Cardinal Cushing Centers

All ages. All abilities. All together.

Dear Parents,

The Cardinal Cushing Parent Advisory Council (CCPAC) is pleased to present this notebook of information which will help in our ongoing mission to be a resource for each other. It is a collection of essential information each family with exceptional children need to have at the ready. The idea behind this notebook is to help families of Cardinal Cushing Students with the journey we need to take with our children. Families are often asked to provide information in many settings and this would give a "filing system" option. Although we do not want to overwhelm people, the reality is that it is more overwhelming to play catch up if certain things are not done in a timely manner and not all people get the same amount of guidance from their home districts and are often presented with tough deadlines for paperwork. Each section contains information about things that you may or may not have heard of depending on the age of your child. We are hoping this will be a living document that will grow as we share essential information with one another. We welcome each and every one of you to please email us any information you would like to see added. Knowledge is power and it is our hope that we can provide our families with support in this journey with our exceptional children.

Sincerely,

Cardinal Cushing Parent Advisory Board

CCC-PAC@cushingcenters.org

Cardinal Cushing School
405 Washington St.
Hanover, MA 02339
(781) 826-6371

St. Coletta Day School
85 Washington St.
Braintree, MA 02184
(781) 848-6250

CCPAC Notebook Table of Contents

1. Medical Documents-
    a. The purpose of this section is house a document that could be a medical summary for your child but could be handed off in case of a medical emergency. We have housed the template or you could use your own. Any medical document should begin with a brief summary of overall medical condition, current medications, doctors, parent and/or guardians, health care proxy, copies of medical cards.
2. IEP - Copy of current and previous year's Individual Education Plan
    a. Current individual reports, OT, PT, Speech, Psychological, etc. Many are needed for guardianship, Mass Health, Social Security, etc
    b. A year's worth of progress reports
    c. Current list of IEP team members and emails
    d. Current information on cab company for day students
3. Mass Health Eligibility information and potential benefits
    a. The purpose of this section is house information for MassHealth. If a child already has MassHealth, it house a copy of the MassHealth cards and the annual renewal of certain benefits such as pull ups, PCA benefits and the report which needs to be filled out to renew benefits.
4. DDS – Cover page could be eligibility flyer or transition checklist
    a. The purpose of this section is to house the application with a list of information needed for our children to access services after they turn 22. Transition Documents are also contained here. This is a long process which begins when a child turns 17 but many of the required documents are created along the way.
5. Equipment information and Medical Supplies
    a. Equipment information with model numbers and serial numbers when appropriate (Example: Charm medical contact information, AFO's, Wheelchairs, strollers, oxygen, etc.)
    b. Medical Supplies: Pullups/Diapers, tubes/syringes, chux (bed pads), Weighted Blanket (Supplier sources and contact information. Ex. Charm medical, web source, etc.
6. Guardianship application- Application and papers once through the courts.
7. RMV ID application and photo of ID once through Registry of Motor Vehicle and Photocopy of Handicap Sticker
8. Social Security Information- information on SSI and eligibility

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Medical Documents

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If you have any suggestions for this section, please feel free to email the PAC at CCC-PAC@cushingcenters.org

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Dear Parent/Guardians:

Per Department of Public Health regulations, each student at Cardinal Cushing Center is required by the DEEC and DESE to have a routine physical examination including vision screening, hearing screening, and postural screening (if age appropriate), as well as up to date immunizations and routine dental cleanings. Religious exemptions to vaccinations must be renewed annually, the same as medical exemptions. If your child has a religious or medical exemption currently on file, a new one needs to be written, signed, dated, and submitted prior to the new school year (2018-2019).

These are required by regulation for your student to remain in school. If any of these were done within the last year, please have your physician/dentist send us a copy of their report. If any of the above has not been done, please schedule an appointment as soon as possible. This information is essential to coordinate your child's care. If you are unable to schedule an appointment for any reason please contact the Health Center.

Signed doctor's orders need to be renewed annually. If your child takes any regular OR as needed medications, please provide us with current signed doctor's orders.

If you have any questions or concerns, please do not hesitate to contact the Health Center.

Thank you!

Cardinal Cushing Health Center Staff

405 Washington Street • Hanover, Massachusetts 02339 • P. 781.826.6371 • F. 781.826.1559

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth: _____

Medical History _____

_____

Pertinent Family History

Current Health Issues

Y N

☐ ☐ Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: _____

☐ ☐ Other (*Please specify*) _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:** _____

Hgt: _____(_____%) Wgt: _____(_____%) BMI: _____(_____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____ ☐ Lungs _____ ☐ Extremities _____

☐ Skin _____ ☐ Heart _____ ☐ Neurologic _____

☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____

☐ Dental/Oral _____ ☐ Genitalia _____

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other _____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
TB Test Type: ☐ TST ☐ IGRA Date: _____ Result: ☐Positive ☐Negative ☐Indeterminate/Borderline
Referred for evaluation to: _____ Date: _____ ☐ Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations: _____

☐Y ☐N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐Y ☐N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.**

_____ _____

Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____ _____

Group Practice Telephone

_____

Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 08/26/13*

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Medication Order for Name:_____ **DOB:** _____

Medication Name	*Dose*	*Route*	*Frequency*	*Diagnosis*

_____
Prescribing Physician Name (*please print*)

_____
Prescribing Physician Signature

_____
Physician Phone Number

_____
Date

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Current and Previous Year's IEP

The purpose of this section is house a copy of the most current signed IEP as well as the one from the previous year as some requests are for multiple years. It should also house the individual reports which helped create the goals reflected in the current document which could include but are not limited to OT, PT, Speech, Psychological, etc. A year's worth of progress reports could also be housed here.

Current Team Members

A current list of team members with contact information so it is easily accessible when needed.

Current Cab/Transportation Information

The purpose of this section is house the current contact information on transportation company for day students but some residential students when appropriate.

If you have any suggestions for this section, please feel free to email the PAC at CCC-PAC@cushingcenters.org

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MassHealth Information

The purpose of this section is house information for MassHealth. If a child already has MassHealth, it could house a copy of the MassHealth cards and the annual renewal of certain benefits such as pull ups, PCA benefits and the report which needs to be filled out to renew benefits.

For more information:

https://www.mass.gov/how-to/apply-for-masshealth-the-health-safety-net-or-the-childrens-medical-security-plan

If you have any suggestions for this section, please feel free to email the PAC at CCC-PAC@cushingcenters.org

Cardinal Cushing Centers

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DDS Transition Information

The purpose of this section is to house the application with a list of information needed for our children to access services after they turn 22. DDS Transition checklist and other information is also in this section. This is a long process which begins when a child turns 17 but many of the required documents are created along the way. Many of our members are willing to share the story of their process. Feel free to email the PAC to get contacts.

For more information:

https://www.mass.gov/orgs/department-of-developmental-services

If you have any suggestions for this section, please feel free to email the PAC at CCC-PAC@cushingcenters.org

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Southeast Area Office Locations and Cities/Towns Covered

Please direct all support/services related questions to your local Area Office listed below.

All supports are subject to funding and availability

Brockton Area Office **60 Main Street 3rd Floor** **Brockton, MA 02301** **774-296-6090** Abington, Avon, Bridgewater, Brockton, East Bridgewater, Eason, Holbrook, Rockland, Stoughton, West Bridgewater, Whitman
Cape Cod/Islands Area Office **181 North Street** **Hyannis, MA 02601** **508-771-2595** Barnstable, Bourne, Brewster, Chatham, Chilmark, Dennis, Eastham, Edgartown, Falmouth, Gay Head, Harwich, Hyannis, Mashpee, Nantucket, Oak Bluffs, Orleans, Provincetown, Sandwich, Tisbury, Truro, Wellfleet, West Tisbury, Yarmouth
Fall River Area Office **1 Father DeValles Boulevard Unit 3** **Fall River, MA 02723** **508-730-1209** Assonet, Fall River, Freetown, Somerset, Swansea, Westport
New Bedford Area Office **1740 Purchase Street** **New Bedford, MA 02740** **508-992-1848** Acushnet, Dartmouth, Fairhaven, Gosnold, Marion, Mattapoisett, New Bedford, Rochester, Wareham
Plymouth Area Office **38 Industrial Park Road** **Plymouth, MA 02360** **508-732-5700** Carver, Duxbury, Halifax, Hanover, Hanson, Kingston, Marshfield, Pembroke, Plymouth, Plympton
South Coastal Area Office **220R Forbes Road** **Braintree, MA 02184** **781-356-8850** Braintree, Cohasett, Hingham, Hull, Milton, Norwell, Quincy, Randolph, Scituate, Weymouth
Taunton/Attleboro Area Office **21 Spring Street Taunton, MA 02780** **508-824-0614** Attleboro, Berkley, Dighton, Lakeville, Mansfield, Middleboro, North Attleboro, Norton, Raynam, Rehoboth, Seekonk, Taunton

Regional Eligibility Office Locations

Central/West Region
Regional Eligibility Coordinator
Central West Region
140 High St. Suite 301
Springfield, MA 01105
Intake Referral Number: 413-205-0940
Fax Number: 413-205-1608

Metro Region
Regional Eligibility Coordinator
411 Waverley Oaks Road, Suite 304
Waltham, MA 02452
Intake Referral Number: 781-314-7513
Fax Number: 781-314-7539

Northeast Region
Regional Eligibility Coordinator
Hogan Regional Center
PO Box A
Hathorne, MA 01937
Intake Referral Number: 978-774-5000 ext. 850
Fax Number: 978-739-0420

Southeast Region
Regional Eligibility Coordinator
151 Campanelli Drive, Suite B
Middleboro, MA 02346
Intake Referral Number: 508-866-5000
Fax Number: 508-866-8859

SRM 11/11/2016

Your Guide to the Eligibility Process

The
Commonwealth of Massachusetts
Executive Office of
Health and Human Services

Department of Developmental Services
500 Harrison Avenue
Boston, MA 02118
Voice: (617) 727-5608
Fax: (617) 624-7577

Email: DDS.Info@state.ma.us
DDS website at: www.mass.gov/dds

Southeast Region
Tracey Daigneau, Eligibility Coordinator
(508) 866-8851

Southeast Region
151 Campanelli Drive, Suite B
Middleboro, MA 02346

Application Process

Mission Statement
The Department is dedicated to creating, in partnership with others, innovative and genuine opportunities for individuals with intellectual disabilities to participate fully and meaningfully in, and contribute to, their communities as valued members.

Applying for eligibility is a choice and we believe that it is important for applicants to fully understand the criteria for eligibility as well as the type of documentation that is required to enable DDS to make such an important decision. Therefore, included in the new application are the criteria for eligibility and explicit instructions about the necessary documentation.

Another important component is legal authorization to proceed with the process. Applicants must give their written permission so that DDS can proceed with the eligibility process. This does not mean that an applicant cannot get help from a family member, friend or agency. However if the applicant chooses to have someone assist him/her, she/he will also need to authorize that by signing a permission form.

This permission is required if the applicant wants DDS to be able to communicate directly with this person on their behalf. These authorizations are now a vital part of the new application form.

After a complete application has been received by the Regional Eligibility Team, applicants can expect to be contacted by a Regional Eligibility Team member to schedule a face-to-face meeting.

