

**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 St., 7th Floor  
Wilmington, DE 19801  
302-255-0544

Register in Chancery  
Sussex County  
34 The Circle  
Georgetown, DE 19947  
302-856-5777

**Procedures for filing a Petition for the Appointment of Guardian(s) of the Person and Property of a Person with an Alleged Disability**

- The petition must be filled out completely.
  - The court clerk cannot complete the petition for you.
  - The petition must be one-sided.
  - The petitioner will need to have their signature notarized on several forms. If you appear in the Register’s Office with identification and the correct paperwork, your signature can be notarized by a court clerk in the Register’s Office.
  - If additional space is needed for any question, please attach a separate sheet of paper and reference the question number.
  - If there is more than one petitioner, only one petition is required but separate personal information sheets and affidavits of proposed guardian’s history are required.
  - A detailed physician’s affidavit must be attached to the petition and is required to be notarized. The person with an alleged disability must have been seen by the physician within the last three (3) months.
- The filing fee for the petition is **\$135.00 plus \$2.00 per page scanning fee**. 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 the “Register in Chancery”). If the Register in Chancery’s office makes photocopies for you, we will charge a \$1.50 per page fee.
- The Court will appoint an attorney to represent the best interests of the person with an alleged disability. The attorney does not represent the petitioner. The Court will award the attorney *ad litem* a reasonable fee for his/her work on behalf of the person with an alleged disability. The petitioner is responsible for paying the attorney’s fee although the Judicial Officer may order the fee be paid from the funds of the person with an alleged disability. For uncontested matters, the fee can be up to \$750.00. Extraordinary cases such as contested petitions or those that require further investigation may exceed \$750.00.
- The petitioner is responsible for obtaining consents from the interested parties or sending notice of the petition to the interested parties. Please see the instruction sheet within this packet for additional information.
- A petition for guardianship should only be filed as a last resort. Information can be found online on the following alternatives:
  - Advance Health Care Directive <https://www.dhss.delaware.gov/dsaapd/advance1.html>
  - Durable Power of Attorney <https://www.dhss.delaware.gov/dhss/dhcq/poa.html>
  - Surrogate Decision Making <https://delcode.delaware.gov/title16/c025/index.shtml>
  - Supported Decision Making [https://www.dhss.delaware.gov/dhss/dsaapd/supported\\_decision\\_making.html](https://www.dhss.delaware.gov/dhss/dsaapd/supported_decision_making.html)

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**Guardianship Monitoring Program**

The Court of Chancery utilizes the Guardianship Monitoring Program to monitor individuals who have been placed under guardianship and whose care is the responsibility of court-appointed guardians. This important monitoring function is coordinated by the Guardianship Advocacy Director of the Office of the Public Guardian and Court of Chancery under Chancery Rule 180-D and enables the Court to receive first-hand information about people for whom the Court has ultimate responsibility. A Guardianship Analyst is assigned a case, given necessary information about the case, and makes an appointment to meet with the guardian and person with a disability. This meeting will likely be virtual or could be face to face. After the meeting, the Guardianship Analyst fills out a report indicating the status of the person with a disability and may make recommendations for action. The Analyst's confidential report is filed by the Office of the Public Guardian and subsequently viewed by Court staff to determine if further action is necessary. The Guardianship Analyst, as well as the Guardianship Monitoring Program itself, is an extension of the Court of Chancery and the Office of the Public Guardian and should be treated accordingly.

Persons subject to guardianship are very important and they deserve every right and protection available. You should expect to be contacted in the future by the Guardianship Monitoring Program and your cooperation with scheduling meeting times in a timely fashion is greatly appreciated. Thank you in advance for your time and effort.

Sincerely,

Sherri Hageman, M.S., Guardianship Advocacy Director  
Office of the Public Guardian (302) 255-1901 or (302) 358-0782



ii. Admission date: \_\_\_\_\_

iii. Reason(s) for admission: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

f. Does the person with an alleged disability require an interpreter?

No.  Yes. If "Yes", what language? \_\_\_\_\_

3. Interested parties

a. Has the person with an alleged disability ever appointed an Agent through a Power of Attorney or Advance Health Care Directive?

