,000. Reimbursement shall not be made for costs otherwise reimbursed from other sources.

25. In the event of my death or incapacitation I/we would like \_\_\_\_\_ to become the successor guardian.  
(NAME OF SUCCESSOR GUARDIAN)

I/We are in agreement with the provisions of this document.

I/We are not in agreement with the provisions of this document and request a state hearing.

LEGAL GUARDIAN	DATE	RESPONSIBLE PUBLIC AGENCY REPRESENTATIVE	DATE
LEGAL GUARDIAN	DATE	RESPONSIBLE PUBLIC AGENCY NAME, ADDRESS TELEPHONE NUMBER	

**TO REQUEST A REASSESSMENT, GET HELP CONCERNING GUARDIANSHIP OR TO REQUEST SERVICES, PLEASE CALL OR WRITE THE PUBLIC AGENCY LISTED ABOVE.**