

**COURT INVESTIGATOR**  
SUPERIOR COURT, ALAMEDA COUNTY  
BERKELEY COURTHOUSE  
2120 MARTIN LUTHER KING, JR. WAY  
BERKELEY, CA 94704  
(510) 636-8820  
(510) 451-2269 FAX

TERMINATION OF GUARDIANSHIP QUESTIONNAIRE

**IMPORTANT INFORMATION REGARDING YOUR FILING – PLEASE READ**

INSTRUCTIONS

**Please read these instructions carefully. They contain important information that will assist you in completing this form and about your guardianship.**

You should be completing this form if you are asking the Court to terminate the guardianship for a child. The Court will usually require the Court Investigator to make a home visit, speak with you, the guardian and the child. The Court Investigator prepares a report for the Court that will address why the guardianship was needed when it was established, what has changed since that time, your ability to resume care, custody and control of the child and whether termination would be in the child's best interests.

Please answer all questions honestly and completely. On the last page, sign the form and declare, under penalty of perjury, that all the information you have provided is true and correct.

IF YOU HAVE ANY QUESTIONS ABOUT FILLING OUT THIS FORM, PLEASE CALL THE COURT INVESTIGATOR'S OFFICE AT (510) 636-8820.

Mail or fax the completed questionnaire to:

COURT INVESTIGATOR  
BERKELEY COURTHOUSE  
2120 MARTIN LUTHER KING, JR. WAY  
BERKELEY, CA 94704  
FAX NO.: (510) 451-2269

IN ORDER TO PREVENT ANY DELAY IN YOUR HEARING, YOU MUST COMPLETE THIS FORM ANSWERING ALL QUESTIONS. FILE IT WHEN YOU FILE YOUR PETITION FOR TERMINATION, AT LEAST 60 DAYS BEFORE YOUR HEARING DATE.

COURT INVESTIGATOR'S OFFICE  
BERKELEY COURTHOUSE  
2120 MARTIN LUTHER KING, JR. WAY  
BERKELEY, CA 94704

SUPERIOR COURT OF CALIFORNIA  
COUNTY OF ALAMEDA

CONFIDENTIAL GUARDIANSHIP TERMINATION QUESTIONNAIRE

In the Guardianship of:

)  
)  
) PROBABE CASE NO: \_\_\_\_\_  
) HEARING DATE: \_\_\_\_\_  
)  
) (Hearing date should be at least 60 days  
) from date of filing)  
)  
)  
)  
)  
)

Minor(s)

THIS IS A CONFIDENTIAL QUESTIONNAIRE

CONFIDENTIAL GUARDIANSHIP SCREENING (PROBATE CODE SECTION 1516)  
GUARDIANSHIP OF: \_\_\_\_\_ CASE NO.: \_\_\_\_\_

1. ATTACH A COPY OF EACH CHILD'S BIRTH CERTIFICATE TO THIS FORM AND LIST THE NAME AND DATE OF BIRTH OF EACH CHILD SUBJECT TO THE GUARDIANSHIP:

- 1. \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_
- 2. \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_
- 3. \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

2. Does the family have Native American/American Indian ancestry or heritage?  YES  NO.

\*\*\*\*\*

3. LIST THE GUARDIAN(S): THIS INFORMATION IS REQUIRED  
NAME RELATIONSHIP TO CHILD

DATE OF BIRTH

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

4. HAVE YOU EVER BEEN ARRESTED, CHARGED WITH OR CONVICTED OF ANY CRIME (REGARDLESS OF THE OUTCOME)? YES  NO

NOTE: THE COURT INVESTIGATOR WILL CONDUCT A CRIMINAL BACKGROUND CHECK.

6. PARENTS OF CHILD(REN) SUBJECT TO THE GUARDIANSHIP:

NAME

ADDRESS

DATE OF BIRTH

- 1. Mother: \_\_\_\_\_
- 2. Father: \_\_\_\_\_

7. OTHER PEOPLE LIVING IN YOUR HOME AGE 18 AND OVER  
(Continue on back if needed):

NAME

RELATIONSHIP

DATE OF BIRTH

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

DO NOT WRITE BELOW THIS LINE

\*\*\*\*\*

DEPARTMENT OF SOCIAL SERVICES USE ONLY

[ ] NO INFORMATION AVAILABLE

[ ] INFORMATION AVAILABLE

Screening by Worker #: \_\_\_\_\_

Date: \_\_\_\_\_ Phone No.: \_\_\_\_\_

**CONFIDENTIAL TERMINATION OF GUARDIANSHIP QUESTIONNAIRE**  
**YOU MUST ANSWER ALL QUESTIONS.** (Write "N/A" if a question does not apply to your situation.)

GUARDIANSHIP OF: \_\_\_\_\_ CASE NO.: \_\_\_\_\_

HEARING DATE: \_\_\_\_\_

Will you or anyone else in the home require an interpreter?  YES  NO

Language : \_\_\_\_\_

Does anyone object to terminating the guardianship?  YES  NO

If yes, who? \_\_\_\_\_

**SECTION I**

1. Explain why the guardianship was needed when it was established (be specific).

---

---

---

2. Why is the guardianship no longer necessary? Be specific about what efforts you made to resolve the problems that led to the need for the guardianship. For example, if you had a drug problem please tell us the name of the program you attended or completed.

---

---

---

---

3. Why is it in the best interests of the child(ren) to end the guardianship? How would they benefit or be better off after the termination?

---

---

---

---

4. Please describe the amount of contact you have had with the child since the guardianship was established. For example, how often did you visit and for how long, day or overnight?

---

---

---

5. Please describe how your visits with the child have been. Describe any problems that have arisen and how you have resolved them.

---

---

---

---

6. Please describe your methods of disciplining the child:

---

7. If the child has any developmental, emotional or psychological needs, please describe your plan to meet the child's needs:

---

---

---

---

8. Have you attended a parenting class? If so, please provide the name of the class and date you completed it.

---

---

**SECTION II**

**PARENT'S INFORMATION:** (This information is about the person who wants to terminate guardianship. Please provide information for each parent.)

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Phone numbers Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

If you have lived at this address for less than five years, please list your previous addresses:

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

Email address: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Driver's License No.: \_\_\_\_\_

Are you currently  Married  Widowed  Single  Separated  Divorced

If currently married or separated, what is the name of your spouse?

\_\_\_\_\_

Name of any previous spouse and date of divorce or death ending the marriage:

\_\_\_\_\_

List **your** children - **even if** they are adults and not living with you. Also provide their date of birth, address, and whether they have ever been arrested or charged with a crime.

NAME	BIRTH DATE	ADDRESS	Name/relationship of adult with whom child lives

More children listed on back.

Have you ever been convicted of any crime, including driving under the influence of drugs/alcohol?

YES  NO

If yes, provide details such as the crime(s), date(s), place(s):

\_\_\_\_\_

Have you ever been involved with Child Protective Services?  YES  NO

If yes, where and when?

\_\_\_\_\_

Are there any circumstances which may affect your ability to resume care, custody or control of the child(ren) if guardianship is terminated? (For example, do you suffer from any health problems or mental illness?)  YES  NO

If yes, describe:

\_\_\_\_\_

\_\_\_\_\_

Who will you rely on for assistance and support if the child(ren) is returned to your custody?

\_\_\_\_\_

**YOUR HEALTH CONDITION:**

Are you being treated by a doctor or other health care practitioner?  YES  NO

If yes, why? \_\_\_\_\_

List any current medications you are taking and the condition/problem for which the medication is prescribed.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Have you ever been in counseling?  YES  NO

If yes, reason for counseling:  Drugs  Alcohol  Grief  Domestic Violence  Other \_\_\_\_\_

Explain: \_\_\_\_\_

**EDUCATIONAL HISTORY:**

Last school attended: \_\_\_\_\_

**Where & When:** \_\_\_\_\_

Highest Degree(s) earned: \_\_\_\_\_ Where & When: \_\_\_\_\_

Other courses taken: \_\_\_\_\_

**MILITARY HISTORY:**

Branch of Service: \_\_\_\_\_ Date Entered: \_\_\_\_\_ Date Discharged: \_\_\_\_\_

Type of Discharge:  Honorable  General  Good of Service  Dishonorable

**EMPLOYMENT:**

Are you employed?  YES  NO

Name of Employer \_\_\_\_\_ Address: \_\_\_\_\_

Length of employment: \_\_\_\_\_ Job Title: \_\_\_\_\_

Responsibilities/duties: \_\_\_\_\_

Are you retired or have you been at your current employment for less than five years?  YES  NO  
If yes, please list your work history for the past five years:

Name of Employer \_\_\_\_\_ Employed From \_\_\_\_\_ To \_\_\_\_\_

Name of Employer \_\_\_\_\_ Employed From \_\_\_\_\_ To \_\_\_\_\_

Name of Employer \_\_\_\_\_ Employed From \_\_\_\_\_ To \_\_\_\_\_

**PARENT'S FINANCIAL INFORMATION:**

Income:	Amount	Expenses:	Amount
Monthly take-home pay	\$ _____	Rent/Mortgage:	\$ _____
Other monthly income:		Credit Card/other monthly payments	
Welfare	\$ _____	Food:	\$ _____
SSI	\$ _____	Clothing:	\$ _____
Unemployment	\$ _____	Medical:	\$ _____
Spousal/Child Support	\$ _____	Transportation:	\$ _____
Other	\$ _____	Childcare:	\$ _____
Total Monthly Income: \$ _____		Total Monthly Expenses: \$ _____	

Does anyone else contribute money to the household?  YES  NO

If yes, who? \_\_\_\_\_ How much? \$ \_\_\_\_\_ How often \_\_\_\_\_

Does anyone else contribute money for the support of the child(ren)?  YES  NO

If yes, who? \_\_\_\_\_ How much? \$ \_\_\_\_\_ How often \_\_\_\_\_

Your financial resources

Checking Accounts Balance \$ \_\_\_\_\_

Savings Accounts Balance \$ \_\_\_\_\_

Other Investments Value \$ \_\_\_\_\_

Are you financially able to support the child(ren)?  YES  NO

If your expenses are greater than your income, how will you make up the difference? \_\_\_\_\_

Have you applied for or, are you already receiving benefits for this child ?

YES  NO

Welfare	<input type="checkbox"/>	<input type="checkbox"/>	Amount \$ _____
Social Security	<input type="checkbox"/>	<input type="checkbox"/>	Amount \$ _____
Medi-Cal	<input type="checkbox"/>	<input type="checkbox"/>	Amount \$ _____
Child Support	<input type="checkbox"/>	<input type="checkbox"/>	Amount \$ _____

Is someone else, such as the guardian, receiving the above benefits for the child(ren)?

UNKNOWN  YES  NO

Who: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

**REFERENCES:**

Please list **three references** who have known you **at least five years and who are friends, NOT relatives**. Give complete name, complete address, including zip codes and daytime phone numbers. Please notify them that we will be contacting them by letter or telephone.

PRINT NAME	STREET ADDRESS, CITY AND ZIPCODE	DAYTIME TELEPHONE
1.		
2.		
3.		

If you cannot provide 3 non-relative references, please explain: \_\_\_\_\_

\*\*\*\*\*

**SECTION III**

**DESCRIBE YOUR HOME:**

Single family home  Apartment No. of bedrooms \_\_\_\_\_ No. of bathrooms \_\_\_\_\_

How long have you lived here? \_\_\_\_\_

Will ward have own room  YES  NO.

If shared, with whom? Name: \_\_\_\_\_ age: \_\_\_\_\_

Do you have any guns or other weapons stored on the property?  YES  NO

If yes, what type of weapon? \_\_\_\_\_

Where and how stored? \_\_\_\_\_

Is there a swimming pool or hot tub?  YES  NO Is it fenced?  YES  NO

Pets in the home: \_\_\_\_\_

**OTHER CHILDREN IN THE HOME: (under 18 years of age)**

Name	Birthdate	School Attending	Relation to guardian

**OTHER ADULTS IN THE HOME: (18 and over)**

Name	Birthdate	Social Security #	Employer/school	Relation to guardian

Does any adult in the home have any problem that could affect the minor, for example, child abuse/molestation, criminal background, violent behavior, alcohol and/or drug problem?

NO  YES

Explain \_\_\_\_\_

Have the police ever been to your home?  YES  NO

If yes, when and why?