Southeast Region Family Support Centers

Brockton Area
Brockton Area Arc
1250 West Chestnut Street, Brockton, MA 02301
(508) 583-8030 www.brocktonareaarc.org

Cape Cod and the Islands Area
Kennedy-Donovan Center
32 Commercial Street, South Yarmouth, MA 02664
(508) 385-6019 www.kdc.org

Martha's Vineyard Community Services
111 Edgartown Road, Vineyard Haven, MA 02568
(508) 693-7900 www.mycommunityservices.com

Fall River Area
Family Advocacy & Community Education (FACE) Center
4 South Main Street, Fall River, MA 02721
(508) 679-5233 www.peopleinc-fr.org

New Bedford Area
Family Connections Center, Nemasket
109 Fairhaven Road, Mattapoisett, MA 02739
(508) 999-4436 www.nemasketgroup.org

Plymouth Area
The Arc of Greater Plymouth
52 Armstrong Road, Plymouth, MA 02360
(508) 732-9292 www.thearcofgp.org

South Coastal Area
Advocates, Inc.
South Coastal Family Support Center
1189 R North Main Street, Randolph, MA 02368
(781) 767-3048 http://southcoastalfamilysupport.org

South Shore Support Services
317 Libbey Industrial Parkway – Unit B300
P.O. Box 890126, Weymouth, MA 02189
(781) 331-7878 www.soshoresupport.org

Taunton/Attleboro Area
The Arc of Bristol County
141 Park Street, Attleboro, MA 02703
(508) 226-1445 www.arcnbc.org

Tri-Area (Brockton, Plymouth, South Coastal
BAMSI Family Support Center
155 Webster Street – Unit D, Hanover, MA 02339
(781) 878-4074 www.bamsi.org

Criteria for Eligibility for Children and Adults

6.06: Eligibility for Children's Supports (1) Persons who are younger than 22 years of age may be eligible for Children's Supports provided, purchased, or arranged by the Department if the person: (a) is domiciled in the Commonwealth; and (b) for persons who are five through 22 years of age, either: 1. have a severe chronic disability that: a. is attributable to a mental or physical impairment resulting from Intellectual Disability, Autism Spectrum Disorder, Smith-Magenis Syndrome or Prader-Willi Syndrome; b. is likely to continue indefinitely; c. results in substantial functional limitations; or 2. have a verified diagnosis of Intellectual Disability or a closely related developmental condition that results in substantial functional limitations, or (c) for persons from birth to age five a substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in a developmental disability if services are not provided

6.04: Adult Eligibility for Intellectual Disability or Developmental Disability Supports (1) Persons who are 22 years of age or older are eligible for Intellectual Disability Supports provided, purchased, or arranged by the Department if the person: (a) is domiciled in the Commonwealth; and (b) is a person with intellectual disability as defined in 115 CMR 2.01: Definitions. (2) Persons who are 22 years of age or older are eligible for Community Developmental Disability Supports provided, purchased or arranged by the department if the person: (a) is domiciled in the commonwealth; and (b) is a person with Autism Spectrum Disorder, Prader-Willi Syndrome or Smith-Magenis Syndrome as defined in 115 CMR 2.01: Definitions; and (c) does not have an intellectual disability as defined in 115 CMR 2.01: Definitions

Metro Area Office Locations and Cities/Towns Covered

Please direct all support/services related questions to your local Area Office listed below.

All supports are subject to funding and availability

Greater Boston Area Office **65 Sprague Street** **Hyde Park, MA 02136** **617-363-2900** Allston, Beacon Hill, Boston, Brighton, Brookline, Charlestown, Chelsea, Chinatown, Dorchester, Downtown Crossing, East Boston, Hyde Park, Jamaica Plain, Mattapan, North Dorchester, North End, Revere, Roslindale, Roxbury, South Boston, South End, West Roxbury, Winthrop
Charles River West Area Office **255 Elm Street, Suite 205** **Somerville, MA 02144** **617-623-5950** Belmont, Cambridge, Somerville, Waltham, Watertown
Middlesex West Area Office **300 Howard Street** **Framingham, MA 01702** **508-861-2211** Ashland, Dover, Framingham, Holliston, Hopkinton, Hudson, Marlboro, Natick, Northborough, Sherborn, Southborough, Sudbury, Wayland, Westborough
Newton/South Norfolk Area Office **125 West Street** **Walpole, MA 02081** **508-668-3679** Canton, Dedham, Foxboro, Medfield, Millis, Needham, Newton, Norfolk, Norwood, Plainville, Sharon, Walpole, Wellesley, Weston, Westwood, Wrentham

Regional Eligibility Office Locations

Central/West Region
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Central West Region
140 High St. Suite 301
Springfield, MA 01105
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Metro Region
Regional Eligibility Coordinator
411 Waverley Oaks Road, Suite 304
Waltham, MA 02452
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Northeast Region
Regional Eligibility Coordinator
Hogan Regional Center
PO Box A
Hathorne, MA 01937
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Voice: (617) 727-5608
Fax: (617) 624-7577

Email: DDS.Info@state.ma.us
DDS website at: www.mass.gov/dds

Metro Region

Kristen O'Melia, Eligibility Manager
Christine Kjellson, Eligibility Coordinator
(781) 314-7513

Metro Region
465 Waverly Oaks Road, Suite 120
Waltham, MA 02452

Application Process

Mission Statement
The Department is dedicated to creating, in partnership with others, innovative and genuine opportunities for individuals with intellectual disabilities to participate fully and meaningfully in, and contribute to, their communities as valued members.

Applying for eligibility is a choice and we believe that it is important for applicants to fully understand the criteria for eligibility as well as the type of documentation that is required to enable DDS to make such an important decision. Therefore, included in the new application are the criteria for eligibility and explicit instructions about the necessary documentation.

Another important component is legal authorization to proceed with the process. Applicants must give their written permission so that DDS can proceed with the eligibility process. This does not mean that an applicant cannot get help from a family member, friend or agency. However if the applicant chooses to have someone assist him/her, she/he will also need to authorize that by signing a permission form.

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After a complete application has been received by the Regional Eligibility Team, applicants can expect to be contacted by a Regional Eligibility Team member to schedule a face-to-face meeting.

Metro Region Family Support Centers

Charles River West Area
Cambridge Family & Children's Services
60 Gore Street, Cambridge MA 02141
(617) 876-4210 www.helpfamilies.org

Greater Boston Area
Bay Cove Family Support Center
66 Canal Street, Boston MA 02114
258 Mill Road, Chelmsford, MA 01824
(617) 371-3121 www.baycove.org

Vinfen Corp. DDS Family Support Center
1208 C VFW Parkway, Suite 103, West Roxbury, MA 02132
(617) 562-4094 www.vinfen.org

Work Inc. Family Support Center
25 Beach Street, Dorchester, MA 02122
(617) 691-1601 www.workinc.org

Cultural/Linguistic-Specific Family Support Center
Project Able
888 Washington Street, Suite 102, Boston, MA 02111
1881 Worcester Road, Framingham, MA 01701
(617) 988-8132 www.advocates.org
Chinese and Vietnamese Families

Cultural/Linguistic-Specific Family Support Center
Haitian Family Support Center
1603 Blue Hill Avenue, Mattapan, MA 02126
(617) 298-8076 www.haphi.org

Cultural/Linguistic-Specific Family Support Center
Dimock Family Support Center
55 Dimock Street, Roxbury, MA 02119
(617) 442-8800 www.dimockcenter.org
African American/Multicultural Families

Cultural/Linguistic-Specific Family Support Center
Solidaridad
25 Beach Street, Dorchester, MA 02122
(617) 691-1620 www.workinc.org

Middlesex West Area
Charles River Center
4 Strathmore Road, Natick, MA 01760
(508) 651-5914 www.charlesrivercenter.org

Greater Marlboro Programs Inc.
65 Boston Post Road West, Suite 220, Marlborough, MA 01752
(508) 485-4227 www.gmpinc.org

Newton/South Norfolk Area
Charles River Center
59 East Militia Heights Road, Needham, MA 02492
(781) 972-1048 www.charlesrivercenter.org

The Arc of South Norfolk Family Support Center
789 Clapboardtree Street, Westwood, MA 02090
(781) 762-4001 www.arcsouthnorfolk.org

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Northeast Area Office Locations and Cities/Towns Covered

Please direct all support/services related questions to your local Area Office listed below.

All supports are subject to funding and availability

Central Middlesex Area Office
35 Nagog Park, Suite 2000
Acton, MA 01720
Beth Gerber: 978-206-2062
Acton, Arlington, Bedford, Boxboro, Burlington, Carlisle, Concord, Lexington, Lincoln, Littleton, Maynard, Stow, Wilmington, Winchester, Woburn.

Lowell Area Office
55 Technology Drive, Suite 202
Lowell, MA 01851
Kathryn LaPlante: 978-322-4300 Ext. 4309
Billerica, Chelmsford, Dracut, Dunstable, Lowell, Tewksbury, Tyngsboro, Westford.

Merrimack Valley Area Office
280 Merrimack St., 2nd Floor
Lawrence, MA 01843
Leila Sarkis: 978 521-1315
Amesbury, Andover, Boxford, Georgetown, Groveland, Haverhill, Lawrence, Merrimack, Methuen, Newbury, Newburyport, North Andover, Rowley, Salisbury, West Newbury.

Metro North Area Office
27 Water Street
Wakefield, MA 01880
Joseph Allouise: 781-338-2300
Everett, Lynnfield, Malden, Medford, Melrose, North Reading, Reading, Saugus, Stoneham, Wakefield.

North Shore Area Office
100 Cummings Center, Suite 150B
181 Elliot Street, Beverly, MA 01915
James Robson: 978-927-2727 Ext. 123
Beverly, Danvers, Essex, Gloucester, Hamilton, Ipswich, Lynn, Manchester, Marblehead, Middleton, Nahant, Peabody, Rockport, Salem, Swampscott, Topsfield, Wenham.

Regional Eligibility Office Locations

Central/West Region
Regional Eligibility Coordinator
Central West Region
140 High St. Suite 301
Springfield, MA 01105
Intake Referral Number: 413-205-0940
Fax Number: 413-205-1608

Metro Region
Regional Eligibility Coordinator
411 Waverley Oaks Road, Suite 304
Waltham, MA 02452
Intake Referral Number: 781-314-7513
Fax Number: 781-314-7539

Northeast Region
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Hogan Regional Center
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Hathorne, MA 01937
Intake Referral Number: 978-774-5000 ext. 850
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Executive Office of
Health and Human Services

Department of Developmental Services
500 Harrison Avenue
Boston, MA 02118
Voice: (617) 727-5608
Fax: (617) 624-7577

Email: DDS.Info@state.ma.us
DDS website at: www.mass.gov/dds

Northeast Region
Cynthia M. O'Donnell, MSW, Eligibility Manager
(978) 774-5000 ext. 515
Erin Krol, Eligibility Coordinator
(978) 774-5000 ext. 523

Hogan Regional Center
PO Box A
Hathorne, MA 01937

Application Process

Mission Statement
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Applying for eligibility is a choice and we believe that it is important for applicants to fully understand the criteria for eligibility as well as the type of documentation that is required to enable DDS to make such an important decision. Therefore, included in the new application are the criteria for eligibility and explicit instructions about the necessary documentation.

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This permission is required if the applicant wants DDS to be able to communicate directly with this person on their behalf. These authorizations are now a vital part of the new application form.

