FILING FOR GUARDIANSHIP –GENERAL INFORMATION

1. The Petitioner will be required to pay a filing fee of $83.50 and will fill out the required forms for guardianship. A lawyer will be appointed for the Respondent (disabled person) by the Court to represent their interest. At this time the attorney's office will request a report from the following agencies:
    - **(a) Pennyroyal Mental Health Center**
    - **(b) Adult Protective Services (DCBS/CHFS APS Social Services)**
    - **(c) Primary Care Physician**
2. **Pennyroyal Mental Health Center** is located **735 North Drive, Hopkinsville, KY 42240**. Pennyroyal Mental Health will call the Petitioner to schedule an appointment once they receive the paperwork from the court. The appointments with Pennyroyal are approximately $**324-$432**. The phone number for Pennyroyal is **(270) 886-5163** and you may ask for **Terry** approximately 2 weeks from the time you file the paperwork in the County Attorney's Office to schedule the appointment with Pennyroyal.
3. Social Services will need to make a home visit and will do so at no cost. You may call **(270) 338-6690** and ask for **Adult Protective Services** in order to schedule the home visit.
4. You will need to make an appointment with the Respondent's (disabled person) Primary Care Physician as soon as possible so that the Primary Care Physician can provide their report to the Court before the court date.
5. You will receive a subpoena served on you by the sheriff's office stating the court date. The Jury or the Judge will listen to the reports from the social worker, physician, and Pennyroyal. The Jury or the Judge will then make a decision on whether or not they think that the Respondent (disabled person) needs a guardian.
6. The **attorney fee** associated with filing for guardianship is **$250.00**. This fee will be assessed after the Jury Trial is complete.

GUARDIANSHIP/INCOMPETENCY HEARING

INFORMATION NEEDED:

1. **Name (Disabled Person)** _____

Mailing Address: _____

Street Address: _____

Sex___ **Race**____ **Weight** ____ **Height**_____ **Eye Color**_____ **Hair Color**_____

DOB: _____ **SSN:** _____ **DLN/State**_____/_____

Where Disabled Person Resides at Present Time: _____

_____

2. **Income (Money Draws Monthly) and Source:**_____

_____

3. **Value of Personal Property** _____

Value of Real Estate _____

4. **Name, Address, and Phone Number of Family Doctor:** _____

_____

5. **Name, Address, Phone Number, and Relationship of Immediate Family Members:**

(Mother, Father, Brother, Sister, Child(ren), and Spouse): _____

_____

_____

_____

_____

_____

_____

6. **Petitioner (Your Information):**

Name: _____

Mailing Address:_____

Street Address:_____

Phone Number: _____

Relationship to Disabled Person: _____

7. **Brief Description of Condition of Disabled Person:** _____

_____

_____

_____

_____

Filing Fee: $83.50 (payable to Muhlenberg District Court)

Muhlenberg County Attorney's Office Phone: (270) 338-1322 Fax: (270) 338-7933