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This program is approved by the Judicial District 17 VASIA Probate Courts as a "volunteer advocates for seniors and incapacitated adults" (VASIA) program under Indiana Code 29-3-8.5.

Recognizing the sensitivity of adult guardianship as a legal concept, each VASIA program shall ensure that guardianship is only sought as a "last resort" support for the protected persons served by the program. If any program has reason to believe that an individual served does not require a legal guardianship and/or meet the definition of "legal incapacity" required for a guardianship, they shall take proactive measures to ensure that other alternative supports are pursued and/or that the guardianship is terminated.

Indiana is a mandatory report state, meaning everyone is required by law to report cases of suspected neglect, battery or exploitation of an endangered adult to an Adult Protective Services Unit. **You must file both an APS report and a police report before submitting a referral.**  
**APS Phone: 1-800-992-6978      Online: APS Reporting Portal: <https://inaps.in.gov/>**

The following criteria are used in evaluating referrals for acceptance to the VASIA Program:

Incapacitated adults (18+) must reside in a nursing facility in Johnson County or Shelby County;  
Determined by their physician to require 24/7 professional supervised care services capable of being paid for through insurance or government benefit programs, whether or not such insurance or government programs have yet been applied for;  
Determined by a licensed physician to be mentally or medically incapacitated and unable to make decisions for themselves;  
Without a willing, able, or suitable relative or other significant person to serve as a guardian or decision maker and;  
Determined by the Judicial District 17 VASIA Probate Courts to require a guardian.

**Completed referrals will include:**

Referrals will not be filed with the court until all documents are submitted via email and family is notified regarding VASIA Guardianship. Emergency Guardianships are not accepted.

1. Completed Referral Packet - **Typed submissions required**
2. Signed Physician's Report - **Typed submissions required**
3. Facesheet
4. Resident Inventory
5. Medication List
6. History & Physical
7. Therapy Evaluations
8. Neuropsychiatric Testing
9. Quarterly Resident Trust Statements
10. Financial Statements from Social Security, Pensions, Veteran Affairs, Life Insurance, Banks, etc.
11. Apply for Medicaid - **Provide Proof**
12. Representative Payee for all income - **Provide Proof**
13. Funeral Arrangements – **Provide funeral and burial documents**

All direct care staff assigned to the adult subject of this proceeding are hereby required to appear and testify at the scheduled hearing. Hearings shall be conducted in person unless the Court grants prior approval for a remote (Zoom) appearance.

**You are further directed to submit the full names, titles, email addresses, and direct telephone numbers of all staff members who will attend the hearing.** Only one representative from each department is required. Failure to comply with this notice will result in the suspension of the referral process and termination of the guardianship hearing.

1. Business Office:
2. Social Services:
3. Nursing:

**VASIA FAMILY NOTIFICATION AND ATTESTATION**

As part of the referral process, a standardized notification letter will be included in the referral packet for distribution to the adult's family or identified interested parties. Nursing facility staff will be required to send this letter prior to initiating a VASIA referral. The purpose of this notification is to inform family members that a referral for guardianship services is being considered and to provide an opportunity for a willing and appropriate individual to step forward before a third-party guardian is appointed.

**VASIA will implement a \$750 non-refundable administrative fee for guardianship referrals in which:**

**VASIA has initiated guardianship services; and another individual or entity is appointed guardian instead of VASIA at or prior to the final hearing.**

To ensure accountability and compliance, the staff member responsible for sending the notification must sign and attest that the letter has been distributed in accordance with this requirement. This attestation will be included as part of the guardianship petition.

Resident Name:

Facility Name:

Date Sent:

Facility Contact:

Phone:

Response Deadline:

You are receiving this notice because you have been identified as a family member or interested party. The facility is considering a referral to the VASIA program for possible guardianship due to concerns regarding the adult's ability to make decisions independently.

Guardianship is a significant legal action and is considered a last resort, pursued only when less restrictive alternatives or appropriate decision-makers are not available.

Before proceeding with a referral, we are providing notice to determine whether there is a willing, able, and suitable individual who can:

- Serve as guardian, or
- Assist with decision-making through less restrictive alternatives (power of attorney, healthcare representative, or other supports)

**If you are interested in serving in this role or wish to discuss alternatives, you must contact the facility within 10 business days of this notice.**

If no appropriate individual is identified within this time-frame, the facility may proceed with a VASIA referral and potential court petition for guardianship.

I certify that notification was sent to all known parties.

Staff Name:

Staff Position:

Signature:

Date:

**NOTIFICATION TRACKING LOG**

**Name / Relationship / Method / Response:**

**Response Date:**

1.

2.

3.

4.

5.

**VASIA Adult Guardianship Referral**  
**Typed submissions required**

Client Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Referring Agency: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**General Information**

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

Status of Home: Own    Rent \_\_\_\_\_    Living Alone? Yes    No    \_\_\_\_\_

Marital Status: Married    Divorced    Separated    Never Married    Widowed    \_\_\_\_\_

Nursing Facility: \_\_\_\_\_ Date of Admission: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Medicare #: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_ Medicaid Case #: \_\_\_\_\_

Describe the client's ability to communicate: \_\_\_\_\_

\_\_\_\_\_

**Medical Information**

Physician's Name and Phone #: \_\_\_\_\_

Psychiatrist's Name and Phone #: \_\_\_\_\_

Dentist's Name and Phone #: \_\_\_\_\_

Optometrist's Name and Phone #: \_\_\_\_\_

Current Diagnosis (Please attach current History and Physical report): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Advance Directives: Full Code    No Code    Living Will    \_\_\_\_\_

Any immediate health care concerns? Explain: \_\_\_\_\_

\_\_\_\_\_

## Personal Contacts

Please list any and all family members:

Name	Relationship	Address	Phone #	Level of Involvement
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Please list any involved friends:

Name	Address	Phone #	Level of Involvement
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## Spouse Information

Spouse's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Current status: \_\_\_Divorced (Date): \_\_\_\_\_ Deceased (Date): \_\_\_\_\_

Spouse's Date of Birth: \_\_\_\_\_

Military Service: Yes \_\_\_ No \_\_\_ Branch: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Former Spouse(s): \_\_\_\_\_

## Legal Information

Does this person currently have any form of advocate? (Power of Attorney, Healthcare Representative, Representative Payee, Guardian?) Yes \_\_\_ No \_\_\_

(Please list or include copies of any documentation pertaining to this.) \_\_\_\_\_

Does the client have a will? Yes \_\_\_ No \_\_\_ Name of will holder: \_\_\_\_\_

Any pending legal action? Yes \_\_\_ No \_\_\_ Please describe: \_\_\_\_\_

## Life Insurance

Life Insurance: Yes \_\_\_ No \_\_\_ Company Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Type of Insurance: Whole Life \_\_\_ Term Life \_\_\_ Paid in full? Yes \_\_\_ No \_\_\_

Name of Beneficiary: \_\_\_\_\_ Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

## Health Insurance

Medicare: Yes \_\_\_ No \_\_\_ Type: Part A Part B Part D \_\_\_

Medicare Part D Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_

Medicare Replacement Insurance: Yes \_\_\_ No \_\_\_

Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_

Medicaid: Yes \_\_\_ No \_\_\_ RID #: \_\_\_\_\_

Caseworker's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Other Health Insurance: Yes \_\_\_ No \_\_\_ Company Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

## Financial Information

Monthly Income: (ex: SSA, SSI, SSDI, Pension, etc.)

Amount: \_\_\_\_\_ Source: \_\_\_\_\_

Amount: \_\_\_\_\_ Source: \_\_\_\_\_

Amount: \_\_\_\_\_ Source: \_\_\_\_\_

Bank Account: Yes \_\_\_ No \_\_\_ Name of Bank: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Checking Account: Yes \_\_\_ No \_\_\_ Account #: \_\_\_\_\_

Savings Account: Yes \_\_\_ No \_\_\_ Account #: \_\_\_\_\_

Resident Account: Yes \_\_\_ No \_\_\_ Account #: \_\_\_\_\_

Other (list): \_\_\_\_\_ Relevant Info: \_\_\_\_\_

Other (list): \_\_\_\_\_ Relevant Info: \_\_\_\_\_

Current Debts and Creditors:

