



**PETITION TO DETERMINE  
IF DISABLED**

Case No. \_\_\_\_\_  
Court \_\_\_\_\_ District \_\_\_\_\_  
County \_\_\_\_\_  
Division \_\_\_\_\_

COMMONWEALTH OF KENTUCKY  
VS.

PETITIONER

RESPONDENT

\_\_\_\_\_ has reasonable grounds or knowledge to lead him/her to believe Respondent appears to be unable to provide for his/her physical health and safety and/or manage his/her financial resources effectively and submits to the Court the following facts upon which he/she supports this belief:

1. Name of Petitioner: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Petitioner's relationship to Respondent: \_\_\_\_\_

2. Name of Respondent: \_\_\_\_\_

Address: \_\_\_\_\_

Respondent's Date of Birth (if known): \_\_\_\_\_

3. The nature of Respondent's disability and the facts or reasons supporting the need for determination of disability are:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Respondent owns the following estate, including government benefits, insurance entitlements, and anticipated yearly income (state none or unknown):

<b><u>ESTATE</u></b>	<b><u>VALUE</u></b>
Real Property	\$ _____
Personal Property	\$ _____
Yearly Income	\$ _____
Source of Yearly Income	_____

5. Name of Person having custody of Respondent: \_\_\_\_\_

Address: \_\_\_\_\_

6. Respondent's  Durable Power of Attorney OR  Health Care Surrogate is:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

7. Respondent's next of kin:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Respondent: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Respondent: \_\_\_\_\_

**WHEREFORE**, Petitioner requests the Court inquire into Respondent's ability to care for himself/herself and to manage his/her financial resources. Petitioner attaches an **Application for Appointment of Fiduciary and further requests:**

1. Trial by jury;
2. Counsel to represent the Respondent; and
3. Court appointment of a physician, psychologist and social worker to evaluate Respondent as provided by law unless the evaluation report is filed with this Petition.

\_\_\_\_\_, 2\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Petitioner**

SUBSCRIBED and SWORN to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

My Commission expires:\_\_\_\_\_.

\_\_\_\_\_  
County, Kentucky

\_\_\_\_\_  
Name/Title

To be completed if Applicant is represented by counsel:

**Attorney's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

\_\_\_\_\_  
**Attorney Signature**