Does anyone object to the guardianship?  YES  NO If yes, who? \_\_\_\_\_

\*\*\*\*\*

**SECTION IV**

**INFORMATION ABOUT THE CHILD OR CHILDREN SUBJECT TO THE GUARDIANSHIP:**

Name	Sex	Date of Birth	Place of Birth	Social Security #

More listed on separate sheet

1. Has the child been involved with the Juvenile Court?  YES  NO  DON'T KNOW

Dates: \_\_\_\_\_ Case Number: \_\_\_\_\_

Where did the proceeding take place? (County) \_\_\_\_\_ (State) \_\_\_\_\_

2. Does the child have a Social Worker?  YES  NO  DON'T KNOW

If, yes, who is the Social Worker? \_\_\_\_\_ Telephone \_\_\_\_\_

3. Is there a custody or visitation order for the child(ren)?  YES  NO  DON'T KNOW

Date of the order: \_\_\_\_\_ Case Number: \_\_\_\_\_

Where did the proceeding take place? (County) \_\_\_\_\_ (State) \_\_\_\_\_

5. Has the child(ren) been subjected to abuse, neglect, or abandonment?

YES  NO  DON'T KNOW

If yes, explain: \_\_\_\_\_

6. Does the child have siblings (brothers and sisters)?  YES  NO

Please provide names and ages of the siblings and the person with whom they live:

NAME OF SIBLING	AGE	WITH WHOM THEY LIVE

9. Does the child visit his/her brothers and/or sisters?  YES  NO How often? \_\_\_\_\_

10. Is there any specific religious or cultural heritage, such as Native American ancestry, that would affect the child's future plans?  YES  NO Explain: \_\_\_\_\_

11. Does the family have Native American ancestry or receive any medical or other services/benefits from a tribe? YES  NO  UNKNOWN

If yes, please explain: \_\_\_\_\_

Name and address of Tribe: \_\_\_\_\_

**SCHOOL AND/OR DAY CARE:**

(Please contact the child/ren's school or daycare and tell them that we will be contacting them. Please attach a copy of the child's most recent report card to this questionnaire).

Name \_\_\_\_\_ Director or Principal

Address \_\_\_\_\_

Teacher's Name \_\_\_\_\_

Grade level \_\_\_\_\_ If Daycare, is it licensed? \_\_\_\_\_

How is the child doing in school? (Attach copy of recent report card) \_\_\_\_\_

Does the child have any problems with teachers or other children in school? If so, please explain.

What school and non-school activities does the child participate in (sports, scouting, dance, Little League, martial arts, music, etc.)? \_\_\_\_\_

Does the child have any special educational needs?  YES  NO

Describe \_\_\_\_\_

Is the child receiving Special Education/Resource Services?  YES  NO

Describe \_\_\_\_\_

Is the child receiving services through the Regional Center?  YES  NO

Case Manager: \_\_\_\_\_ Telephone: \_\_\_\_\_

If the child has special needs, how do you plan to address these needs? \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL/HEALTH CARE:**

(Please attach a copy of the child's immunization record).

Doctor's Name: \_\_\_\_\_

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

Dentist's Name: \_\_\_\_\_

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

Medical Insurance Provider: \_\_\_\_\_ Medical Number: \_\_\_\_\_

Date of last medical appointment: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Date of last dental appointment: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Are all required immunizations current?  YES  NO

Does the child have any medical problems, physical or developmental disabilities, etc.?

YES  NO

If yes, what is your plan to meet these needs? \_\_\_\_\_

Does the child take any prescribed medications?  YES  NO

If yes, what? \_\_\_\_\_

Does the child have any behavioral, emotional or psychological problems?  YES  NO

Describe \_\_\_\_\_

Has the child ever been hospitalized?  YES  NO Why, When? \_\_\_\_\_

Has the child seen a counselor in the past?  YES  NO Why, When? \_\_\_\_\_

Is the child seeing a counselor now?  YES  NO If yes, how often? \_\_\_\_\_

Name of counselor: \_\_\_\_\_ Telephone: \_\_\_\_\_

Is there any additional information not requested on this form that you would like the Court to be aware of or consider?  YES  NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I declare under penalty of perjury that the foregoing is true and correct and executed in

\_\_\_\_\_ on \_\_\_\_\_  
(city, state) (date)

Signature: \_\_\_\_\_