OFFICE OF GUARDIANSHIP SERVICES APPLICATION

The checklist below will help you identify ***required*** documents you need to submit with the attached application. Accurate contact information must be provided. If any changes occur after the application is submitted, contact our office. Failure to do so may result in the application being closed. **The person needing services MUST BE age 18 or older.**

Please print clearly. Illegible or incomplete applications will delay processing.
If you have questions or need assistance, please call (505) 841-4549.
Applications can be submitted in person or sent via:

Email: DDPCOOG.Intake@ddc.nm.gov
Fax: (505) 841-4455
U.S. Mail:
DDC-Office of Guardianship
Attn: Intake Coordinator
625 Silver Avenue SW, Suite 100
Albuquerque, NM 87102

YOU MUST SUBMIT ALL REQUIRED DOCUMENTS FOR THE INDIVIDUAL NEEDING GUARDIANSHIP
*****FAILURE TO SUBMIT REQUIRED DOCUMENTATION WILL RESULT IN A DELAY OF PROCESSING*****

(1) Identification
- ☐ Government Issued ID
- ☐ Social Security Card/Individual Taxpayer Identification Number

(2) Financial Documentation **(as applicable)**
- ☐ Current Federal Income Tax Return
- ☐ Social Security Income
- ☐ Food Stamps
- ☐ Pension Information
- ☐ Unemployment Compensation
- ☐ Other: ____________________
- ☐ Trust Information
- ☐ Child Support

(3) Legal Documentation **(as applicable)**
- ☐ Power of Attorney
- ☐ Surrogate Decision Maker
- ☐ Healthcare Directive
- ☐ N/A

(4) Report of Health Care Professional **(Part II Pages 1-7)**

YOU MUST SUBMIT THE REQUIRED DOCUMENTATION IF YOU ARE A FAMILY MEMBER/FRIEND AND YOU ARE APPLYING TO BE THE GUARDIAN
*****FAILURE TO SUBMIT REQUIRED DOCUMENTATION WILL RESULT IN A DELAY OF PROCESSING*****

If a family member or friend is able and willing to serve as guardian, that family member or friend is considered to be applying for Family Guardianship and **must provide** their financial information to determine eligibility.

(1) Identification
- ☐ Government Issued ID

(2) Financial Documentation **(as applicable)**
- ☐ Current Federal Income Tax Return
- ☐ Social Security Income
- ☐ Food Stamps
- ☐ Pension
- ☐ Unemployment Compensation
- ☐ Other: ____________________
- ☐ Trust Information
- ☐ Child Support

IF THERE IS AN EXISTING GUARDIANSHIP YOU MUST PROVIDE THE FOLLOWING DOCUMENTS
*****FAILURE TO SUBMIT REQUIRED DOCUMENTATION WILL RESULT IN A DELAY OF PROCESSING*****

If the request for services is for appointment of a successor guardian; termination of the guardianship; or review of the scope of a guardian's authority, the following documentation must be provided:

(1) Guardianship Legal Documents
- ☐ Guardianship Order
- ☐ Letters of Guardianship
- ☐ Acceptance Letters of Guardianship
- ☐ Last Two Years Guardian's Annual Report

OFFICIAL USE ONLY	DATE STAMP RECEIVED
Staff Reviewing: ________________ **Date of Determination:** ________________ ☐ **Eligible** ☐ **Ineligible** **Case ID#:** ________________ **Total Household #:** ________________ **Total Income: $**________________	

OFFICE OF GUARDIANSHIP SERVICES APPLICATION

SERVICE REQUEST:

☐ Professional Guardianship
☐ Family/Friend Guardianship
☐ Successor/Replacement Guardian
☐ Termination or Change in Level of Guardianship

CONTACT INFORMATION FOR THE PERSON REQUESTING THE GUARDIANSHIP

Legal Name: ____
First Name *MI* *Last Name*

______________________ ______________________
Agency/Facility Name (if applicable) *Title of Requestor (if applicable)*

Address: ____

____
City *State* *Zip Code*

Mailing Address: ____
(Only If Different from Above)

____
City *State* *Zip Code*

______________________ ______________________
Home & Cell Phone Numbers *Email Address*

______________________ ______________________
Relationship to Person Who May Need a Guardian *Prrimary Language of Requestor*

Has the person been informed you are applying to have a guardian appointed to make life decisions for them?
☐ Yes ☐ No
If "yes," describe their response. If "no," explain why:
____
____

Why do you believe this person needs a guardian?______________________________
____
____
____

revised 04/26/2023

There Are Many Alternatives to Guardianship. What Alternatives Have Been Attempted or Considered?