After a complete application has been received by the Regional Eligibility Team, applicants can expect to be contacted by a Regional Eligibility Team member to schedule a face-to-face meeting.

Northeast Region Family Support Centers

Central Middlesex Area
Riverside Community Care
Riverside Family Support Center
300 West Cummings Park, Suite 354, Woburn, MA 01801
(781) 801-5247 phone (781) 569-0037 fax
www.riversidefamilysupport.org

Lowell Area
Lifelinks, Inc.
Lifelinks Family Support Center
4 Omni Way, Chelmsford, MA 01824
(978) 349-3000 www.lifelinksinc.net

Cambodian Mutual Assistance Association of Greater Lowell (Cultural/Linguistic-Specific Family Support Center)
Monorom Family Support Program, **Serving Cambodian Families**
465 School Street, Lowell, MA 01851
(978) 454-6200 www.cmaalowell.org

Merrimack Valley Area
Fidelity House Human Services
Merrimack Valley Family Support Center
Heritage Place
439 South Union St. Suite 401, Lawrence, MA 01843
(978) 685-9471 www.fidelityhhs.org

Metro North Area
The Arc of East Middlesex
The Arc of East Middlesex Family Resource Center
30 Audubon Road, Wakefield, MA 01880
(781) 587-2314
www.theemarc.org

North Shore Area
Northeast Arc
Northeast Arc Family Resources
6 Southside Road, Danvers, MA 01923
(978) 762-4878
www.ne-arc.org

Criteria for Eligibility for Children and Adults

6.06: Eligibility for Children's Supports (1) Persons who are younger than 22 years of age may be eligible for Children's Supports provided, purchased, or arranged by the Department if the person: (a) is domiciled in the Commonwealth; and (b) for persons who are five through 22 years of age, either: 1. have a severe chronic disability that: a. is attributable to a mental or physical impairment resulting from Intellectual Disability, Autism Spectrum Disorder, Smith-Magenis Syndrome or Prader-Willi Syndrome; b. is likely to continue indefinitely; c. results in substantial functional limitations; or 2. have a verified diagnosis of Intellectual Disability or a closely related developmental condition that results in substantial functional limitations, or (c) for persons from birth to age five a substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in a developmental disability if services are not provided

6.04: Adult Eligibility for Intellectual Disability or Developmental Disability Supports (1) Persons who are 22 years of age or older are eligible for Intellectual Disability Supports provided, purchased, or arranged by the Department if the person: (a) is domiciled in the Commonwealth; and (b) is a person with intellectual disability as defined in 115 CMR 2.01: Definitions. (2) Persons who are 22 years of age or older are eligible for Community Developmental Disability Supports provided, purchased or arranged by the department if the person: (a) is domiciled in the commonwealth; and (b) is a person with Autism Spectrum Disorder, Prader-Willi Syndrome or Smith-Magenis Syndrome as defined in 115 CMR 2.01: Definitions; and (c) does not have an intellectual disability as defined in 115 CMR 2.01: Definitions

Central/West Area Office Locations and Cities/Towns Covered

Please direct all support/services related questions to your local Area Office listed below.

All supports are subject to funding and availability

Berkshire Area Office
333 East St. 5th Floor, Pittsfield, MA 01201 413-447-7381
Adams, Alford, Ashley Falls, Becket. Cheshire, Clarksburg, Dalton, Egremont, Florida, Gr. Barrington, Hancock, Hinsdale, Housatonic, Lanesboro, Lee, Lenox, Monroe, Monterey, Mt. Washington, New Ashford, New Marlboro, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy, Sheffield, Stockbridge, Tyringham, Washington, Williamstown, Windsor

Franklin/Hampshire Area Office
One Roundhouse Plaza Ste 204, Northhampton, MA 01060
413-586-4948
Amherst, Ashfield, Athol, Bernardston, Buckland, Charlemont, Chesterfield, Colrain, Conway, Cummington, Deerfield, Easthampton, Erving, Gill, Goshen, Greenfield, Hadley, Hatfield, Hawley, Heath, Leeds, Leverett, Leyden, Middlefield, Millers Falls, Montague, New Salem, Northampton, Northfield, Orange, Pelham, Petersham, Phillipston, Plainfield, Rowe, Royalston, Shelburne, Shutesbury, Sunderland, Turners Falls, Warwick, Wendell, Westhampton, Whately, Williamsburg, Worthington

Holyoke/Chicopee Area Office
88 Front Street, 1st Floor, Holyoke, MA 01040 413-535-1022
Belchertown, Bondsville, Chicopee, Granby, Holyoke, Ludlow, Monson, Palmer, S. Hadley, Southhampton, Thorndike, Three Rivers, Ware

North Central Area Office
435 Main Street, Fitchburg, MA 01420 978-342-2140
Ashburnham, Ashby, Ayer, Baldwinville, Barre, Berlin, Bolton, Clinton, Fitchburg, Gardner, Groton, Hardwick, Harvard, Hubbardston, Lancaster, Leominster, Lunenburg, New Braintree, Oakham, Pepperell, Petersham, Princeton, Rutland, Shirley, Sterling, Templeton, Townsend, Westminster, Winchendon

South Valley Area Office (Milford)
194 West Street #9 Milford, MA 01757 508-634-3345
Bellingham, Blackstone, Douglas, Franklin, Grafton, Hopedale, Medway, Mendon, Milford, Millbury, Millville, Northbridge, Sutton, Upton, Uxbridge, Whitinsville

South Valley Area Office (Southbridge)
1 North Street, Southbridge, MA 01550 508-764-0751
Brimfield, Brookfield, Charlton, Dudley, Charlton Depot, Holland, Oxford, Southbridge, Spencer, Sturbridge, Wales, Warren, Webster

Springfield/Westfield Area Office
436 Dwight St., Suite 205, Springfield, MA 01103
413-784-1339; 800-370-8525
Agawam, Blandford, Chester, Feeding Hills, Granville, Hampden, Huntington, Indian Orchard, Longmeadow, Montgomery, Russell, Southwick, Springfield, Tolland, Westfield, Wilbraham

Worcester Area Office
24 Southbridge Street, Worcester, MA 01608 508-792-6200
Auburn, Boylston, Cherry Valley, Holden, Leicester, Paxton, Shrewsbury, West Boylston, Worcester

Regional Eligibility Office Locations

Central/West Region
Regional Eligibility Coordinator
Central West Region
140 High St. Suite 301
Springfield, MA 01105
Intake Referral Number: 413-205-0940
Fax Number: 413-205-1608

Metro Region
Regional Eligibility Coordinator
411 Waverley Oaks Road, Suite 304
Waltham, MA 02452Intake Referral
Intake Referral Number: 781-314-7513
Fax Number: 781-314-7539

Northeast Region
Regional Eligibility Coordinator
Hogan Regional Center
PO Box A
Hathorne, MA 01937
Intake Referral Number: 978-774-5000 ext. 850
Fax Number: 978-739-0420

Southeast Region
Regional Eligibility Coordinator
151 Campanelli Drive, Suite B
Middleboro, MA 02346
Intake Referral Number: 508-866-5000
Fax Number: 508-866-8859

SRM 11/11/2016

Your Guide to the Eligibility Process

The
Commonwealth of Massachusetts
Executive Office of
Health and Human Services

Department of Developmental Services
500 Harrison Avenue
Boston, MA 02118
Voice: (617) 727-5608
Fax: (617) 624-7577

Email: DDS.Info@state.ma.us
DDS website at: www.mass.gov/dds

Central/West Region
David Tobin, Ph.D., Eligibility Manager
Elizabeth O. Cullinane, Eligibility Coordinator
(413) 205-0940

Central/West Region
140 High St. Suite 301
Springfield, MA 01105

Application Process

Mission Statement
The Department is dedicated to creating, in partnership with others, innovative and genuine opportunities for individuals with intellectual disabilities to participate fully and meaningfully in, and contribute to, their communities as valued members.

Applying for eligibility is a choice and we believe that it is important for applicants to fully understand the criteria for eligibility as well as the type of documentation that is required to enable DDS to make such an important decision. Therefore, included in the new application are the criteria for eligibility and explicit instructions about the necessary documentation.

Another important component is legal authorization to proceed with the process. Applicants must give their written permission so that DDS can proceed with the eligibility process. This does not mean that an applicant cannot get help from a family member, friend or agency. However if the applicant chooses to have someone assist him/her, she/he will also need to authorize that by signing a permission form.

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After a complete application has been received by the Regional Eligibility Team, applicants can expect to be contacted by a Regional Eligibility Team member to schedule a face-to-face meeting.

Central/West Region
Family Support Centers

Berkshire Area
Berkshire County Arc Central & Southern Berkshire County Family Support Center
395 South Street, Pittsfield, MA 01201 (413) 499-4241 www.bcarc.org
133 Quarry Hill Road, Lee, MA 01238 (413) 464-7962

UCP Central & Northern Berkshire Family Support Center
535 Curran Highway, North Adams, MA 01247 (413) 664-9345 208 West Street, Pittsfield, MA 01201 (413) 442-1562 www.ucpberkshire.org

Franklin/Hampshire Area
Pathlight/Family Empowerment
41 Russell Street, Hadley, MA 01035 (413) 585-8010
www.family-empowerment.org

Franklin County Family Support Center
294 Avenue A, Turner Falls, MA 01376 (413) 774-5558
www.unitedarc.org

North Quabbin Family Support Center- GAAAFSN
361 Main Street, Athol, MA 01331 (978) 249-4052 www.unitedarc.org

Holyoke/Chicopee Area
Multicultural Community Services, MCS Family Support Center
260 Westfield Road, Holyoke, MA 01040 (413) 534-3299
www.mcsnet.org

North Central Area
Seven Hills Family Services, Family Support Center of N. Central
1460 John Fitch Highway, Fitchburg, MA 01402
(978) 632-4322 www.sevenhills.org/family support

Cultural/Linguistic-Specific Family Support Center
Multicultural Family Development Center
437 Main Street, Fitchburg, MA 01420 (978) 343-5836 centroinc.org

South Valley Area
Kennedy Donovan Center
171Main Street 3rd Floor, Milford, MA 01757 (508) 473-5700 kdc.org

Seven Hills Family Services, Family Support Center of S. Valley
208 Charlton Road, Sturbridge, MA 01566 (508) 796-1950
www.sevenhills.org/family support

Springfield/Westfield Area
Multicultural Community Services, MCS Family Support Center
1000 Wilbraham Road, Springfield, MA 01109 (413) 782-2500
www.mcsnet.org

Cultural/Linguistic-Specific Family Support Center
New North Family Support Center
11 Wilbraham Rd. 2nd Floor, Springfield, MA 01109
(413) 731-3110 www.scan360.org

Cultural/Linguistic-Specific Family Support Center
The SC@N 360 Family Center 11 Wilbraham Rd. 2nd Floor, Springfield, MA 01109 (413) 731-3110 www.scan360.org

Seven Hills Family Services
Family Support Center of Greater Worcester
799 West Boylston Street, Worcester, MA 01606
(508) 796-1850 www.sevenhills.org/familysupport

Cultural/Linguistic-Specific Family Support Center
Worcester Multicultural Family Support center
11 Sycamore Street, Worcester, MA 01608
(508) 798-1900 www.cetrolasamericas.org

Criteria for Eligibility for Children and Adults

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Cardinal Cushing Centers

All ages. All abilities. All together.

