



Person's Name (First MI Last):		Record #:	
Organization Name:			
Legal Status Addendum			
Rep Payee: <input type="checkbox"/> No <input type="checkbox"/> Yes		Phone #:	
Name/Agency:			
Relationship to Person:			
Legal Guardian: <input type="checkbox"/> No <input type="checkbox"/> Yes		Phone #:	
Name:			
Relationship to Person:			
Type: <input type="checkbox"/> Full Guardianship <input type="checkbox"/> Roger's Guardian <input type="checkbox"/> Medical Guardian			
<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary (Explain):			
Conservatorship: <input type="checkbox"/> No <input type="checkbox"/> Yes		Phone #:	
Name/Agency:			
Relationship to Person:			
Provider - Print Name/Credential:	Date:	Supervisor - Print Name/Credential (if needed):	Date:
Provider Signature:	Date:	Supervisor Signature (if needed):	Date:
Person's Signature (Optional, if clinically appropriate):	Date:	Parent/Guardian Signature (If appropriate):	Date: