

IN THE COURT OF CHANCERY OF THE STATE OF DELAWARE

Register in Chancery Kent County 38 The Green, Ste. 208 Dover, DE 19901 302-735-1930	Register in Chancery New Castle County 500 N. King Street, Ste. 11600 Wilmington, DE 19801 302-255-0544	Register in Chancery Sussex County 34 The Circle Georgetown, DE 19947 302-856-5775
--	---	--

Procedures for filing a Petition to Terminate Guardianship Due to Recovery

- The petition to terminate requires the following:
 - A complete petition. The court clerk cannot complete the petition for you. The petitioner(s) will need to have their signature(s) notarized on the petition. If you appear in the Register's Office with identification and the correct paperwork, your signature(s) can be notarized by a court clerk in the Register's Office.
 - Physician's affidavit. A detailed physician's affidavit stating the person with a disability has recovered and a guardian is no longer necessary must be attached to the petition.
 - Final accounting. If the guardian(s) is/are required to file accountings, a final accounting may be required before the guardian(s) is/are released from their fiduciary duty or bond.
 - The filing fee for the petition is \$15.00. Payment must be received at the time of filing, or the petition will not be accepted by our office. We accept cash, check or money order (made payable to "Register in Chancery").
- It is the petitioner's responsibility to provide the Court with photocopies of all supporting documentation. If the Register in Chancery's office makes photocopies for you, we will charge a \$1.50 per page fee. When submitting your supporting documentation, it must be filed on regular 11 x 8.5 paper that can be easily scanned onto the computer and it must be one-sided.
- Once the petition is filed, the Court may appoint an attorney *ad litem* to represent the best interest of the person with a disability and file a report with the Court. A hearing may be scheduled after the attorney files his/her report. The cost of the attorney *ad litem*, usually around \$750, may be charged to the person with a disability. Extraordinary cases such as contested petitions, those that require out of state travel or further investigation may exceed \$750.00.
- The petitioner(s) is/are responsible for obtaining consents from the interested parties or sending notice of the petition to the interested parties by regular U.S. mail. Please review the enclosed instruction sheet for additional instructions on notifying the interested parties.

IN THE COURT OF CHANCERY OF THE STATE OF DELAWARE

IN THE MATTER OF: _____ :
 :
 : C.M. # _____
 a person with a disability :
 :

**Petition to Terminate Guardianship Due to the Recovery of the
Person with a Former Disability**

1. Name of person filing the petition: _____
2. Name of guardian(s): _____
3. Date guardian(s) was/were appointed: _____
4. Since the appointment of the guardian(s), the person with a disability has made sufficient recovery to allow the guardianship to be terminated.
5. The guardianship should be terminated for the following reason(s):

(Please attach a separate sheet if necessary.)

6. A notarized physician's affidavit from the current treating physician is attached reciting the improvement of the person with a disability and his/her ability to now handle his/her person and property.

7. The names and addresses of any interested parties including the next-of-kin who would be entitled to inherit through the estate of the person with a disability if that person died intestate.

Name of interested party	Relationship to person with a disability	Address and phone number of interested party	Age

8. The guardian(s)

a. Was/Were previously relieved of the requirement of filing annual accountings **or**

b. The guardian(s) shall file a final accounting within thirty (30) days of the guardianship being terminated.

WHEREFORE, Petitioner(s) respectfully requests that this Court:

1) Appoint an attorney *ad litem* to represent the best interests of the person with a disability and to file a report with his/her recommendations.

2) Terminate the guardianship of the person and/or property of the person with a disability.

3) Any financial assets titled in the name of the guardianship be retitled to the name of the person with a disability alone subsequent to the termination of the guardianship.

Signature of Co-Petitioner
(If Applicable)

Signature of Petitioner

Address

Address

Phone number

Phone number

STATE OF _____ :

COUNTY OF _____ :

This instrument was acknowledged before me on this _____ day of _____, 20____ by _____ [Name of affiant].

Notary Public/Chancery Court Clerk

PHYSICIAN'S AFFIDAVIT – TO PETITION TO TERMINATE DUE TO RECOVERY

NOTE: This affidavit will be used in a legal proceeding to terminate a guardianship for the patient named below. Detailed information is necessary for the court to assess whether the patient has a disability under Delaware law. A person with a disability is defined under Delaware law as someone who “[b]y reason of mental or physical incapacity is unable properly to manage or care for their own person or property, or both, and, in consequence thereof, is in danger of dissipating or losing such property or of becoming the victim of designing persons or, in the case where a guardian of the person is sought, such person is in danger of substantially endangering person’s own health, or of becoming subject to abuse by other persons or of becoming the victim of designing persons[.]” 12 Del. C. § 3901(a)(2). The information in this affidavit must be specific and detailed and based on your personal examination of the patient. Thank you for your concern and cooperation.

PATIENT’S NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

I, _____, (check one) M.D., D.O., Ph.D., Psy.D., of full age, hereby certify as follows:

I am duly licensed and accredited in the following areas of medical practice:

The history of my involvement with this patient is the following: (check the appropriate box(es) and add further clarification on the blank lines)

10+ years 5-10 years 1-5 years Less than 1 year First visit

The patient’s diagnoses/conditions related to their incapacity include:

1. _____ Mild Moderate Severe N/A
2. _____ Mild Moderate Severe N/A
3. _____ Mild Moderate Severe N/A

Patient Name: _____

I personally examined this patient on _____, 20_____.