No

Yes. If "Yes", name, address, and phone number of the Agent: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b. Has the person with an alleged disability been represented by a Delaware attorney within the last two years?

No

Yes. If "Yes", include the name of the attorney, explain the reason, and include the years of service: \_\_\_\_\_

\_\_\_\_\_

c. Has someone been primarily responsible in the past six (6) months for providing care or handling the finances for the person with an alleged disability?

No

Yes. If "Yes", provide their name, address, and phone number: \_\_\_\_\_

\_\_\_\_\_

d. The names and contact information of the next of kin, including anyone who would be entitled to inherit through the estate of the person with an alleged disability if that person died without a will, a named fiduciary, executor, or beneficiary. If an interested party is a minor, please provide the name and contact information for the minor’s parent or other guardian as the parent or guardian will require notice.

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

4. Who is paying the expenses of the person with an alleged disability and out of what funds? \_\_\_\_\_

5. The marital status of the person with an alleged disability is: (check one)

- Single       Married       Divorced       Widowed

6. Has the person with an alleged disability ever executed a Will?

a.  No

b.  Yes. If “Yes”, the Will is located at the following address:

\_\_\_\_\_ and is in the custody of the following person/entity: \_\_\_\_\_.

7. Does the person with an alleged disability have a health-care instruction expressing:

- a.  Preferred health-care professionals or health-care institutions. If so, what is their preference: \_\_\_\_\_
- b.  Preferences for how a health-care decision will be made and communicated. If so, what are their preferences: \_\_\_\_\_  
\_\_\_\_\_
- c.  Persons who should or should not be consulted regarding a health-care decision.
  - i. If so, who should: \_\_\_\_\_
  - ii. If so, who should not: \_\_\_\_\_
- d.  Who should serve as default surrogate or guardian, if needed. If so, who: \_\_\_\_\_
- e.  The person with an alleged disability has no health-care instructions.
- f.  Unknown.

8. Has the person with an alleged disability ever been a member of the military?  
 No  Yes

9. Are you aware of any reports made to, or investigations by, Adult Protective Services regarding you or the person with an alleged disability?

- a.  No
- b.  Yes. If “Yes”, please provide an explanation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Are there areas of decision-making that you think the person with an alleged disability can continue to make?

a.  No

b.  Yes. If “Yes”, please explain what areas: \_\_\_\_\_

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

11. Explain in detail why the person with an alleged disability is in need of a guardian. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

12. Explain in detail why you should be appointed guardian. \_\_\_\_\_

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

13. List **ALL** the assets of the person with an alleged disability.

<b>Property</b>	<b>Estimated Value</b>	<b>Retail Value</b>	<b>If jointly owned, name and address of co-owner</b>
Cash			
Bank Accounts			
Stocks/Bonds			
Mutual Funds			
Securities/Options			
Annuities			
Home/Residence			

<b>Property</b>	<b>Estimated Value</b>	<b>Retail Value</b>	<b>If jointly owned, name and address of co-owner</b>
Other real estate			
Motor vehicles			
Business			
Other valuable property (except ordinary household furnishings and clothes)			
Life Insurance Policy			
Other: _____			
Other: _____			

14. List **ALL** the current sources of income for the person with an alleged disability.

<b>Benefit or source of income</b>	<b>Amount</b>	<b>When received</b> ( <i>e.g.</i> monthly/ quarterly)
Business (professional/self-employment)		
Payments received for rental property		
Interest		
Dividends from stocks or bonds		
Pension		
Social Security*		
VA Benefits*		
Disability		

<b>Benefit or source of income</b>	<b>Amount</b>	<b>When received</b> (e.g. monthly/ quarterly)
IRA/401K/Annuity payments		
Gifts		
Other: _____		

\*Who is the representative payee for these benefits? \_\_\_\_\_

15. List **ALL** the debts and monthly expenses for the person with an alleged disability, including any debts incurred for care of legal dependents.