- ☐ Power of Attorney
- ☐ Medical Power of Attorney
- ☐ Financial Power of Attorney
- ☐ Treatment Guardian
- ☐ Health Care Advanced Directive
- ☐ Representative Payee
- ☐ Surrogate Decision Maker
- ☐ Fiduciary/Trustee
- ☐ Other: ________________

Please Visit www.nmddpc.com/guardianship_program to Learn About Alternatives to Guardianship

Why were these alternatives unsuccessful or not attempted?

____

____

____

____

INFORMATION ABOUT THE PERSON WHO MAY NEED A GUARDIAN

Legal Name: ____
First Name *MI* *Last Name*

Physical Address: ____

____
City *State* *Zip Code*

Mailing Address: ____

____
City *State* *Zip Code*

____
Phone Numbers

Marital Status: ☐ Single ☐ Married ☐ Significant Other ☐ Divorced ☐ Widowed

Gender: ____________________ Ethnicity: ____________________

Date of Birth: ____________________ Social Security Number: ________________________

Primary Language: ____________________ Are Interpreter Services Needed? ☐ Yes ☐ No

Current Living Arrangement:

- ☐ Lives Alone
- ☐ Boarding/Group Home
- ☐ Supported Living Provider
- ☐ Lives with Family/Supports
- ☐ Hospital
- ☐ Family Living Provider
- ☐ Tribal Land/Reservation
- ☐ Facility
- ☐ Other: ____________________
- ☐ Homeless
- ☐ Incarcerated

If the person is currently in a hospital/facility or is incarcerated please complete the following:

______________________________________ ______________________________________
Name of Hospital/Facility *Address City, State Zip*

______________________________________ ______________________________________
Contact Person with their title or position *Contact Person Phone Number & Email Address*

Describe How the Person Best Communicates: ____

____

Select All That Apply to The Person:

☐ Adult Protective Services referral ☐ Jackson Class Member ☐ Foley Settlement Party ☐ Veteran

Is the Person Currently Receiving or Waiting for Any of the Following Benefits?

☐ Central Registry/DD Waiver Waitlist ☐ State General Funds ☐ Case Management/Care Coordination
☐ DD Waiver ☐ Mi Via Waiver ☐ Self-Directed Community Benefit

MEDICAL/MENTAL HEALTH INFORMATION OF PERSON WHO MAY NEED A GUARDIAN

PRIMARY DIAGNOSES:

____

____

____

Health and Safety Risks For The Person Who May Need A Guardian. Select all that apply.

☐ Chronic Medical Condition(s) ☐ Refuses Medication ☐ Danger to Self
☐ Medically Fragile ☐ Refuses Medical Care ☐ Danger to Others
☐ Unable to Care for Self ☐ Substance Abuse ☐ Other: ________________
☐ Unsuitable Living Conditions ☐ Elopement/Flight Risk ☐ Financial Exploitation

For any risks checked, how are they currently being addressed?

____

____

____

PRIMARY CARE PHYSICIAN:

Physician's Name: ____

Mailing Address: ____

____
City *State* *Zip Code*

______________________ ______________________
Phone Number *Email Address*

DOES THE PERSON HAVE HEALTH INSURANCE?

☐ Institutional Medicaid ☐ Private Health Insurance: ____________________
☐ Medicaid MCO ☐ Other: ____________________
☐ Medicare ☐ None

INCOME ELIGIBILITY & FINANCIAL INFORMATION OF THE PERSON WHO MAY NEED A GUARDIAN

*****MUST PROIVDE INFORAMTION AND DOCUMENTATION WITH APPLICATION*****

Financial Source(s)	Monthly Amount	Financial Source(s)	Monthly Amount
☐ Retirement/Pension	**$**	☐ Trust	**$**
☐ SSDI	**$**	☐ Wages	**$**
☐ SSI	**$**	☐ Other Income	**$**

Total Monthly Income from All Sources (provide documentation): $ ________________

Does the Person Have A Bank Account? ☐ Yes ☐ No

Does the Person Own Real Property (e.g., House, Condo, Rental Property, Land)? ☐ Yes ☐ No

If checked "yes," provide the complete property address:

____

Address *City* *State* *Zip Code*

Does the Person Reside at the Property Listed Above? ☐ Yes ☐ No

SOCIAL SECURITY BENEFITS

Does the Person Have A Representative Payee Appointed by the Social Security Administration?