The examination lasted approximately _____
(Time)

Relevant tests and results related to their incapacity:

Does the patient have difficulty communicating? If so, describe the difficulty in detail, and provide the cause of the patient's difficulty with communication:

Based on tests and my examination of this patient, it is my professional opinion that she/he:

does not have

does have

a disability that significantly interferes with the ability to make responsible decisions regarding health care, food, clothing, shelter, or finances.

(Optional) The following documents are attached as supporting information regarding the particulars of the disability:

Describe the patient's disability:

The disability impairs the patient's ability to perform the following functions and activities:

In my opinion, the patient

does have

does not have

sufficient mental capacity to understand the nature of guardianship in order to consent to the appointment of a guardian.

Patient Name: _____

The patient is or is not able to perform the following functions independently:

- | | | |
|--|----------------------------------|--------------------------------------|
| Activities of daily living | <input type="checkbox"/> Is able | <input type="checkbox"/> Is not able |
| Pay his/her own bills | <input type="checkbox"/> Is able | <input type="checkbox"/> Is not able |
| Live alone | <input type="checkbox"/> Is able | <input type="checkbox"/> Is not able |
| Take medication appropriately | <input type="checkbox"/> Is able | <input type="checkbox"/> Is not able |
| Give informed consent for medical procedures | <input type="checkbox"/> Is able | <input type="checkbox"/> Is not able |
| Resist scams | <input type="checkbox"/> Is able | <input type="checkbox"/> Is not able |

I solemnly swear and affirm under the penalties of perjury and upon personal knowledge that the contents of this affidavit are true.

Date

Physician's Signature

Printed Name

Physician's Address: _____

Physician's Phone Number: _____

STATE OF _____:

COUNTY OF _____:

This instrument was acknowledged before me on this ____ day of _____, 20____ by
_____ [Name of affiant].

Notary Public

**INSTRUCTIONS FOR NOTIFYING INTERESTED PARTY(IES) OF
PETITION TO TERMINATE GUARDIAN DUE TO RECOVERY**

It is the petitioner's(s') responsibility to notify the interested party(ies) when a petition is filed with the Court.

If you do not know the address for an interested party, you must make every attempt to locate the address and file the enclosed affidavit of efforts to locate address of interested party with your petition (a separate affidavit is required for each individual).

Option 1 – Consent

Any interested party may sign a copy of the attached “Consent” form.

Option 2 – Send Notice

If any interested party does not sign the consent form, you must send them a copy of the attached “Notice of Petition”. You may send the notice by regular U.S. Mail.

Any interested party who has not signed a consent must receive notice of your petition at least thirteen (13) days before the Court will consider the petition. This ensures that all interested parties have adequate time to contact the Court with any questions they may have or file any objection to the petition.

To be filed with the Court

You must file the following documents with the Court before the petition will be reviewed by a Judicial Officer:

- a. Any and all consent forms,
- b. The attached “Certificate of Mailing” (if any notices were sent), and
- c. Any affidavit(s) of efforts to locate address of interested party.

IN THE COURT OF CHANCERY OF THE STATE OF DELAWARE

IN THE MATTER OF: _____ :
:
_____ : C.M. # _____
a person with a disability :

CONSENT TO THE PETITION TO TERMINATE GUARDIANSHIP

I, _____ [Name of interested party], whose relationship to the person with a disability is that of _____ (e.g. mother, brother), hereby consent to the termination of the guardianship due to the recovery of the person with a disability.

Interested Party’s signature
Address: _____
Phone Number: _____

STATE OF _____ :
COUNTY OF _____ :
This instrument was acknowledged before me on this _____ day of _____, 20____ by _____ [Name of affiant].

Notary Public/Chancery Court Clerk

IN THE COURT OF CHANCERY OF THE STATE OF DELAWARE

Register in Chancery
Kent County
38 The Green, Ste. 208
Dover, DE 19901
302-735-1930

Register in Chancery
New Castle County
500 N. King Street, Ste. 11600
Wilmington, DE 19801
302-255-0544

Register in Chancery
Sussex County
34 The Circle
Georgetown, DE 19947
302-856-5775

IN THE MATTER OF: _____ :
 :
 : C.M. # _____
A person with a disability :

NOTICE OF PETITION TO TERMINATE GUARDIANSHIP

Dear Interested Party:

This is a notice that I am/we are petitioning to terminate the guardianship due to the recovery of the person with a disability. If you object to the petition, you must immediately contact the Register in Chancery’s Office that has been marked above within thirteen (13) days of the date of this notice.

Petitioner’s Signature

Co-Petitioner’s Signature

Dated: _____

IN THE COURT OF CHANCERY OF THE STATE OF DELAWARE

IN THE MATTER OF: _____ :
 :
 : C.M. # _____
 A person with a disability :

CERTIFICATE OF MAILING

I/We hereby certify that on _____, 20_____, I/we
 did send via U.S. Mail a “Notice of Petition” to the following interested parties:

Name	Address

Petitioner

Co- Petitioner (if applicable)

I declare under penalty of perjury under the laws of Delaware that the foregoing is true and correct.	I declare under penalty of perjury under the laws of Delaware that the foregoing is true and correct.
Executed on the _____ day of _____ (month) _____ (year).	Executed on the _____ day of _____ (month) _____ (year).
_____ (Petitioner’s Printed Name)	_____ (Co- Petitioner’s Printed Name)
_____ (Petitioner’s Signature)	_____ (Co- Petitioner’s Signature)

messaging the missing person through electronic means;

Other: _____

If I/We subsequently locate the missing interested party, I/We will notify the Court of his/her address.

Petitioner

Co-Petitioner

STATE OF _____ :

COUNTY OF _____ :

This instrument was acknowledged before me on this ____ day of _____, 20____ by _____ [Name of affiant].

Notary Public/Chancery Court Clerk