<b>Description of debts and monthly expenses/bills</b>	<b>Total debt</b>	<b>Monthly payment</b>
Mortgage (including taxes, insurance, and escrow)		
Rent		
Water		
Sewer		
Electric/Gas		
Oil		
Trash		
Television		
Telephone		
Groceries		
Household maintenance and repairs (list) Item: _____ Item: _____		
Clothing		

<b>Description of debts and monthly expenses/bills</b>	<b>Total debt</b>	<b>Monthly payment</b>
Health insurance		
Medication		
Dental/Out of pocket medical expenses		
Laundry/dry cleaning		
Cosmetics/toiletries		
Hobbies/Entertainment		
Barber/Hairdresser		
Newspaper/magazine subscription(s)		
Child support		
Charitable and/or religious donations		
Vacation		
Public Transportation		
Automobile: Monthly payment Repairs and maintenance Insurance Gasoline		
Life insurance payment		

16. All the following statements must be true before the Court of Chancery will consider this petition. Check the following statements to acknowledge they are true:

- a.  There is currently no guardian for the person or property of the person with an alleged disability.
- b.  The person with an alleged disability is unable to properly manage and care for his/her person and, as a consequence therefore, is in danger of

becoming the victim of a designing person. He/she is in danger of substantially endangering his/her own health or becoming subject to abuse by other persons.

- c.  The person with an alleged disability is unable to properly manage and care for his/her property and, as a consequence therefore, is in danger of dissipating or losing such property by becoming the victim of designing person(s).
- d.  The person with an alleged disability has lived in the State of Delaware for at least the last six (6) months.
- e.  Attached is the notarized physician's affidavit.
- f.  I/We consent to the Register in Chancery of the Court being my/our agent for acceptance of service as to any claim arising out of the guardianship if, by reason of the guardian's(s') absence(s) from this State, I/We cannot be personally served.
- g.  I/We understand the Court may require a guardianship bank account to be opened and for all the income and assets to be deposited into the guardianship bank account. I/We wish to establish the guardianship bank account at this Delaware bank, \_\_\_\_\_.
- h.  I/We understand the following about the court appointed attorney *ad litem*: (1) the Court will appoint an attorney to represent the best interests of the person with an alleged disability; (2) the Court will award the attorney *ad litem* a reasonable fee for his/her work on behalf of the person with an alleged disability; (3) I/We as the petitioner(s) am/are responsible for paying the attorney's fee although the Judicial Officer may order the fee be paid from the funds of the person with an alleged disability; and (4) for uncontested matters, the fee can be up to \$750.00 and for extraordinary cases such as contested petitions, those that require out of state travel or further investigation, the fee

may exceed \$750.00.

**WHEREFORE**, Petitioner(s) respectfully request that:

1. This Court appoint him/her/them as guardian(s) of the person and property of the person with an alleged disability.
2. A preliminary order be entered to appoint an attorney *ad litem*, schedule a hearing and to notify interested parties.

Petitioner's signature: \_\_\_\_\_

Petitioner's full address: \_\_\_\_\_

Petitioner's phone number: \_\_\_\_\_

Co-petitioner's signature: \_\_\_\_\_

Co-petitioner's full address: \_\_\_\_\_

Co-petitioner's 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

NOTE: This affidavit will be used in a legal proceeding to appoint a guardian 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. By completing this form, you consent to make reasonable accommodations to speak to the court appointed attorney *ad litem* should they need to speak to you regarding the statements you made in this affidavit. Sample forms are available on the court’s website at <https://courts.delaware.gov/forms/>. Thank you for your concern and cooperation.

**IS THIS AN EMERGENCY GUARDIANSHIP PETITION?** If an **emergency** appointment of guardian is needed, please complete page four (4) of this form *in addition* to pages one (1) through three (3).

Patient’s name: \_\_\_\_\_

Patient’s address: \_\_\_\_\_

Patient’s 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\_\_\_\_\_  
(patient must have been seen within the last 3 months).