☐ No ☐ Yes ____

Name of Agency or Person Acting as Representative Payee

If "yes," Mailing Address: ____

____

City *State* *Zip Code*

_________________________________ _________________________________

Phone Number *Email Address*

VETERANS BENEFITS

If the Person Receives Veteran Benefits, Does the Person Have A Fiduciary Appointed by the Federal Department of Veterans Affairs?

☐ No ☐ Yes ____

Name of Agency or Person Acting as Fiduciary

If "yes," Mailing Address: ____

____

City *State* *Zip Code*

_________________________________ _________________________________

Phone Number *Email Address*

TRUSTS

Does the Person Have A Trust with A Trustee?

☐ No ☐ Yes ____

Name of Agency or Person Acting as Trustee

If "yes," Mailing Address: ____

____

City *State* *Zip Code*

_________________________________ _________________________________

Phone Number *Email Address*

NEW MEXICO LAW REQUIRES SPECIFIC PERSONS TO BE NOTIFIED OF A GUARDIANSHIP COURT CASE

The Parents of the Person Needing Guardianship
Both parents (either biological or adoptive) **MUST** be identified. If either parent has deceased please identify.

Mother's Name: ______________________________________Phone Number: ______________________________

Mailing Address: ____

____
City *State* *Zip Code*

Father's Name: ______________________________________Phone Number: ______________________________

Mailing Address: ____

____
City *State* *Zip Code*

Does the Person Have A Spouse Or Other Adult With Whom They Have Demonstrated A Commitment Similar To That Of A Marriage?

☐ No ☐ Yes ____
Name of Spouse or Partner

If "yes," Mailing Address: ____

____
City *State* *Zip Code*

____ ____
Phone Number *Email Address*

Does The Person Have Any Living Brothers Or Sisters Over 18 Years Old? (you must include all blood-related adult siblings, even if the person no longer interacts with them)

☐ No ☐ Yes If yes, how many? ______________________________

List the Names, Phone Numbers, & Mailing Addresses for Each Adult Sibling. If there are more than two siblings, you MUST attach a separate sheet with their names, phone numbers, and mailing addresses.

Sibling #1 Name: _____________________________________ Phone Number: ______________________________

Mailing Address: ____

____
City *State* *Zip Code*

____
Email Address

Sibling #2 Name: ______________________________________Phone Number:______________________________

Mailing Address: ____

____
City *State* *Zip Code*

____
Email Address

Does The Person Have Any Living Adult Children Or Stepchildren?

List the Names, Phone Numbers, & Mailing Addresses for each Adult Child. If there are more than two children, you **MUST** attach a separate sheet with their names, phone numbers, and mailing addresses.

Name of Adult Son/Daughter #1: ___________________________________Phone Number:___________________________

Address:____

____
City *State* *Zip Code*

Name of Adult Son/Daughter #2: ___________________________________Phone Number:___________________________

Address:____

____
City *State* *Zip Code*

If there are no living parents, adult children, or adult siblings, provide the closest blood relative who can be found (i.e., aunt, uncle, grandparent or cousin)

Name: ____ Relationship: _________________________________

Address:____

____
City *State* *Zip Code*

____ ____
Phone Number *Email Address*

Is There Any Person Known to Have Routinely Assisted the Person with Decision Making in The Past Six Months?

☐ No ☐ Yes ____
Name of Person and Relation

If "yes," Mailing Address: ____

____
City *State* *Zip Code*

____ ____
Phone Number *Email Address*

By signing below, I acknowledge that I have answered truthfully to the best of my ability. I understand that the Office of Guardianship reserves the right to grant services based on funding and resources available.

Printed Name: ____

Signature: ____ **Date:** ________________________

COMPLETE THIS SECTION IF YOU ARE APPLYING TO HAVE A FAMILY MEMBER, FRIEND, OR YOURSELF APPOINTED AS GUARDIAN
(skip this section if applying for a professional guardian)

PROPOSED GUARDIAN INFORMATION:

Legal Name: ____
First Name *MI* *Last Name*

Physical Address: ____

____
City *State* *Zip Code*

Mailing Address: ____
(Only If Different From Above)

____
City *State* *Zip Code*

____________________ ____________________
Phone Number *Email Address*

____________________ ____________________
Relationship to Person *Primary Language of Proposed Guardian*

ARE YOU SEEKING AN APPOINTMENT FOR A CO-GUARDIAN? (Financial Information must be submitted with this application)

☐ Yes (provide information below) ☐ No

Legal Name: ____
First Name *MI* *Last Name*

Physical Address: ____

____
City *State* *Zip Code*

Mailing Address: ____
(Only If Different From Above)

____
City *State* *Zip Code*

____________________ ____________________
Phone Number *Email Address*

____________________ ____________________
Relationship to Person *Primary Language of Proposed Guardian*

INCOME ELIGIBILITY OF PROPOSED NON-PROFESSIONAL GUARDIAN

*****IF YOU ARE APPLYING WITH A CO-GUARDIAN, GUARDIAN AND CO-GUARDIAN FINANCIAL INFORMATION MUST BE SUBMITTED WITH APPLICATION*****

New Mexico law requires that any non-professional, non-certified guardian be financially eligible for services through the Office of Guardianship.

How Many People Live in the Proposed Guardian's Home? _________________

What is the Total Monthly Household Income? (attach documentation): $ _________________

PRIMARY PROPOSED GUARDIAN SIGNATURE

By signing below, I acknowledge that I have answered truthfully to the best of my ability. I understand that the Office of Guardianship reserves the right to grant services based on funding and resources available.

Printed Name: _______________________________________

Signature: ____ **Date:** ______________________

CO-GUARDIAN SIGNATURE

By signing below, I acknowledge that I have answered truthfully to the best of my ability. I understand that the Office of Guardianship reserves the right to grant services based on funding and resources available.

Co-Guardian Printed Name: ____

Signature: ____ **Date:** ______________________

PART II

REPORT OF HEALTHCARE

MUST BE SUBMITTED WITH COMPLETED APPLICATION

STATE OF NEW MEXICO
COUNTY OF ________________

________________ JUDICIAL DISTRICT COURT

Case No. ________________

IN THE MATTER OF
THE ADULT GUARDIANSHIP PROCEEDING FOR _________________________,
A PERSON IN NEED OF PROTECTION.

REPORT OF HEALTH CARE PROFESSIONAL

HEALTH CARE PROFESSIONAL:

______________________________	______________________________
Health Care Professional's Name	*Qualifications (e.g., M.D., Ph.D., PA-C, RN, LMHC, etc.)*
______________________________	______________________________
Agency/Provider Name	*Alternative Contact Person and Title*

Address: ____

____
City *State* *Zip Code*

Mailing Address: ____
(Only If Different From Above)

____
City *State* *Zip Code*

______________________________	______________________________
Phone Number	*Email Address*

My Training and Experience Aids in the Assessment of Functional Impairment/Capacity: ☐ Yes ☐ No

I am Duly Authorized and Licensed in the State of New Mexico as a:

☐ Physician
☐ Physician Assistant
☐ Nurse Practitioner
☐ Psychologist
☐ Mental Health or Behavioral Health Care Professional: ____________________
☐ Other Health Care Professional: ____________________

PERSON WHO MAY NEED A GUARDIAN:

Legal Name: ____
First Name *MI* *Last Name*

Preferred Name (if applicable): ____
First Name *MI* *Last Name*

PERSON WHO MAY NEED A GUARDIAN CONT'D:

Gender: ______________________ DOB: _____/_____/________

Primary Language: ______________________ Ethnicity: ______________________

Health Care Professional's Date of Evaluation: _____/_____/________

The person is under my continuing treatment/care beginning on or about: _____/_____/________

Evaluation was Conducted at:

☐ Person's Residence ☐ Medical Facility ☐ Other: ______________________

Source of Information:

☐ Interview with the person
☐ Interview with collateral contact(s) (list names and dates):

____

____

☐ Records reviewed (e.g., medical, legal, financial) (list document and date, if possible):

____

____

EVALUATION OF THE PERSON'S PHYSICAL CONDITION

PHYSICAL DIAGNOSES:

____

____

____

Prognosis:

____

____

____

Treatment/Medical History (e.g., hospitalizations, surgeries, comprehensive testing):

____

____

____

PERSON'S PHYSICAL CONDITION CONT'D

The person's physical health affects their ability to make or communicate decisions. ☐ Yes ☐ No

If you checked "yes," to what extent is improvement of the condition(s) likely and after what period should the person be re-evaluated to determine whether a guardianship continues to be necessary?

____

____

____

____

EVALUATION OF THE PERSON'S MENTAL AND BEHAVIORAL HEALTH FUNCTIONING

MENTAL AND BEHAVIORAL HEALTH DIAGNOSES:

____

____

____

Prognosis:

____

____

____

Treatment/Medical History (e.g., hospitalizations, in/out patient treatment, comprehensive testing):

____

____

____

The person's mental and behavioral health affects their ability to make or communicate decisions. ☐ Yes ☐ No

If you checked "yes," to what extent is improvement of the condition(s) likely and after what period should the person be re-evaluated to determine whether a guardianship remains necessary?

