Tennessee Department of Children's Services

Conservatorship Request and Worksheet

Submit completed form to:

STATE OF TENNESSEE
DEPARTMENT OF CHILDREN'S SERVICES
OFFICE OF GENERAL COUNSEL
PHONE: (615) 741-7236 FAX: (615) 532-2348

INFORMATION ON PERSON COMPLETING THIS FORM AND REQUESTING REVIEW BY DCS LEGAL:

Date: ________________

Name: ______________________________ Title: ______________________________

Address: ______________________________ Office Phone: ( ) ______________

____

Zip Code: ______________________________ Fax: ______________________________

I REQUEST THE DCS OFFICE OF GENERAL COUNSEL TO REVIEW THE ENCLOSED INFORMATION AND DETERMINE WHETHER THERE ARE SUFFICIENT GROUNDS TO SUPPORT PURSUING A CONSERVATORSHIP.

____________________	____________________	____________________	____________________
SIGNATURE OF FSW	NAME OF FSW	COUNTY	REGION

NOTE: *IF DCS LEGAL DETERMINES THERE IS SUFFICIENT INFORMATION TO SUPPORT PURSUING A CONSERVATORSHIP AND FILES A PETITION, IT WILL BE NECESSARY FOR THE FSW TO ATTEND ALL COURT PROCEEDINGS.*

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THE FOLLOWING DOCUMENTS ARE ATTACHED TO THIS REQUEST:

☐ The medical or psychological report by the youth's treating physician or psychologist

☐ The signed and notarized consent to serve by the proposed conservator

☐ Background check results for the proposed conservator (see list of required checks in DCS Policy 19.10, Section C.)

List any other documents attached:

Total number of pages:

CHILD AND FAMILY TEAM MEMBERS WHO PARTICIPATED IN THE DECISION TO PURSUE A CONSERVATORSHIP FOR THIS YOUTH:

DATE OF CFTM:

	Title: FSW
	Title: Regional DCS Child Health Psychologist
	Title: Regional DCS Child Health Nurse
	Title:
	Title:
	Title:
	Title:
	Title:
	Title:
	Title:

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INFORMATION ON DISABLED YOUTH WHO WILL BE AGING OUT OF DCS CUSTODY:

Full Name:		SSN:		TFACTS ID:	
Primary Diagnosis:		DOB:			
Secondary Diagnosis:		Sex:	Male ☐	Female ☐	

Other disabling conditions:

Name and contact information for youth's physician or psychologist who prepared the report and affidavit in support of a conservatorship:

Name: ______________________ Phone: ______________________

WHERE DOES THE DISABLED YOUTH RESIDE? (Provide <u>complete</u> address and phone number):

If disabled youth resides in a facility, please complete the following:

Name of Facility:		Building Name:	
Phone # of Facility:	( )	County:	
Facility Director's Name:		Director's Phone:	( )
Facility Social Worker or Case Manager Name:		Phone Number:	( )

If disabled youth resides in a foster home, please complete the following:

Foster Home Address:		Foster Parent Name:	
Zip Code/County:		Foster Parent Phone:	

FOR NOTICE PURPOSES THE DISABLED YOUTH'S CLOSEST LIVING RELATIVES <u>MUST</u> BE LISTED.
Per the requirements from Tenn. Code Ann. § 34-3-104 (5): "The name, mailing address, and relationship of the closest relative or relatives of the **Respondent** and the name and mailing address of the person or institution, if any, having care and custody of the respondent or with whom the respondent is living. If the respondent has no then living spouse, child, parent or sibling, the petition shall so state and more remote relatives are not to be listed."

(Grandparents, aunts, uncles, and cousins do not need to be listed unless they are the closest living relative.)

1. Name: Address: _____
_____ Phone: ( )
Relationship to youth:

2.. Name: Address: _____
_____ Phone: ( )
Relationship to youth:

3. Name: Address: _____
_____ Phone: ( )
Relationship to youth:

4. Name: Address: _____
_____ Phone: ( )
Relationship to youth:

5. Name: Address: _____

_____ Phone: ( )

Relationship to youth:

6. Name: Address: _____

_____ Phone: ( )

Relationship to youth:

Has TPR been done? ☐ Yes ☐ No Date of TPR: _____

(*If you have names and addresses of additional family members, please attach a sheet with this form.)*

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PROPOSED CONSERVATOR(S) INFORMATION

Name: _____ SSN: _____

(Full Name)

DOB: _____

Mailing Address: _____ Relationship: _____

_____ Phone: ( )

_____ Work: ( )

If the proposed conservator is not the closest relative, explain why the closest relative is not recommended:

_____

_____

_____

PROPOSED STANDBY CONSERVATOR(S):

Name: _____ SSN: _____

(Full Name)

DOB: _____

Mailing Address: _____ Relationship: _____

_____ Phone: ( )

_____ Work: ( )

<u>If a specific person is not being recommended as the proposed conservator, please list all persons considered, contacted, and the reason they are not being recommended.</u>

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REMOVAL OF RIGHTS

Place a check by all the recommended <u>rights to be removed</u> from the disabled youth and entrusted to the Conservator:

☐	To acquire or dispose of property
☐	To make purchases above $ ____ .00
☐	To make purchases of any amount
☐	To execute instruments and/or contracts or enter into any other contractual relationship
☐	To give or withhold consent to medical and mental examinations, hospitalization, treatment and therapeutic or rehabilitative services or programs
☐	To make other health care decisions
☐	To give or withhold consent to custodial arrangements
☐	To file or pursue litigation in vindication of rights

DISABLED YOUTH'S FINANCIAL DATA

Monthly Income:	
Source of Income:	
Current Trust Account Balance:	
Any Other Assets:	

(If the youth has been awarded Victim's Compensations Funds, please include info re: where that money is being held for the youth; i.e. Juvenile Court Clerk address and case no.)