Medical Equipment Information

The purpose of this part of the section is to house the current information on any medical equipment that a student might have along with the source in case maintenance and/or repairs are needed. Model numbers as well as serial numbers and sales/repair slips can also be kept here when appropriate. (Example: Charm Medical contact information, AFO's, wheelchairs, strollers, oxygen, etc.)

Medical Supplies

The additional purpose of this section is house a current list of medical equipment that a student might need refilled like tubes/syringes, chux(bed pads) pullups/diapers, weighted blankets, etc. The number for the source as well as brand and size.

If you have any suggestions for this section, please feel free to email the PAC at CCC-PAC@cushingcenters.org

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All ages. All abilities. All together.

Guardianship Information

The purpose of this section is house an application for Guardianship and all reports as well as guardianship papers. A copy of the application and annual Care Report are included. Many of our members are willing to share their paths to Guardianship. Some have done it on their own while others have sought the help of their lawyers. Feel free to email the PAC for contact information.

If you have any suggestions for this section, please feel free to email the PAC at CCC-PAC@cushingcenters.org

PETITION FOR APPOINTMENT OF GUARDIAN FOR AN INCAPACITATED PERSON	Docket No.	Commonwealth of Massachusetts The Trial Court Probate and Family Court

In the Interests of:

_____ _____ _____
First Name Middle Name Last Name

Alleged Incapacitated Person/Respondent

_____ **Division**

The Court shall encourage the development of maximum self-reliance and independence of the Incapacitated Person and make appointive and other orders only to the extent necessitated by the Incapacitated Person's limitations or other conditions warranting the procedure.

1. **Information about the Respondent:**

Name: _____ _____ _____
First Name M.I. Last Name

Primary Language: ◯ English ◯ Other: _____ Primary Phone #: _____

Date of Birth: _____ Age: _____ Gender: _____

Principal Residence: _____ _____ _____ _____ _____
(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Date Residence was established: _____

Current Address: ◯ Same as Above or ◯ the following address:

_____ _____ _____ _____ _____
(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

If this appointment is made, Respondent will reside at ◯ Principal Residence ◯ Current Address ◯ the following address:

_____ _____ _____ _____ _____
(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Respondent ◯ is ◯ is not alleged intellectually disabled.

2. **Information about the Petitioner:**

Name: _____ _____ _____
First Name M.I. Last Name

_____ _____ _____ _____ _____
(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Primary Phone #: _____ Relationship to Respondent: _____

State your interest in the appointment:

☐ **An attachment to this petition provides information on co-petitioner(s).**

3. **The Petitioner is requesting:**

☐ to be appointed ☐ that some suitable person be appointed ☐ that the person named below be appointed:

Name: _____ _____ _____
First Name M.I. Last Name

_____ _____ _____ _____ _____
(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Primary Phone #: _____ Relationship to Respondent: _____

☐ **An attachment to this petition provides information on co-Guardian(s).**

4. **He or she has priority of appointment because the nominee is (choose one):**

☐ Nominated in a durable power of attorney by Respondent; ☐ Respondent's parent or a parental nominee; OR

☐ Respondent's spouse or a spousal nominee; ☐ None of the above.

State the reason the proposed guardian(s) should be appointed:

5. **This is a Petition for appointment of a (choose one):**

☐ Limited Guardian. State the powers being sought:

☐ to apply for health insurance benefits including MassHealth on behalf of Respondent;

☐ to obtain copies of statements or any other records from banks, insurance companies, or other financial institutions verifying balances and transactions of accounts standing in the name of the Incapacitated Person, individually or jointly with another.

☐ Other:

OR

☐ General Guardian. State the reasons why a Limited Guardianship is inappropriate:

6. **A Medical Certificate dated with an examination having taken place within 30 days of the filing of the petition or, if Respondent is alleged to be intellectually disabled, a Clinical Team Report dated with an examination having taken place within 180 days of the filing of the petition:**

◯ is filed with this Petition or is on file with the Court (Docket No. _____) ; OR

◯ is not filed with this Petition and is not on file with this Court.

If a Medical Certificate or Clinical Team Report is not filed with this Petition, or on file with this Court, you must immediately file and present a motion requesting that the Court permit it to be filed late or waive the filing requirement. An affidavit must accompany the motion explaining why it is impossible to file a Medical Certificate or Clinical Team Report with this Petition.

7. **The reason a guardianship is necessary is detailed in the most recent Medical Certificate or Clinical Team Report filed with this petition or is described as follows:**

8. **The nature and extent of Respondent's alleged incapacity is detailed in the Medical Certificate or Clinical Team Report filed with this petition or is described as follows:**

9. List Respondent's:

A. Spouse, if any.

B. Children, if any. If none, list parents and brothers and sisters or, if none, list heirs apparent or presumptive.

C. Current Guardian in the Commonwealth or elsewhere;

D. Nominated Guardian in the Commonwealth or elsewhere;

E. Current Conservator in the Commonwealth or elsewhere;

F. Health Care Agent;

G. Durable Power of Attorney/Agent;

H. Representative Payee; and/or

I. Caretaker in the last 60 days.

Name	Primary Address	Primary Phone	Relationship (Check all that apply)	Indicate if this person is:
			☐ Spouse ☐ Representative Payee ☐ Child ☐ Health Care Proxy ☐ Guardian ☐ Durable Power Holder ☐ Nominated Guardian ☐ Had care & custody in the last 60 days. ☐ Conservator ☐ Relative: ____________ (relationship)	☐ Minor ☐ Incompetent
			☐ Spouse ☐ Representative Payee ☐ Child ☐ Health Care Proxy ☐ Guardian ☐ Durable Power Holder ☐ Nominated Guardian ☐ Had care & custody in the last 60 days. ☐ Conservator ☐ Relative: ____________ (relationship)	☐ Minor ☐ Incompetent
			☐ Spouse ☐ Representative Payee ☐ Child ☐ Health Care Proxy ☐ Guardian ☐ Durable Power Holder ☐ Nominated Guardian ☐ Had care & custody in the last 60 days. ☐ Conservator ☐ Relative: ____________ (relationship)	☐ Minor ☐ Incompetent

10. Does the Respondent have, in the Commonwealth or elsewhere:		**If yes, a copy of the document is:**	**Information/Explanation: (If a Petition has been filed but not allowed, please list Court and Docket Number of pending case)**
A current Guardian?	☐ Yes and the person's information is listed at Q.9 ☐ No ☐ Uncertain	☐ Attached ☐ Unavailable	
A document nominating a Guardian?	☐ Yes and the person's information is listed at Q.9 ☐ No ☐ Uncertain	☐ Attached ☐ Unavailable	
A current Conservator?	☐ Yes and the person's information is listed at Q.9 ☐ No ☐ Uncertain	☐ Attached ☐ Unavailable	
A Representative Payee?	☐ Yes and the person's information is listed at Q.9 ☐ No ☐ Uncertain	☐ Attached ☐ Unavailable	
A Health Care Agent?	☐ Yes and the person's information is listed at Q.9 ☐ No ☐ Uncertain	☐ Attached ☐ Unavailable	
A Durable Power of Attorney/Agent?	☐ Yes and the person's information is listed at Q.9 ☐ No ☐ Uncertain	☐ Attached ☐ Unavailable	

11. Respondent ◯ is ◯ is not entitled to benefits from the Department of Veterans Affairs or ◯ Uncertain.

12. Does Respondent have any assets, e.g. bank accounts, property? ◯ Yes ◯ No ◯ Uncertain. **If Yes, identify:**

Description of Assets, e.g. Bank Accounts, Property, Insurance, Pensions DO NOT INCLUDE NAMES OF INSTITUTIONS OR ACCOUNT NUMBERS	**Estimated Value of Property**
Total	

☐ An attachment to this petition provides additional information.

13. Does Respondent have any anticipated income? ◯ Yes ◯ No ◯ Uncertain. **If Yes, identify:**

Description of Income, e.g. Social Security, Interest DO NOT INCLUDE NAMES OF INSTITUTIONS OR ACCOUNT NUMBERS	**Amount of Anticipated Monthly Income or Receipts**
Total	

☐ An attachment to this Petition provides additional information.

14. ☐ **Petitioner seeks specific Court authorization:**

☐ to admit Respondent to a nursing facility;

☐ to treat Respondent with antipsychotic medication in accordance with a treatment plan;

☐ for the following treatment or action for which a substituted judgment determination may be required:

☐ to revoke the Health Care Proxy of Respondent.

WHEREFORE, PETITIONER REQUESTS THAT THIS HONORABLE COURT:

Appoint ☐ Petitioner

☐ _____ _____ _____
First Name M.I. Last Name

☐ Some suitable person

as ◯ limited guardian(s) ◯ general guardian(s) of Respondent, with any specific authorization as may be requested in paragraph 14 above.

☐ Petitioner requests the Court waive sureties on the Bond for the following reasons:

☐ The Respondent has minimal funds to be managed and requiring sureties would place a financial burden on the Respondent.

☐ A Conservator is appointed or is being requested.

☐ Other:

☐ In addition, Petitioner requests that the Court:

SIGNED UNDER THE PENALTIES OF PERJURY

I affirm or swear under oath that I have read the foregoing Petition and that the statements set forth therein are true and correct to the best of my knowledge.

Date: _____ _____
Signature of Petitioner

Date: _____ _____
Signature of Co-petitioner (if applicable)

I assent to the foregoing Petition:

	Print Name	Signature
Date _____	_____	_____
Date _____	_____	_____
Date _____	_____	_____
Date _____	_____	_____

Attorney for Petitioner

_____
(Print name)

_____ _____
(Address) (Apt, Unit, No. etc.)

_____ _____ _____
(City/Town) (State) (Zip)

Primary Phone: _____

B.B.O. # _____

GUARDIAN'S CARE PLAN/REPORT	Docket No.	Commonwealth of Massachusetts The Trial Court Probate and Family Court

In the Interests of:

_____ _____ _____
First Name Middle Name Last Name

Incapacitated Person

_____ **Division**

INSTRUCTIONS TO GUARDIAN:

Fill this Report out completely, then sign and date on the last page. Attach separate sheets if needed to complete your response to the numbered questions. File original Report with the Court and serve the Incapacitated Person in hand or by certified mail, return receipt requested. Complete the Certificate of Service at the end of this Report.

(Check one box)

Age of Incapacitated Person _____

☐ **INITIAL 60 DAY CARE PLAN**

Your relationship to Incapacitated Person _____

☐ **ANNUAL REPORT**

☐ **OTHER:**

Current Reporting Period From: _____ (date) to _____ (date)

CURRENT CONDITION OF THE INCAPACITATED PERSON

1. Describe the Incapacitated Person's mental, physical, and social condition.

LIVING ARRANGEMENTS

1a. List the name, type of facility and address of each place where the Person currently resides and where the person stayed or resided during the reporting period, and include the dates each stay or residence began and ended.

Dates of Stay or Residency	Address	If facility, list name and type of facility and answer Q1b. below

1b. Please explain whether you consider the current living arrangements or habilitation plan and level of care and treatment to be in the Incapacitated Person's best interest.

The Guardian's Care Plan/Report was acknowledged on _____ .
Date

CONDITIONS AND SERVICES

2. SERVICES PROVIDED TO THE INCAPACITATED PERSON

Describe the medical, educational, vocational and other services provided to the Incapacitated Person during the reporting period.

Do you believe that the current care and services are adequate to meet the Person's needs? ◯ Yes ◯ No

Please explain your opinion about the adequacy of care and services.

3. ANTIPSYCHOTIC MEDICATION

Is the Incapacitated Person taking and/or receiving antipsychotic medication(s)? ◯ Yes ◯ No

If **Yes** and you are also the Court appointed Rogers Monitor, you may attach a **Rogers Monitor Supplemental Report**, in lieu of a Roger's Monitor Report.

4. PROTECTION OF INCAPACITATED PERSON

Have any criminal charges or reports of abuse or neglect involving the Incapacitated Person been filed with a court or agency since the last report? ◯ Yes ◯ No

If **Yes,** please explain:

5. GUARDIAN'S VISITS AND CONTACT WITH CAREGIVERS

Describe the nature and frequency of your visits with the Incapacitated Person, your contact with caregivers and health care providers, and any other activities you undertook on the Incapacitated Person's behalf during the reporting period.

6. INCAPACITATED PERSON'S PARTICIPATION IN DECISION-MAKING

Describe the extent to which the Incapacitated Person did/did not participate in decision-making about personal and health care decisions.

7. LEVEL OF CARE

The Incapacitated Person's care is ☐ very good ☐ good ☐ adequate ☐ poor

FUTURE CARE

8. RECOMMENDED CHANGES

Describe the needs of the Incapacitated Person for a continued guardianship including any recommended changes to the guardianship or the Incapacitated Person's future care.

9. FUTURE ARRANGEMENTS

Describe what residence, services and levels of personal/health care you expect to arrange for the Incapacitated Person during the next 18 months.

FINANCES

10a. Are you a Representative Payee? ◯ Yes ◯ No

10b. Do you hold or receive funds belonging to the Incapacitated Person in your role as Guardian other than as a Representative Payee?

◯ Yes, if the answer is yes, answer question 10c. ◯ No, if the answer is no, skip to question 11.

10c. Is there a Conservator appointed?

◯ Yes, if the answer is yes, skip to question 11. ◯ No, if the answer is no, answer question 10d.

10d. SUMMARY OF FINANCIAL ACTIVITY DURING REPORTING PERIOD

Beginning balance of bank accounts (savings, checking, CDs, money market, etc.)	**$**	
Plus (+) money received from any source on behalf of the Incapacitated Person (Social Security, SSI, pension, disability, interest, etc.)	**+**	
Less (-) total fees to care providers	**-**	
Less (-) total monies paid to the Incapacitated Person (personal needs, etc.)	**-**	
Less (-) total fees paid to the Guardian	**-**	
Less (-) any other expenses (housing, insurance, maintenance, etc.)	**-**	
ENDING BALANCE OF BANK ACCOUNTS $		

It is unlawful for a Guardian to co-mingle personal funds with funds belonging to the Incapacitated Person. All funds of the Incapacitated Person MUST be maintained separately and accounted for in this Summary of Financial Activity.

You are required to maintain supporting documentation for all receipts and payments. The Court or any Interested Persons may request copies at any time.

11. PLEASE ADD ANY ADDITIONAL COMMENTS OR CONCERNS THAT YOU HAVE ABOUT THE INCAPACITATED PERSON OR ABOUT THE GUARDIANSHIP.

Note: If you wish to modify or terminate this Guardianship, you must file a separate Petition with the Court.

VERIFICATION AND ACKNOWLEDGEMENT

I swear or affirm that the statements contained in this Report are accurate and complete, to the best of my knowledge and belief.

Signed under the penalties of perjury _____ .
(date)

Guardian's Signature	Co-Guardian's Signature (if applicable)
Print Name	Print Name
(Address) (Apt, Unit, No. etc.)	(Address) (Apt, Unit, No. etc.)
(City/Town) (State) (Zip)	(City/Town) (State) (Zip)
Primary Phone #:	Primary Phone #:

CERTIFICATE OF SERVICE

I certify that on _____ I provided a copy of this Guardian's Care Plan/Report to the
(date)

Incapacitated Person ☐ in hand or ☐ by certified mail, return receipt requested, at the current address as listed in Section 2 of this Report.

Signature of Guardian or Attorney for Guardian

Print Name

(Address) (Apt, Unit, No. etc.)

(City/Town) (State) (Zip)

Primary Phone #: _____

BBO No.: _____

Cardinal Cushing Centers

All ages. All abilities. All together.

RMV ID Information and Handicap Sticker

The purpose of this section is house an application for an ID which is available through the RMV. This ID can be given once a child turns 14 and is easier if acquired before 18. A "Real ID" is needed for boarding an airplane after October 1, 2020, entering federal buildings, and is an acceptable form of ID for all federal purposes.

This section could also house a copy of a handicap sticker.

If you have any suggestions for this section, please feel free to email the PAC at CCC-PAC@cushingcenters.org

Cardinal Cushing School
405 Washington St.
Hanover, MA 02339
(781) 826-6371

St. Coletta Day School
85 Washington St.
Braintree, MA 02184
(781) 848-6250

REGISTRY OF MOTOR VEHICLES

Driver's License, Learner's Permit or ID Card Application

(Passenger (Class D), Motorcycle (Class M), Class D/M, or Massachusetts Identification Card)

Save time, go to mass.gov/RMV to apply online!

A. Service Type

1. Type: ☐ REAL ID ☐ Standard ID

2. Document to Issue: ☐ Learner's Permit ☐ Driver's License ☐ Massachusetts ID Card

3. Class of Learner's Permit/License (if applicable): ☐ Passenger (Class D) ☐ Motorcycle (Class M) ☐ Both (Class D/M)

4. Service Type: ☐ New ☐ Renewal ☐ Replacement ☐ Out-of-State Conversion ☐ Reinstatement ☐ CDL Downgrade
☐ Change of Information (Enter new information in applicable fields): ☐ Name ☐ Address ☐ DOB ☐ Gender ☐ Height ☐ Eye Color

B. Applicant Information

Last Name (If you're getting a REAL ID, provide your full legal name)	First Name	Middle Name	Suffix

Current Massachusetts Learner's Permit or Driver's License # (if applicable)	Date of Birth (MM/DD/YYYY)	

What is your Social Security Number?	If you do not have a Social Security Number, you will need an SSA Denial notice & Foreign Passport.
	Foreign Passport #

Residential Address (Where you actually reside)

Street | Apt. # | City | State | Zip Code

Mailing Address ☐ (same as above)

Street | Apt. # | City | State | Zip Code

Email	Phone Type	Phone #
	☐ Cell ☐ Home ☐ Work	

Emergency Contact Information: (optional)

Email	Name	Phone Type	Phone #
		☐ Cell ☐ Home ☐ Work	

C. Out of State Conversion (Skip if not converting from out of state)

Driver's License, Learner's Permit or ID Card #	Document Type	Restriction(s) (if applicable)
	☐ Learner's Permit ☐ Driver's License ☐ ID Card	

Country	State	Issue Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)

D. Required Demographic Information

Gender	Eye Color	Height (feet, inches)
☐ M ☐ F	☐ Black ☐ Brown ☐ Gray ☐ Hazel ☐ Pink ☐ Blue ☐ Dichromatic ☐ Green ☐ Maroon ☐ Unknown	Ft. In.

Organ Donor: ☐ Yes ☐ No For more information on organ donation, visit: neds.org.

Would you like to donate $2 to the Organ and Tissue Donor Registration Fund? ☐ Yes ☐ No
(to be answered for renewal and replacement transactions only)

Military Status (documentation is required if checked – visit mass.gov/rmv for acceptable documents)

☐ Are you an active duty member?	What military branch?	☐ If you are a veteran of the U.S. Armed Forces, do you want the word "VETERAN" printed on your ID?

E. CDL Downgrade (if applicable)

CDL Downgrade: I understand that my CDL will be downgraded to a Class D, M, or D/M license and I authorize the RMV to process this transaction.

Applicant Signature: _____

9011-WALK-IN

F. Voter Registration

To vote in Massachusetts you must be: A U.S. CITIZEN, a resident of Massachusetts and at least 18 years old on or before the next election in your city or town, which could be a town meeting, city or town preliminary, city or town election, state primary, state election, special state primary, special state election, or special city or town election.

1. Do you want to register to vote? ..... ☐ Yes ☐ No
   - Check "Yes" if you want to register to vote, or you are changing your name or address and want to be registered to vote with this new information.
   - If you answered "Yes," complete question #2 and read the Affirmation Section below.
   - Check "No" if you are currently registered to vote and do not want to change your voter registration.
2. Are you a citizen of the United States of America? ..... ☐ Yes ☐ No
   NOTE: If you answered "no" to this question, do not complete question #3. You are not eligible to register to vote at this time.
3. Please indicate party enrollment or political designation (check one). ☐ Democratic ☐ Republican ☐ Libertarian ☐ No Party (unenrolled)
   ☐ Political Designation (not a political party) (Print desired designation): _____
   PLEASE ASK THE LICENSE CLERK FOR YOUR VOTER REGISTRATION RECEIPT

AFFIRMATION TO BE READ BY APPLICANTS REGISTERING TO VOTE

I hereby swear (affirm) that I am the person named above, that the above information is true, that **I AM A CITIZEN OF THE UNITED STATES,** that I am at least 16 years old and I understand that I must be 18 years old to be eligible to vote, that I am not a person under a guardianship which prohibits my registering to vote, that I am not temporarily or permanently disqualified by law from voting because of corrupt practices in respect to elections, that I am not currently incarcerated for a felony conviction, and that I consider this residence to be my home. Signed under the penalty of perjury.

Confidentiality of voter registration information: If you register to vote, the office at which you submit your application will remain confidential and will be used only for voter registration purposes. If you decline to register to vote, the fact that you declined to register will remain confidential and will be used only for voter registration purposes.

Penalty for illegal voter registration: Fine of not more than $10,000 or imprisonment for not more than five years or both (M.G.L., Chap. 56, Section 8).

G. Mandatory Questions

1. In the past 10 years, have you held any class of license, in any other state, country or jurisdiction? ..... ☐ Yes ☐ No

   If yes, where? (Country/State) _____What credential class? _____ What credential #? _____

   List any current license/permit also: _____
   You may use additional paper if necessary.
2. Do you have a cognitive, neurologic, physical or any other impairment that may affect your functional ability to operate a motor vehicle safely? ..... ☐ Yes ☐ No
3. Are you currently taking any medication that may affect your ability to safely operate a motor vehicle? ..... ☐ Yes ☐ No
4. Is your license or RIGHT to operate suspended, revoked, canceled, withdrawn, or disqualified here or in another state, country or jurisdiction? ..... ☐ Yes ☐ No

H. Parent/Guardian Consent for Applicants under the age of 18

(Information & Certification of Person Providing Consent)

If the person giving consent IS NOT a parent, proper documentation of authority must be shown.

I hereby certify I am: (check one) ☐ parent ☐ legal guardian ☐ Department of Children and Families ☐ boarding school headmaster

of the above-named applicant who is less than 18 years of age, but not less than 16 years of age, if applying for a Learner's Permit or Driver's License OR who is less than 18 years of age, but not less than 14 years of age, if applying for an ID card, and that my consent is given as required by M.G.L. Chap. 90, Section 8 for the issuance of a Driver's License; or as required by M.G.L. Chap. 90, Section 8B for a Learner's Permit; or by M.G.L. Chap. 90, Section 8E for an Identification Card (ID). **False certification is punishable by fine, imprisonment, or both (M.G.L. Chap. 90, Section 24B).**

Parent/Guardian's Address: _____

Parent/Guardian's Signature: _____

I. Certification and Signature of Applicant (application not complete without signature)

I have reviewed this completed **Application Form,** including the **Voter Registration Section,** and hereby apply for a Learner's Permit/Driver's License or an ID card and swear (affirm), under the penalties of perjury, that the information I have provided is true and correct.

I am aware that false statements are punishable by fine, imprisonment, or both under M.G.L. Chapter 90, Section 24B.

Signature: _____ Date: _____

The Registrar reserves the right to cancel, revoke, or recall, any learner's permit, driver's license, or ID card if it is determined that the applicant was not qualified for such learner's permit, driver's license, or ID card.

RMV Use Only

Date: _____ Clerk Initials: _____

REGISTRY OF MOTOR VEHICLES

Identification Documents Checklist

WHAT DOCUMENTS DO I NEED?

Learner's Permit, Driver's License, or Mass ID Card

Save time in line. Check each document you will present with your application.

If you are missing a document, you will NOT be successful.

All documents must be originals, photocopies will not be accepted.

Laminated documents will not be accepted.

"Get Ready" online for faster service – mass.gov/ID

PROOF OF LAWFUL PRESENCE AND PROOF OF DATE OF BIRTH

Check One

All Documents must be valid and unexpired – Check One

- ☐ U. S. Passport or Passport Card
- ☐ Original or Certified version of U.S. Birth Certificate (must be issued from municipality and have a raised seal – hospital certificates are not accepted)
  - – Puerto Rican Birth Certificate must be issued after July 1, 2010
- ☐ Consular Report of Birth Abroad (CRBA) issued by the Department of State Form FS-240, DS-1350, FS-545
- ☐ Permanent Resident Card issued by DHS or INS – Form: I-551
- ☐ Temporary I-551 stamp in Foreign Passport
- ☐ Employment Authorization Document (EAD) issued by DHS, Form I-766, or Form I-668B

NOTE: All immigration documents must show a valid 12-month stay in the U.S.

- ☐ Foreign Passport with a valid, U.S. visa affixed
  - – A non-U.S. Passport must contain a current visa and be presented with an I-94 Record of Arrival and Departure, unless you have a Permanent Resident Card or other change in status
  - – The I-94 can be either a paper version from U.S. Customs and Border Protection or a printout of an electronic version downloaded from their website at cbp.gov/i94
  - – For customers who have a Certificate of Eligibility (I-20) or Certificate of Eligibility for Exchange Visitor Status (DS-2019) documentation verifying the applicant's most recent admittance into the United States must be shown
- ☐ Certificate of Citizenship issued by DHS Form N-560 or Form N-561
- ☐ Certificate of Naturalization Form N-550 or N-570
- ☐ Re-Entry Permit – Form I-327 **(for Standard license/ID only)**
- ☐ Refugee Travel Document – Form I-571 **(for Standard license/ID only)**

NAME MUST MATCH for REAL ID

If your current name doesn't match the one that appears on your lawful presence document(s), you must prove your legal name change in order to qualify for a REAL ID driver's license/ID card. If multiple name changes, documentation for each name change must be provided. You will need to provide one of the following:

- ☐ Marriage Certificate (must be issued from the municipality)
- ☐ Divorce Decree
- ☐ Court Document

For a Standard driver's license/ID card, a proof of name change document is not required.

PROOF OF SOCIAL SECURITY NUMBER

Check One for REAL ID

For REAL ID license/ID, one document below must be presented. No hand-written documents will be accepted. For a Standard license/ID, your SSN must validate with SSA or you must provide a SSN Denial Notice with Passport, Visa, and I-94.

- ☐ SSN Card (**cannot** be laminated)
- ☐ W-2 Form that displays 9-digit SSN
- ☐ SSA-1099 Form that displays 9-digit SSN
- ☐ Non-SSA-1099 Form that displays 9-digit SSN
- ☐ Pay Stub with Name and 9-digit SSN on it
- ☐ SSN Denial Notice issued by SSA with Passport, Visa, and I-94 (dated within 60 days)

REGISTRY OF MOTOR VEHICLES

Identification Documents Checklist

All documents must be originals, photocopies will not be accepted.

☑ Check One for Standard
Check Two for REAL ID

PROOF OF MASSACHUSETTS RESIDENCY

Document must display residential address with applicant's name — no PO Boxes or 'in care of' can be accepted.
For a REAL ID license or ID– You need to check two
For a Standard license or ID – You need to check one

Massachusetts RMV-issued documents:
(Only one item can be accepted)

- ☐ Current license
- ☐ Current Massachusetts ID card (Liquor ID not accepted)
- ☐ Current learner's permit
- ☐ RMV-issued mail dated within 60 days (including license/registration reminders, vehicle registration)

State/federal/city/town/county agency-issued documents:

- ☐ 1st class, government-issued mail dated within 60 days
- ☐ Current MA-issued professional license
- ☐ Medicaid statement dated within 60 days
- ☐ Current firearms card
- ☐ Jury duty summons dated within 60 days
- ☐ Court correspondence dated within 60 days
- ☐ Property tax for current year
- ☐ Excise tax for current year

Bills: Must be dated within 60 days

- ☐ Utility bill (electric, telephone, water, sewer, cable, satellite, heating)
- ☐ Credit card statement
- ☐ Medical/hospital statement
- ☐ Insurance bill (auto, medical, home, rental)
- ☐ Cell phone bill

Lease/Mortgage:

- ☐ Current lease/mortgage or similar rental contract
- ☐ Mortgage statement dated with 60 days

Financial-related documents:

- ☐ W-2 wage and tax statement from immediate prior year
- ☐ Current pension statement (401k, 457, SEP, etc.)
- ☐ Current retirement statement
- ☐ Pay stub dated within 60 days
- ☐ Current SSA statement
- ☐ Current installment loan contract (car loan)
- ☐ Bank statement (savings or checking account) dated within 60 days

School-issued documents:

- ☐ Official school transcript for current year
- ☐ Official letter from school (proof of enrollment) dated within 60 days
- ☐ Tuition bill for current year
- ☐ Certified school record for current year

Insurance-related documents: Current year only

- ☐ Auto insurance policy, Renter's insurance policy
- ☐ Homeowner's insurance policy

For applicants under the age of 18

- ☐ Alternative Residency Affidavit

Please present this checklist and the documents selected with your completed application.
Be sure to "Get Ready" online for faster service – mass.gov/ID
Note: After October 1, 2020, you will need a REAL ID or passport to fly within the U.S. or enter federal buildings.

REGISTRY OF MOTOR VEHICLES

Application for Disabled Parking Placard/Plate

Mail to: Medical Affairs, PO Box 55889, Boston, MA 02205-55889 ● 857-368-8020 ● mass.gov/rmv

For Walk-in Service Only: Haymarket Center, 136 Blackstone Street, Boston, MA

This side of application must be completed in the disabled person's name.
Please note the information required in this application may affect your driver's license.

- Incomplete application will not be processed and will be returned.
- **Both disabled person and healthcare provider must sign and date this application. The disabled person's information must be provided in sections A, B, and C. The healthcare provider must complete sections D and E.**
- This application must be submitted to Medical Affairs within thirty (30) days of the healthcare provider's certification.
- RMV Service Center locations do not process disability parking applications; dropping off at a service center location may add processing time.
- Additional documentation may be required.

A. Disabled Applicant Information

Last Name	First Name	Middle Name	Suffix

Date of Birth (MM/DD/YYYY)	Current Massachusetts Learner's Permit, Driver's License # (if applicable) or MA ID	What is your Social Security Number?

Residential Address (Where you actually reside)

Street | Apt. # | City | State | Zip Code

Mailing Address ☐ (same as above)

Street | Apt. # | City | State | Zip Code

Email	Phone Type	Phone #
	◯ Cell ◯ Home ◯ Work	

Emergency Contact Information: (optional)

Email	Name	Phone Type	Phone #
		◯ Cell ◯ Home ◯ Work	

B. Service Type

Type:

- ☐ Placard ..... No fee required for a placard. Disabled person is not required to have a vehicle registered in his/her name.
- ☐ Plate ..... Only issued to individual who is primary owner with vehicle registered in his/her name. Registration fees apply.
- ☐ Motorcycle Plate ..... Only issued to individual who is primary owner with vehicle registered in his/her name. Registration fees apply.
- ☐ DV Plate — Only issued to individual who: a) is primary owner with vehicle registered in his/her name; b) provide the DV (Disabled Veteran) Plate Letter from the Veteran's Administration listing service-connected disabilities and total combined rating; c) has qualifying conditions which meet Medical Affairs guidelines and total at least 60% of the service-connected disability.

C. Certification and Signature of Applicant

Rules:

- It is illegal to allow someone to use your placard if you are not in the vehicle.
- It is illegal for an individual to have more than one placard (temporary or permanent).
- It is illegal to provide false information (persons can be prosecuted under Massachusetts Law).
- It is illegal to possess or display a counterfeit placard (altered or photocopied).
- It is illegal to forge a healthcare provider's signature.

Acknowledgment:

- I have read the rules.
- I understand misuse of disabled parking may result in high motor vehicle citation fines ($500, first offense), license suspension terms, and the revocation of my disabled parking privileges.
- I certify under the penalty of perjury that all the information provided in this application, including the representation of my medical status/condition, is true and correct to the best of my knowledge.
- AUTHORIZATION TO RELEASE MEDICAL RECORDS – I hereby authorize the healthcare provider completing this form to discuss and release any or all medical records pertaining to its content with or to representatives of the RMV.
- For applicants for Disabled Veteran plates, I hereby authorize the Veteran's Administration to release medical information concerning my service connected disability rating(s).

I have reviewed this completed **Application Form** and swear (affirm), under the penalties of perjury, that the information I have provided is true and complete.

I am aware that false statements are punishable by fine, imprisonment, or both under M.G.L. Chapter 90, Section 24B.

Signature of Disabled Person:_____ Date: _____

Applicant's Name/Patient's Name	Last 4 Digits of Social Security #
	☐☐☐☐

D. Healthcare Provider Information – To be completed by Healthcare provider ONLY

Complete this section regardless of the patient's license status or age. Failure to complete all sections will result in delayed processing and a request for more information about this patient.

In my professional opinion and to a reasonable degree of medical certainty:

☐ The reported condition ***WILL NOT IMPAIR*** the safe operation of a motor vehicle.

☐ The person applying for this permit is ***NOT*** medically qualified to operate a motor vehicle safely.

☐ The medical condition as stated below is of such severity as to require a ***COMPETENCY ROAD TEST***.

This application is completed for individuals who are severely restricted in mobility/ability to walk due to a neurological, orthopedic, arthritic, or other medically debilitating qualifying condition. I acknowledge the RMV grants disabled parking on the basis of necessity and not as a convenience. Disabled parking misuse carries heavy fines and strict license suspension penalties.