The examination lasted approximately \_\_\_\_\_ [time]

Relevant tests and results related to their incapacity:

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---

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

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---

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

- does not have** a disability that significantly interferes with the ability to make responsible decisions regarding health care, food, clothing, shelter, or finances.
- 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** sufficient mental capacity to understand the nature of guardianship in order to consent to the appointment of a guardian.
- 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:

<b>Function</b>	<b>The patient can perform independently</b>	<b>The patient cannot perform independently</b>
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 printed name: \_\_\_\_\_

Physician's signature: \_\_\_\_\_

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

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

**TO BE COMPLETED WHEN REQUESTING AN EMERGENCY GUARDIANSHIP OF THE PERSON**

Nature of the emergency, such as medical, abuse, neglect, exploitation, etc.: \_\_\_\_\_

\_\_\_\_\_

If this is a medical emergency, provide the diagnosis: \_\_\_\_\_

\_\_\_\_\_

Describe the testing or treatment related to the diagnosis that is urgently needed and cannot be accomplished without imposition of a guardianship and why it is urgently needed within the next 72 hours: \_\_\_\_\_

\_\_\_\_\_

Do you recommend a change in the code status at this time?  Yes  No

Do you recommend withdrawal of treatment at this time?  Yes  No

If you responded "Yes" to either of the above, please respond to the following:

What is the current code in the patient's file?  Full code  DNR  Other \_\_\_\_\_

Is there a living will in the patient's file?  Yes  No

If "Yes", please attach a copy. The court will not grant a change of code against the patient's existing living will without clear and convincing evidence that the patient would choose withdrawal of life-sustaining treatment.

Have you spoken with the patient about their end of life wishes?  Yes  No

If "Yes", what are their wishes and how you know what their wishes are

\_\_\_\_\_

Date: \_\_\_\_\_

Physician's printed name: \_\_\_\_\_

Physician's signature: \_\_\_\_\_

STATE OF \_\_\_\_\_:

COUNTY OF \_\_\_\_\_:

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

\_\_\_\_\_  
Notary Public

**Court of Chancery**  
**Personal Information Sheet**

Please Note: If there is more than one proposed guardian, each person will need to complete a separate form and use separate contacts on page two of this form.

**Information about the person with an alleged disability/minor**

Name of person with an alleged disability/minor: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Information about the proposed guardian**

I have applied to the Court of Chancery to be appointed as guardian of the person with an alleged disability/minor named above. I understand that I must complete this form in full or my guardianship petition may be denied. In order to provide the Court with sufficient information to determine my qualification to serve as guardian and to assist the Court in assuring that the Court's staff will always be able to locate and make contact with me, the following information and consent is given:

Proposed Guardian's current full name: \_\_\_\_\_

Proposed Guardian's physical address: \_\_\_\_\_

\_\_\_\_\_

Proposed Guardian's mailing address (if different): \_\_\_\_\_

\_\_\_\_\_

Home phone number: \_\_\_\_\_ Work phone number: \_\_\_\_\_

Cell phone number: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number: \_\_\_\_\_

Driver's License number and State: \_\_\_\_\_

Place of employment and address: \_\_\_\_\_

\_\_\_\_\_

Name of supervisor and telephone number: \_\_\_\_\_

\_\_\_\_\_

Name/Address/Telephone number of spouse (if not a co-petitioner/co-guardian):

\_\_\_\_\_

**Information about the proposed guardian's contacts**

List the information for two people who should always be able to locate or contact you. The contacts cannot live at the same address as each other or the petitioner(s). If there is more than one proposed guardian, separate contacts must be listed.

1. Name: \_\_\_\_\_

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

Phone number: \_\_\_\_\_ Relationship: \_\_\_\_\_

2. Name: \_\_\_\_\_

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

Phone number: \_\_\_\_\_ Relationship: \_\_\_\_\_

I fully understand that it is my duty to keep the Court informed of my whereabouts and to provide the Court with any change in my name, physical address or mailing address. I hereby authorize the staff of this Court to contact any of the persons named above and authorize and direct any of the persons named above and my attorney(s) to provide to the Court any information which might assist the Court in locating or contacting me in the future. I also authorize the court staff to search government or public databases to locate me. I further agree that any federal, state, public, or private agency with information about my whereabouts, or the whereabouts of the person with an alleged disability or minor named above, may release that information to the Court and its staff, and I authorize and direct such persons to release that information. I release the Court and the Court's staff from all liability associated with efforts to determine my whereabouts or the whereabouts of the person with an alleged disability or minor over whom guardianship has been established.