Rent: \$ \_\_\_\_\_ Mortgage: \$ \_\_\_\_\_ Utilities: \$ \_\_\_\_\_

Loans: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_

Credit Cards: \$ \_\_\_\_\_ Credit Card Company(s): \_\_\_\_\_

## Real Estate

Please complete this section only if the client owns real estate

Address of Property: \_\_\_\_\_

Property Type: House \_\_\_ Mobile Home \_\_\_ Other \_\_\_

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

Mortgage Type: Traditional \_\_\_ Reverse \_\_\_ Balloon \_\_\_

Mortgage Paid in Full? Yes \_\_\_ No \_\_\_ Total Owed \$ \_\_\_\_\_ Monthly Payment: \$ \_\_\_\_\_

Mortgage Company Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Years Owned: \_\_\_\_\_ Are there any liens against the property? Yes \_\_\_ No \_\_\_

Lien Holder: \_\_\_\_\_ Amount Owed \$ \_\_\_\_\_

Are taxes current? Yes \_\_\_ No \_\_\_ Back Taxes Owed: \$ \_\_\_\_\_

## Funeral/Burial Arrangements

Funeral Home: \_\_\_\_\_ Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Pre-Paid Plan or Trust: Yes \_\_\_ No \_\_\_ Paid in full \_\_\_ Amount Owed: \$ \_\_\_\_\_

Company Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Burial \_\_\_ Cremation \_\_\_ Cemetery Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Own Plot? Yes \_\_\_ No \_\_\_ Paid in full \_\_\_ Amount Owed: \$ \_\_\_\_\_

Location of Plot: \_\_\_\_\_

Own Vault? Yes \_\_\_ No \_\_\_ Paid in Full? Yes \_\_\_ No \_\_\_ Amount Owed: \$ \_\_\_\_\_

Own Headstone? Yes \_\_\_ No \_\_\_ Paid in Full? Yes \_\_\_ No \_\_\_ Amount Owed: \$ \_\_\_\_\_

Own Marker? Yes \_\_\_ No \_\_\_ Paid in Full? Yes \_\_\_ No \_\_\_ Amount Owed: \$ \_\_\_\_\_

**PHYSICIAN'S REPORT**

COUNTY OF JOHNSON	SUPERIOR COURT II	CAUSE NO. 41D02 -	- GU -
COUNTY OF SHELBY	CIRCUIT COURT	CAUSE NO. 73C01 -	- GU -
COUNTY OF HANCOCK	CIRCUIT COURT	CAUSE NO. 30C01 -	- GU -

IN THE MATTER OF THE GUARDIANSHIP OF

1. General Information

Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Office Address \_\_\_\_\_  
\_\_\_\_\_

What is your License/Certification? \_\_\_\_\_

What is your area of specialty? \_\_\_\_\_

I last examined the Person on: \_\_\_\_\_, 20\_\_\_\_

The Person is under my continuing treatment.

- YES, since \_\_\_\_\_, 20\_\_\_\_
- NO

2. Evaluation of the Person's Physical Condition

Physical Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Severity:     Mild             Moderate             Severe

Prognosis:    Continuing             Degenerative             Recovering    Relapsing

Treatment/Medical History/Additional Comments (attach additional pages, if necessary):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Evaluation of the Person's Mental Functioning

The Person is oriented to the following (check all that apply):

- Person                       Time                       Place                       Situation

Do you have concerns about the Person's functioning in the following areas? (check all that apply)

YES	NO	UNKNOWN	FUNCTION
			Short-term memory
			Long-term memory
			Immediate recall
			Understanding and communicating (verbally or otherwise)
			Recognizing familiar objects and persons
			Solving problems
			Reasoning logically
			Grasping abstract aspects of his or her situation
			Interpreting idiomatic expressions or proverbs
			Breaking down complex tasks into simple steps and carrying them out

Mental Diagnosis: \_\_\_\_\_

Severity:     Mild                       Moderate                       Severe  
 Prognosis:     Continuing                       Degenerative                       Recovering                       Relapsing

Treatment/Medical History/Additional Comments:  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Medication Information

YES  NO Is the Person currently taking medication related to Person's physical or mental functioning as reported in sections 2 and 3? If "YES," please list:

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

Additional Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



## 5. Decision-Making

Is the Person able to make decisions regarding the following?