____

____

____

____

COGNITIVE STATUS

A Mental Status Examination or similar test was conducted (if yes, attach copy). ☐ Yes ☐ No

The Person is Oriented to the Following (check all that apply):

☐ Person ☐ Time ☐ Place ☐ Situation

The Person Demonstrates Cognitive Impairment in the Following Areas (check all that apply):

☐ Attention and Information Processing
☐ Memory (e.g. difficulty tracking a conversation, tangential associations, repeating questions throughout an interview, difficulty learning or retaining and recognizing new information)
☐ Communication and Understanding (Verbally or Otherwise)
☐ Recognizing Familiar Objects and Persons
☐ Planning, Initiating, and Self-Monitoring Problem-Solving Responses
☐ Logical Reasoning
☐ Grasping Abstract Aspects of Their Situation
☐ Identifying and Self-Correcting Errors
☐ Breaking Down Complex Tasks into Simple Steps and Carrying Them Out
☐ Self-Regulating Mood and Behavior
☐ Loss of Insight and Self-Awareness

Please explain further, if the person's cognitive status indicated above (if any) varies substantially in frequency, severity, or duration:

____

____

____

____

____

ABILITY TO MAKE OR COMMUNICATE DECISIONS

Can the Person Initiate, Make and Communicate Decisions in Regard to the Following:

Complex Business and Financial Decisions	☐ Yes	☐ No	☐ Unknown
Engage in Estate Planning	☐ Yes	☐ No	☐ Unknown
Personal Bank Account Management	☐ Yes	☐ No	☐ Unknown
Designate Power of Attorney	☐ Yes	☐ No	☐ Unknown
Safe Operation of a Motor Vehicle	☐ Yes	☐ No	☐ Unknown
Determination of Residence	☐ Yes	☐ No	☐ Unknown
Administration of Medications as Prescribed	☐ Yes	☐ No	☐ Unknown
Informed Consent	☐ Yes	☐ No	☐ Unknown
Consideration of Provider's Instructions/Recommendations	☐ Yes	☐ No	☐ Unknown
Consent to Medical and Dental Treatment	☐ Yes	☐ No	☐ Unknown
Consent to Psychological and Psychiatric Treatment	☐ Yes	☐ No	☐ Unknown

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs):

Mark all that apply: The person can complete the following IADLs without assistance, with assistance, needs total assistance, or unknown.

IADLs	w/o Assistance	w/Assistance	Total Assistance	Unknown
Routine Bill Paying				
Investing/Handling Large Sums of Money				
Accessing Emergency Response				
Choosing/Planning Enjoyable Activities				
Cleaning/Housework				
Laundry				
Arranging Transportation or Driving Self				
Shopping				
Meal Preparation/Cooking				
Arranging/Directing Own Care Services				
Arranging Medical Appointments				
Following Health Care Provider's Recommendations				
Administering Own Medication as Prescribed				

ACTIVITIES OF DAILY LIVING (ADLs):

Mark all that apply: The person can complete the following ADLs without assistance, with assistance, needs total assistance, or unknown.

ADLs	w/o Assistance	w/Assistance	Total Assistance	Unknown
Bathing				
Toileting				
Oral Care				
Eating/Drinking				
Grooming/Shaving				
Dressing/Undressing				
Ambulating				

Additional Comments/Observations:

____

____

____

____

____

RECOMMENDED CARE AND LIVING ARRANGEMENTS

Does the person have a neurocognitive disorder?	☐ Yes	☐ No
Do you recommend the person be transferred to a long-term care facility that specializes in memory/dementia care?	☐ Yes	☐ No
Do you recommend the person is administered medications appropriate for the care and treatment of neurocognitive disorders?	☐ Yes	☐ No
Does the person have a developmental disability?	☐ Yes	☐ No
Is the person receiving services through the Developmental Disabilities Waiver?	☐ Yes	☐ No
If not already receiving services through the Developmental Disabilities Waiver, do you recommend the person apply?	☐ Yes	☐ No
Does the person have a psychiatric or behavioral health diagnosis?	☐ Yes	☐ No
Is the person likely to require treatment for their psychiatric condition?	☐ Yes	☐ No
Is the person likely to require a mental health treatment guardian?	☐ Yes	☐ No
Is chronic substance abuse a primary concern?	☐ Yes	☐ No
Is the person experiencing homelessness?	☐ Yes	☐ No
Does the person require caregiver monitoring and/or assistance?	☐ Yes	☐ No
Is the person able to live at home with support, supervision or monitoring?	☐ Yes	☐ No
Do you recommend the person be transferred to an assisted living, long-term care, or rehabilitation facility?	☐ Yes	☐ No
Does the person currently have sufficient capacity to give informed consent to the administration of medications?	☐ Yes	☐ No

EVALUATION OF CAPACITY

Based upon my Observations and Evaluation it is my Opinion that the Person is Incapacitated in the Following Specific Areas of Decision-Making:

Financial Decisions ----------------------------	☐ Retains Full Capacity	☐ Partially Incapacitated	☐ Incapacitated
Healthcare Decisions --------------------------	☐ Retains Full Capacity	☐ Partially Incapacitated	☐ Incapacitated
Mental Healthcare Decisions ----------------	☐ Retains Full Capacity	☐ Partially Incapacitated	☐ Incapacitated
Independent Living ----------------------------	☐ Retains Full Capacity	☐ Partially Incapacitated	☐ Incapacitated
Other (Please Specify Below) ---------------	☐ Retains Full Capacity	☐ Partially Incapacitated	☐ Incapacitated

Additional Comments/Observations:

____

____

____

Indicate the Level of Incapacity Below:

☐ **RETAINS FULL CAPACITY**
The person is not incapacitated and is able to make reasonable arrangements for their care and safety as well as for their personal and financial matters.

☐ **PARTIALLY INCAPACITATED**
The person lacks the capacity to do some, but not all, of the tasks necessary to care for them self or to manage their property.

☐ **TOTALLY INCAPACITATED**
The person is totally without capacity (1) to care for them self and (2) to manage their property.

EVIDENCE OF ABUSE, NEGLECT, OR EXPLOITATION

Do you have any concern that this person might be vulnerable to abuse, neglect, or exploitation? ☐ Yes ☐ No

If checked "yes," please explain:

____

____

____

ABILITY TO ATTEND COURT HEARING

Are there safety concerns preventing the person from attending and participating in the court hearing for guardianship? ☐ Yes ☐ No

Does a current medication or medical treatment affect the person's ability to participate fully (and safely) in the court hearing for guardianship? ☐ Yes ☐ No

If you checked "yes," to the last question, please explain:

____

____

____

ADDITIONAL INFORMATION OF BENEFIT TO THE COURT

I have attached additional information or concerns that is not included above, that may assist the court in resolving the issue of capacity of the person. ☐ Yes ☐ No

---

By signing below, I acknowledge that I have answered truthfully to the best of my ability. My medical opinions and recommendations are supported by observation, medical records, social history, assessments and reports.

Printed Name & Credentials: ________________________________

Signature: ________________________________ **Date:** ____________________

APPENDIX – REPORT OF HEALTH CARE PROFESSIONAL

Pursuant to the New Mexico Uniform Probate Code, **NMSA 1978, § 45-5-303(E):**

The person alleged to be incapacitated shall be examined by a qualified health care professional appointed by the court who shall submit a report in writing to the court.

The report shall:

(1) describe the nature and degree of the alleged incapacitated person's incapacity, if any, and the level of the alleged incapacitated person's intellectual, developmental and social functioning; and

(2) contain observations, with supporting data, regarding the alleged incapacitated person's ability to make health care decisions and manage the activities of daily living.

For purposes of this evaluation, pursuant to the New Mexico Uniform Probate Code, **NMSA1978, § 45-5-101,** the following definitions apply:

Functional Impairment means "an impairment that is measured by a person's inability to manage the person's personal care or the person's inability to manage the person's estate or financial affairs or both."

Incapacitated Person means "any person who demonstrates over time either partial or complete functional impairment by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication or other causes, except minority, to the extent that the person is unable to manage [their] personal affairs or the person is unable to manage [their] estate or financial affairs or both."

Inability to Manage the Person's Personal Care means "the inability, as evidenced by recent behavior, to meet one's needs for medical care, nutrition, clothing, shelter, hygiene or safety so that physical injury, illness or disease has occurred or is likely to occur in the near future."

Inability to Manage the Person's Estate or Financial Affairs or Both means "gross mismanagement, as evidenced by recent behavior, of one's income and resources or medical inability to manage one's income and resources that has led or is likely in the near future to lead to financial vulnerability."