Proposed Guardian's signature: \_\_\_\_\_

Date this form is completed: \_\_\_\_\_

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**

**Affidavit of Proposed Guardian's History**

Each proposed guardian must complete a separate form.

Name of person with an alleged disability/minor: \_\_\_\_\_

Name of proposed guardian: \_\_\_\_\_

1. Have you ever declared bankruptcy?  Yes  No  
If yes, when? \_\_\_\_\_ what type? \_\_\_\_\_

2. Have you ever been convicted of a misdemeanor?  Yes  No  
If yes, describe which misdemeanor, when and in what jurisdiction you were convicted (e.g. State, County and Police Department). \_\_\_\_\_  
\_\_\_\_\_

3. Have you ever been convicted of a felony?  Yes  No  
If yes, describe which felony, when and in what jurisdiction you were convicted (e.g. State, County and Police Department). \_\_\_\_\_  
\_\_\_\_\_

4. I give the State of Delaware permission to conduct a criminal background check on me at any time during the consideration of my petition for guardianship and, if granted, at any time during the period I am guardian. I solemnly swear and affirm under penalty of law that the statements and answers above are true to the best of my knowledge.

Proposed guardian's signature: \_\_\_\_\_

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

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

\_\_\_\_\_  
Notary Public/Chancery Court Clerk

## **Instructions for Notifying Interested Parties of Petition for Guardianship**

It is the petitioner's responsibility to notify the interested parties when a petition for guardianship is filed with the Court. This includes notifying all the parties you listed on number three (3) of the guardianship petition.

Each interested party may sign and have notarized a copy of the attached "Waiver of Notice and Consent". The petitioner will be required to send notice to anyone who does not sign a consent. Additional information will be provided to the petitioner after the order is signed appointing the attorney for the person with an alleged disability and scheduling the hearing.

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.

**IN THE COURT OF CHANCERY OF THE STATE OF DELAWARE**

In the matter of: \_\_\_\_\_ :  
 :  
 : C.M. #: \_\_\_\_\_  
A person with a disability :  
 :

**Waiver of Notice and Consent of Interested Party to Guardianship**

I, \_\_\_\_\_ [Name of interested party],

whose relationship to the person with an alleged disability is that of

\_\_\_\_\_ (e.g. mother, brother), hereby waive my right

to notice of the hearing and hereby consent to the appointment of

\_\_\_\_\_ as guardian(s) of the (check all that

apply)  person (to make his/her medical decision) and/or  property (to make

his/her financial decisions) without further notice.

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**

In the matter of: \_\_\_\_\_ :  
: C.M. #: \_\_\_\_\_  
A person with an alleged disability :

**Affidavit of Efforts to Locate Address of Interested Party**

1. Name of petitioner(s): \_\_\_\_\_

2. Name of interested party whose address cannot be located:  
\_\_\_\_\_

3. To the best of my/our knowledge, the last contact the interested party had with me/us was on or around \_\_\_\_\_ [month/year] and with the person this petition is being filed for was on or around \_\_\_\_\_ [month/year].

4. Any additional information you would like to provide regarding the last contact: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

5. My/Our efforts have included the following [please check all that apply]:
- a.  performing an internet search for the address of the interested party;
  - b.  asking other individuals for the interested party's contact information;

c.  messaging the interested party through electronic means;

d.  Other: \_\_\_\_\_

6. I/We have been unable, after exercising reasonable diligence, to locate an address for the interested party to provide them with notice of the petition.

I/We will notify the Court if an address is later obtained.

Signature section for petitioner	Signature section for any co-petitioner
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.
Date: _____	Date: _____
Print name: _____	Print name: _____
Signature: _____	Signature: _____

*Pursuant to Court of Chancery Rule 178B, the notary requirement is waived.*