YES	WITH SUPPORT	NO	UNKNOWN	ACTION/DECISION
				Make complex business, managerial, and/or financial decisions.
				Manage a personal bank account.  If "YES," or "WITH SUPPORT," should amount deposited in any such bank account be limited? <input type="checkbox"/> YES <input type="checkbox"/> NO
				Pay his or her own bills.
				Safely operate a motor vehicle.
				Make decisions regarding marriage.
				Determine the Person's own residence.
				Live alone.
				Obtain food.
				Administer own medications daily.
				Attend to basic activities of daily living (ADLs) (e.g., bathing, grooming, dressing, walking, and/or toileting) with/out services.
				Attend to instrumental activities of daily living (e.g., shopping, cooking, traveling, and/or cleaning).
				Make appropriate judgments that will protect them personally, physically, and/or financially.
				Consent to medical and dental treatment.
				Consent to psychological and/or psychiatric treatment.

Additional Comments:

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**“Incapacitated person”** means an individual who:

- (1) cannot be located upon reasonable inquiry;
- (2) is unable:
  - (A) to manage in whole or in part the individual's property;
  - (B) to provide self-care; **or**
  - (C) both;because of insanity, mental illness, mental deficiency, physical illness, infirmity, habitual drunkenness, excessive use of drugs, incarceration, confinement, detention, duress, fraud, undue influence of others on the individual, or other incapacity; or
- (3) has a developmental disability (as defined in [IC § 12-7-2-61](#) ).

Ind. Code § 29-3-1-7.5

(a) **“Less restrictive alternatives”** means an approach to meeting a person's needs that restricts fewer rights of the person than would the appointment of the guardian.

(b) **“Less restrictive alternatives”** may include, but are not limited to, the following:

- (1) A supported decision making agreement (as defined in IC § 29-3-14-2).
- (2) Appropriate technological assistance.
- (3) The appointment of a representative payee.
- (4) The appointment of a health care representative (as defined in IC § 16-36-1-2).
- (5) The creation of a power of attorney (as defined in IC § 30-5-2-7).

Ind. Code § 29-3-1-7.8

## 6. Evaluation of Less Restrictive Alternatives

According to the definition in Ind. Code § 29-3-1-7.8 and based upon your last examination and observations of the Person, in your opinion, the following less restrictive alternatives could be considered or implemented:

YES	NO	UNKNOWN	LESS RESTRICTIVE ALTERNATIVE
			Supported decision making agreement
			Appropriate technological assistance
			Representative payee
			Health care representative
			Power of attorney
			Other _____

7. Evaluation of Capacity

According to the definition in Ind. Code § 29-3-1-7.5 and based upon your last examination and observations of the Person, in your opinion, the Person is:

- Not incapacitated
- Not incapacitated with use of the following less restrictive alternative:

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- Partially incapacitated
  - Personal      OR       Financial
- Totally incapacitated

Additional Comments:

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8. Recommendation of Living Arrangement

In your opinion, what is the least restrictive living arrangement that you consider appropriate for the Person?

- At home/at home with services
- Facility based residence
- Community based residence
- Hospital based residence

Additional Comments:

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9. Ability to Attend Court Hearing

- YES      There is no significant threat to the Person’s health and/or safety that would prevent them from attending the court hearing.
- NO      There is a significant threat to the Person’s health and/or safety that would prevent them from attending the court hearing.
- YES      Appear via Zoom held by the court.

10. Additional Information of Benefit to the Court

Please provide any additional information that would benefit the court (attach additional pages, if necessary).

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11. Additional Professional Evaluations

If the descriptions of the Person's condition or skills is based on evaluations or assistance by other professionals, please provide the names and contact information of those professionals who are able to provide additional information or evaluations.

Professional's Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Office Address or E-mail \_\_\_\_\_

Professional's Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Office Address or E-mail \_\_\_\_\_

I affirm under the penalties for perjury that the foregoing representations are true.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name Printed  
\_\_\_\_\_