Clinical Diagnosis:_____ **(Required)**

Duration of placard to be issued (check one): ◯ Temporary ◯ Permanent

If temporary, please estimate number of months of disability: ☐☐

Please check ***ALL*** that apply:

☐ Unable to walk 200 feet without stopping to rest; list any necessary ambulatory aids: _____

☐ Legally Blind* (Certificate of Blindness may substitute for professional certification). *automatic loss of license

☐ Chronic Lung Disease To such an extent that the applicant's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than 1 liter (attach most recent FEV1 Test results):

_____FEV 1 test result _____ O^2 saturation with minimal exertion (*automatic loss of license if O^2 saturation ≤ 88%)

Use of Portable Oxygen? ◯ Yes ◯ No

NOTE: Asthma alone is not a qualifying condition. Please describe degree and frequency of impairment (pulmonary function test results are required).

_____

☐ Cardiovascular Disease

AHA Functional Classification (check one): ◯ I ◯ II ◯ III ◯ IV* (*automatic loss of license)

☐ Loss of Limb or permanent loss of use of a limb (please describe):

_____

E. Healthcare Provider Certification and Signature – All fields must be completed

Provider's Last Name (please print)	Provider's First Name

Provider's Address

Street Apt. # City State ☐☐ Zip Code

NPI #	Board of Registration in Medicine #	Email

I am a: ◯ Medical Doctor ◯ Chiropractor ◯ Registered Nurse ◯ Physician Assistant ◯ Osteopath ◯ Optometrist (legal blindness only) ◯ Podiatrist

I certify under the penalty of perjury that the information I have provided is true and correct to the best of my knowledge.

Provider's Signature: _____ Date: _____

Cardinal Cushing Centers

All ages. All abilities. All together.

Social Security Information

The purpose of this section is house an application for Social Security benefits which many of our children are eligible for but the process is a daunting one. Many of our members are willing to share the story of their processes. Feel free to email the PAC for contact information.

For more information:

https://www.ssa.gov/benefits/disability/

If you have any suggestions for this section, please feel free to email the PAC at CCC-PAC@cushingcenters.org

Cardinal Cushing School
405 Washington St.
Hanover, MA 02339
(781) 826-6371

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MEDICAL CERTIFICATE GUARDIANSHIP OR CONSERVATORSHIP	Docket No.	**Commonwealth of Massachusetts** **The Trial Court** **Probate and Family Court**

INSTRUCTIONS FOR COMPLETION

This document will be used by the Probate and Family Court in the process of determining whether to appoint a guardian and/or conservator to assume responsibility for this individual in some or all areas of decision-making and functioning. If, however, a guardianship or conservatorship is being sought for an intellectually disabled person, do not use this document. A separate Clinical Team Report is required.

_____ **Division**

To the registered physician, licensed psychologist, certified psychiatric nurse clinical specialist or a nurse practitioner completing this document:

You must complete this document. If there is any information about which you do not have direct knowledge, you are encouraged to make inquiry of such other persons as may be necessary to complete the entire form. These persons might include other healthcare professionals and/or others acquainted with the individual (*e.g.*, family members or social service professionals). If you receive information from others, the names of those individuals must be listed in the Certification Section and attribution identified.

If you are completing this form on the computer and additional space is required for any narrative section, the section will expand to permit additional information. Do not use medical terminology and/or abbreviations without explaining them in terms that a lay person can understand.

ALL OF THE ATTACHED PAGES AND SECTIONS CONTAINED THEREIN MUST BE COMPLETED.

To the Honorable Justices of the Probate and Family Court:

The undersigned hereby certifies under the penalties of perjury that I am:

- ☐ a registered physician specializing in the area of: _____ .
- ☐ a licensed psychologist.
- ☐ a certified psychiatric nurse clinical specialist.
- ☐ a nurse practitioner with experience in the area of: _____ .

I am prepared to present a statement of my qualification to the Court by written affidavit or personal appearance if directed to do so.

I personally examined: _____ (First Name) _____ (Middle Name) _____ (Last Name) _____ (age)

who resides at _____ (Address Line 1) _____ (Apt, Unit, No. etc.) _____ (City/Town) _____ (State) _____ (Zip)

on _____ (Date(s) of Examination(s))

Prior to examination, I informed the patient that communications would not be confidential.

- ☐ Yes.
- ☐ No, Explain:

1. CLINICALLY DIAGNOSED CONDITION(S) THAT RESULT IN INCAPACITY

A. Description of mental and physical condition

Describe the individual's mental and physical conditions necessitating the appointment of a guardian and/or conservator, including the date of onset and disease course.

B. Stability of mental and physical condition and living setting

I. In the past 90 days, has the individual's mental and/or physical condition changed?

◯ Yes ◯ No ◯ Uncertain

If yes, please explain:

II. In the past 90 days, has the individual's living setting (i.e. community, hospital, nursing facility) changed?

◯ Yes ◯ No ◯ Uncertain

If yes, please explain:

C. Prognosis for Improvement

With reasonable medical certainty, within the next 90 days, is the individual's mental and/or physical conditions likely to change substantially?

◯ Yes ◯ No ◯ Uncertain

If yes, explain whether the condition is likely to worsen or improve, as well as if there are any aggravating factors that could make the individual appear confused but could improve with time or treatment (*e.g.* delirium, acute medical illness, the interaction of multiple medications, hearing loss, vision loss, bereavement, etc.):

If improvement is possible, the individual should be re-evaluated in _____ weeks.

D. List all Medications (or attach list):

Name	Dosage/Schedule	If an anti-psychotic medication indicate with a checkmark.
		☐
		☐
		☐
		☐

Could any of these medications impair mental functioning: ◯ Yes ◯ No ◯ Uncertain

If yes, explain:

2. INABILITY TO RECEIVE AND EVALUATE INFORMATION OR TO MAKE OR COMMUNICATE DECISIONS

A. Alertness/Level of Consciousness

Overall Impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Non-Responsive

B. Memory and Cognitive Functioning (*e.g.*, memory, comprehension, reasoning, judgment, planning, insight)

Overall Impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe

C. Emotional and Psychiatric Functioning (*e.g.*, mood, anxiety, psychotic, substance use and other disorder)

Overall Impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Describe how impairments in A, B, and/or C cause the individual to have an inability to receive and evaluate information or make or communicate decisions:

3.1 GUARDIANSHIP: INABILITY TO MEET ESSENTIAL REQUIREMENTS FOR PHYSICAL HEALTH, SAFETY, AND SELF-CARE

If seeking guardianship of the person, complete section 3.1. If seeking only a conservatorship, do not complete this section. Limited Guardianship is preferred by the Court; describe how the guardianship may be limited. Describe how the assessment was performed and give specific examples.

A. Areas in which the individual <u>is able</u> to meet the essential requirements for physical health, safety, and self-care:

Describe the individual's retained abilities and adaptive behavior for physical health, safety, self-care for which the guardianship may be limited (*e.g.*, ability to manage ADL's and IADL's such as health, hygiene, home, communication, driving, leisure, social; functioning in the community; ability to express treatment choices and make medical decisions; ability to complete any or some legal transactions).

B. Areas in which the individual <u>is unable</u> to meet essential requirements for physical health, safety, or self-care: Describe the impairments in physical health, safety, and self-care for which the individual requires a guardian.

C. If individual is unable to make any decisions for him or herself or is unable to meet any essential requirements for physical health, safety, and self-care (*i.e.* requires a full guardianship), describe why:

3.2 CONSERVATORSHIP: INABILITY TO MANAGE PROPERTY OR BUSINESS AFFAIRS EFFECTIVELY

If seeking conservatorship of the estate and affairs, complete section 3.2. If seeking only a guardianship of the person, do not complete this section. Limited Conservatorship is preferred by the court; describe how the conservatorship may be limited. Describe how the assessment was performed and give specific examples.

A. Areas in which the individual is able to manage property or business affairs effectively:

Describe the individual's retained abilities and adaptive behavior for management of property and estate for which the conservatorship may be limited (*e.g.*, ability to manage allowance, bills, donations, investments, real estate, protect assets, resist fraud).

B. Areas in which the individual is unable to manage property or business affairs effectively:

Describe the impairments in the management of property and business affairs for which the individual requires a conservator. Describe how the person has property that will be wasted or dissipated unless management is provided and/or how protection is necessary to provide money for the support, care and welfare of the person or those entitled to the person's support.

C. If the individual is unable to make any decisions about, and is unable to manage, any property or business affairs effectively (*i.e.* requires a full conservatorship), describe why:

4. VALUES AND PREFERENCES

Describe the individual's values, preferences, and patterns, including previously described preferences (*e.g.*, under durable power of attorney, advance directive, health care proxy, or living will documents), whether the individual accepts or opposes the guardianship/conservatorship, where the individual prefers to live, what makes life meaningful for the individual, and religious or cultural considerations.

5. SOCIAL NETWORKS AND RISK OF HARM TO SELF OR OTHERS

A. Social Network Relationships

Social Support (Check one)

◯ Very good supportive network ◯ Some support from family and friends ◯ Limited or nonexistent support

Social Skills (Check one)

◯ Very good social skills ◯ Good social skills ◯ Poor social skills

B. Nature of Risks

Describe the significant risks facing this individual and specify whether these risks are due to this individual's condition and/or due to another person harming or exploiting him or her:

C. The individual's risk of harm to self or others is: ◯ Mild ◯ Moderate ◯ Severe

D. The likelihood of harm is: ◯ Almost Certain ◯ Probable ◯ Possible ◯ Unlikely

6. RECOMMENDATIONS FOR LEVEL OF CARE/SUPERVISION NEEDED, INCLUDING HOUSING

A. An institutional placement being pursued at the following:

◯ Nursing home/Rehabilitation ◯ Psychiatric facility ◯ Other facility ◯ None ◯ Uncertain

If none, skip to section 7; if yes, answer:

B. The individual requires the following level of supervision:

◯ Locked facility ◯ 24 hr. supervision ◯ Some ◯ None

Less restrictive placement options have been pursued:

◯ Yes ◯ No ◯ Uncertain

The placement is anticipated to be:

◯ Long-term ◯ Short-term ◯ Uncertain

Describe the specific reasons for placement and efforts made to preserve the person's social support system (*e.g.* placement in community of residence or near family):

7. RECOMMENDATIONS FOR APPROPRIATE TREATMENT AND HABILITATION: The individual may benefit from:

Educational potential, training, or rehabilitation	◯ Yes	◯ No	◯ Uncertain
Technological assistance or accommodations	◯ Yes	◯ No	◯ Uncertain
Mental health treatment	◯ Yes	◯ No	◯ Uncertain
Occupational, physical, or other therapy	◯ Yes	◯ No	◯ Uncertain
Home and/or social services	◯ Yes	◯ No	◯ Uncertain
Medical treatment, operation or procedure	◯ Yes	◯ No	◯ Uncertain

Other: _____

Describe any specific recommendations:

8. ATTENDANCE AT HEARING

☐ It would be clinically harmful for the individual to attend the hearing. Describe why:

☐ The individual is able to attend the court hearing

What accommodations, if any, would enable the individual to attend the hearing:

9. CERTIFICATIONS

This form was completed based on an in-person clinical evaluation of the individual:

who ◯ is ◯ is not a patient under my continuing care and treatment.

In addition to a clinical examination, other sources of information for this examination:

☐ Review of medical record.

☐ Discussion with health care professionals involved in the individual's care.

☐ Discussion with family or friends.

☐ Other _____

Names and titles/relationships of those individuals who assisted in preparation of this report:

Name	Title/Relationship

List any tests which bear upon the issues of incapacity and date of tests:

Test	Date

This document must be signed and dated by the person completing it. It does not need to be notarized.

I hereby certify that the evaluation of diagnosis, cognition, and function is within the scope of my professional competence based upon my education, training, and experience. I further certify that this report is complete and accurate to the best of my information and belief.

Signed under the penalties of perjury:

_____ Date _____

SIGNATURE OF CLINICIAN

_____ _____

(Print name) License type, number, and date

Office Address: _____ _____ _____ _____ _____

(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Office Phone: _____

CLINICAL TEAM REPORT	Docket No.	Commonwealth of Massachusetts The Trial Court Probate and Family Court

INSTRUCTIONS FOR COMPLETION

This document will be used by the Probate and Family Court in the process of determining whether to appoint a guardian and/or conservator to assume responsibility for an individual with an intellectual disability. A licensed psychologist, registered physician, and licensed social worker, each of whom is experienced in the evaluation of persons with an intellectual disability, must complete this form.

_____ **Division**

To the licensed psychologist, registered physician, and licensed social worker completing this document:

You must complete this document. If there is any information about which you do not have direct knowledge, you are encouraged to make inquiry of such persons as may be necessary to complete the entire form. These might include other healthcare professionals and/or others acquainted with the individual (*e.g*. family members or social service professionals). Identify sources of written or oral information under Section 1.

If you are completing this form on the computer and additional space is required for any narrative section, the section will expand to permit additional information. Do not use medical terminology and/or abbreviations without explaining them in terms that a lay person can understand.

ALL PAGES AND SECTIONS CONTAINED HEREIN MUST BE COMPLETED

To the Honorable Justices of the Probate and Family Court:

The clinicians listed below in section 8 hereby certify under the penalties of perjury that they:

1. are licensed by the Commonwealth of Massachusetts and are experienced in evaluation of persons with an intellectual disability;
2. personally examined _____ (First Name) _____ (Middle Name) _____ (Last Name) _____ (Age)

   who resides at _____ (Address) _____ (Apt, Unit, No. etc.) _____ (City/Town) _____ (State) _____ (Zip)

Dates of Examination(s):

Licensed psychologist on: _____ (Date(s) of Examination(s))

Registered physician specializing in _____ (Area of specialty) on _____ (Date(s) of Examination(s))

Licensed social worker on: _____ (Date(s) of Examination(s))

The undersigned are prepared to present a statement of qualifications to the Court by written affidavit or personal appearance if directed to do so.

Prior to examination, the individual was informed that communications would not be confidential.

◯ Yes ◯ No

Explain:

1. CERTIFICATION OF METHODS OF EVALUATION

This form was completed based on an in-person clinical evaluation of the individual.

In addition to a clinical examination, other sources of information for this examination:

- ☐ Review of intellectual, adaptive and other relevant evaluations;
- ☐ Discussion with professionals involved in the individual's care;
- ☐ Discussion with family or friends;

☐ Other.

Names and titles/relationships of those individuals who assisted in preparation of this report:

Name	Title/Relationship to individual

List any intellectual, adaptive or other evaluations reviewed and dates of tests.

Test	Date

State numerical result for IQ test. _____

2. CLINICALLY DIAGNOSED CONDITION(S) THAT MAY RESULT IN INCAPACITY

A. Intellectual Disability

Diagnosis of Intellectual Disability

Does the individual have an Intellectual Disability which is defined in G.L. c. 190B, §5-101(12) as a substantial limitation in present functioning beginning before age 18, manifested by significantly sub average intellectual functioning existing concurrently with related limitations in two or more of the following applicable skills area: communication, self-care, home living, social skills, community use, self-direction, health and safety, functioning academics, leisure and work.

◯ Yes ◯ No

List diagnosis and describe level of Intellectual Disability and impact on capacity to make informed decisions.

B. Other Relevant Diagnoses: (List other relevant physical or mental diagnoses that affect decision making ability.)

C. List all Medications that may influence ability to make informed decisions:

Name of medication/dosage/schedule	Describe any positive or negative influence of each medication on the individual's ability to make informed decisions

D. Factors believed to impede current capacity for decision-making.

Are there any factors that could make the individual appear confused but which could improve with time or treatment, such as delirium, acute medical illness, the interaction of multiple medications, hearing loss, vision loss, bereavement, etc.? If so, describe these factors and explain how functioning might improve:

3. INTRUSIVE TREATMENTS PRESCRIBED/PROPOSED

A. Antipsychotic Medications

☐ Check if the individual is prescribed any antipsychotic medications that may require a Rogers treatment plan.

In your opinion is the individual capable of giving informed consent to treatment with antipsychotic medication?

◯ Yes ◯ No

Explain:

B. Other Intrusive Interventions

☐ Check if other intrusive interventions and/or any extraordinary medical treatments are being proposed at this time, such as electroconvulsive therapy, Level III behavioral treatment plan, sterilization, amputation(s), removal of organ(s) and organ transplant(s).

If checked, describe the procedure or intervention being proposed:

In your opinion is the individual capable of giving informed consent to the proposed intervention?

◯ Yes ◯ No

Explain:

4. SOCIAL NETWORKS TO ASSIST IN DECISION MAKING

Does the individual have a social network that he or she utilizes to assist in decision making?

◯ Yes ◯ No

Explain:

5. RISK OF HARM TO SELF OR OTHERS

A. Nature of Risks. Describe any significant risks of physical or emotional harm to or exploitation of the individual:

B. How severe is risk of harm?

◯ Mild ◯ Substantial ◯ Life Threatening

C. How likely is risk of harm or exploitation?

◯ Almost Certain ◯ Probable ◯ Possible ◯ Unlikely

6. RECOMMENDATION ON GUARDIANSHIP/CONSERVATORSHIP

If seeking guardianship of the person, complete section 6.1. If seeking only a conservatorship, do not complete this section. Limited Guardianship is preferred by the court; describe how the guardianship may be limited. Describe how the assessment was performed and give specific examples.

6.1 GUARDIANSHIP: INABILITY TO MEET ESSENTIAL REQUIREMENTS FOR HEALTH, SAFETY, AND SELF CARE

A. Areas in which the individual is able to make informed decisions with respect to his or her adaptive skill areas including physical health, safety, and self-care:

Describe the individual's retained abilities and adaptive behavior for physical health, safety, self-care for which the guardianship may be limited (*e.g.*, ability to manage ADL's and IADL's such as health, hygiene, home, communication, driving, leisure, social; functioning in the community; ability to express treatment choices and make medical decisions; ability to complete any or some legal transactions).

B. Areas in which the individual is unable to make informed decisions with respect to his or her adaptive skill areas including physical health, safety, or self-care:

Describe the impairments in physical health, safety, and self-care for which the individual requires a Guardian.

C. If individual is unable to make any decisions for him or herself or is unable to make informed decisions with respect to physical health, safety, and self care (*i.e.* requires a full guardianship), describe why:

6.2 CONSERVATORSHIP: INABILITY TO MANAGE PROPERTY OR BUSINESS AFFAIRS EFFECTIVELY

If seeking a full or limited conservatorship of the person, complete section 6.2. Limited Conservatorship is preferred by the court.

A. Areas in which the individual is able to manage property or business affairs effectively:

What abilities can the individual retain in management of his or her property and estate (e.g., ability to manage allowance, bills, donations, investments, real estate, protect assets, resist fraud)?

B. Areas in which the individual is unable to manage property or business affairs effectively:

What are the impairments in the management of property and business affairs for which the individual requires a conservator? Describe how the person has property that will be wasted or dissipated unless management is provided or describe how protection is necessary to provide money for the support, care and welfare of the person or those entitled to the person's support.

C. If the individual is unable to make any decisions about, and is unable to manage, any property or business affairs effectively (*i.e.* requires full conservatorship), describe why:

7. ATTENDANCE AT HEARING

The individual is able to attend the court hearing.

◯ Yes ◯ No

Is it likely that it would be clinically or emotionally harmful for the individual to attend the court hearing?

◯ Yes ◯ No

Explain:

Describe the accommodations, if any, that are required to facilitate the individual's participation in the court hearing:

8. SIGNATURES OF CLINICIANS WHO COMPLETED THIS FORM

This document must be signed and dated by the 3 persons completing it. It does not need to be notarized. *

I hereby certify that the evaluation of this individual is within the scope of my professional competence based upon my education, training and experience. I further certify that this report is complete and accurate to the best of my information and belief.

_____ Date: _____
(SIGNATURE OF LICENSED PSYCHOLOGIST)

_____ _____
(Print name) (License type, number and date)

_____ _____ _____ _____ _____
(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Office Phone #: _____

_____ Date: _____
(SIGNATURE OF REGISTERED PHYSICIAN)

_____ _____
(Print name) (License type, number and date)

_____ _____ _____ _____ _____
(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Office Phone #: _____

_____ Date: _____
(SIGNATURE OF LICENSED SOCIAL WORKER)

_____ _____
(Print name) (License type, number and date)

_____ _____ _____ _____ _____
(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Office Phone #: _____

*** All Signatures must be originals but all signatures need not be on the same page.**

Court Required Duties as a Guardian of Incapacitated Persons

In order for your guardianship appointment to be finalized, the court must approve **both** a decree and a bond. Once approved, you are responsible to the court and to the Incapacitated Person as follows:

☐ **BEST INTEREST**

A Guardian acts in the Incapacitated Person's best interests and with consideration of the Incapacitated Person's expressed desires and personal values. A Guardian acts only as necessitated by the Incapacitated Person's limitations, encouraging him/her to the extent possible, to participate in decisions, act on his/her own behalf, and develop or regain capacity.

☐ **INITIAL GUARDIAN CARE PLAN REPORT**

An initial Guardian Care Plan Report (MPC 821) is due to be filed within sixty (60) days of the appointment of a Permanent Guardian.

☐ **ANNUAL GUARDIAN CARE PLAN REPORT**

An Annual Guardian Care Plan Report (MPC 821) is due to be filed every year on the anniversary of the Guardian's appointment. Failure to file this report could result in a hearing being scheduled requiring you to appear in court.

☐ **CHANGE OF ADDRESS OF THE INCAPACITATED PERSON OR GUARDIAN**

You must inform the court if the address of the Incapacitated Person changes or if your address changes.

☐ **DEATH OF INCAPACITATED PERSON**

Upon the death of the Incapacitated Person, you must file a copy of the death certificate or a suggestion of death with the court.

☐ **TERMINATION AS GUARDIAN**

If it is determined that the Incapacitated Person is no longer incapacitated, you must petition the court to terminate the guardianship (MPC 203). A medical certificate would be required indicating that the Incapacitated Person no longer has an incapacity.

☐ **RESIGNATION AS GUARDIAN**

You must file a Petition for Resignation (MPC 202) if you no longer wish to serve as Guardian.

Additionally:

☐ **CHANGE OF GUARDIAN'S AUTHORITY**

If the Incapacitated Person is in need of more treatment/services than was authorized by the original guardianship decree, you must file a petition with the court to expand your authority (MPC 220). There is a different form to use when seeking authority to place an Incapacitated Person in a nursing facility for a period of 60 days or less (MPC 829).

All forms required for filing are available at each division or on the Probate and Family Court website at www.mass.gov/courts