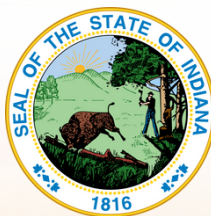


## **ALTERNATIVES TO VASIA**

### **INSTRUCTIONS TO PETITION GUARDIANSHIP**

#### **SUPERIOR COURT 2 / JOHNSON COUNTY, INDIANA**

- <https://co.johnson.in.us/egov/apps/document/center.egov?view=item&id=4263>
- All forms included in this form packet are required to file your guardianship case with the court. However, Johnson County may require you to file additional forms.
- You must file the documents at the courthouse in the county in which the adult resides in, or e-file the documents. If you want to file your paper documents at the courthouse, you will need to print them when you have finished filling them out. You can review the information about how to file your forms with the court in person at this link: <https://indianalegalhelp.org/how-to-file-forms-with-the-court-in-person/>
- If you choose to e-file, instead of filing in person, make sure you review the information at this link: <https://indianalegalhelp.org/how-to-electronically-file-forms-with-the-court/>
- There is a filing fee. Contact your local county clerk's office to find out what the filing fee is at this link: <https://www.in.gov/courts/files/court-directory.pdf>.
- The Clerk's Office can accept the adult guardianship packet via email at [guardianships@co.johnson.in.us](mailto:guardianships@co.johnson.in.us).
- To pay the \$177.00 guardianship filing fee, please call 317-346-4450.
- You might qualify for a fee waiver. You can learn more about filing for a fee waiver here: <https://indianalegalhelp.org/filing-fee-frequently-asked-questions/>



**GUARDIANS ARE SUBJECT TO THE FOLLOWING REQUIREMENTS FOR REPORTING AND ACCOUNTING:**

**Guardianship of the Person Report:** A guardian must file a report with the court at least every two (2) years, or as otherwise ordered by the court. I.C. 29-3-8-1 and I.C. 29-3-9-6. The report shall state the protected person's residence and contain a statement of his or her current welfare and general condition, along with whether the need for guardianship still exists, and whether any less restrictive alternatives have been considered or implemented. I.C. 29-3-9-6(c). **DUE DATE:** \_\_\_\_\_

**Guardianship of the Estate Inventory:** A temporary guardian shall file an Inventory of the property subject to the guardian's control within thirty (30) days after appointment. A permanent guardian shall file an Inventory within ninety (90) days after appointment. I.C. 29-3-9-5. **DUE DATE:** \_\_\_\_\_

**Current Accounting:** A permanent guardian shall file with the court, at least biennially (or as otherwise ordered by the court), and not more than thirty (30) days after the anniversary of appointment, a written verified account of the guardian's administration. I.C. 29-3-9-6. Each accounting shall follow the three-schedule format set forth in I.C. 29-1-16-4. **DUE DATE:** \_\_\_\_\_

**Final Accounting:** A temporary or permanent guardian shall file with the court, not more than thirty (30) days after termination of the appointment, a written verified account of the guardian's administration. I.C. 29-3-9-6. Each accounting shall follow the three-schedule format set forth in I.C. 29-1-16-4.

**DUE DATE:** \_\_\_\_\_

- A guardianship case may be terminated after a guardianship has been established by the court. A case is closed once it is terminated.
- A guardianship case may be terminated in the following situations: when the minor attains the age of 18, has died, or custody has been restored to a natural parent. I.C. 29-3-12-1(a);
- When a guardianship terminates the powers of the guardian cease. The guardian may continue to fulfill accounting and administration obligations as approved by the court. I.C. 29-3-12(d) and (e).
- Upon the death of the protected person, the guardian may do the following: control the disposition of the deceased protected person's body, make anatomical gifts, request an autopsy, make funeral or ceremonial arrangements. I.C. 29-3-12(e).

Accounts rendered to the court by a personal representative shall be for a period distinctly stated and shall consist of three (3) schedules, of which the first shall show the amount of the property chargeable to the personal representative; the second shall show payments, charges, losses and distributions; the third shall show the property on hand constituting the balance of such account, if any. When an account is filed, the personal representative shall also file receipts for disbursements of assets made during the period covered by the account. Whenever the personal representative is unable to file receipts for any disbursements, the court may permit him to substantiate them by other proof. The court may provide for an inspection of the balance of assets on hand. The court may, upon its own motion, or upon petition, provide that verification of accounts or credits thereon may be made by the unqualified certificate of a certified public accountant in lieu of receipts or other proof.

It is critical for the guardian(s) to notify the court if any contact information changes at any time during the duration of the guardianship.

We recommend that any person with questions about their case seek the advice of a licensed attorney. The Indiana Coalition for Court Access <https://indianalegalhelp.org> can assist in finding low-cost legal help.

Additionally, the Indiana Coalition for Court Access <https://indianalegalhelp.org/what-if-i-dont-qualify> and Bar Associations provide options if you do not qualify for low-cost legal aid.