

**APPLICATION/APPOINTMENT OF
TEMPORARY CONSERVATOR
PC-302 REV. 10/96**

**STATE OF CONNECTICUT
COURT OF PROBATE**

Type or print in black ink.

TO: COURT OF PROBATE, DISTRICT OF	DISTRICT NO.	RECORDED
IN THE MATTER OF	RESPONDENT'S SOCIAL SECURITY NO. (if available)	RESPONDENT'S DATE OF BIRTH
Hereinafter referred to as the respondent, a proceeding for involuntary representation. DOMICILE OF RESPONDENT (Complete address)		PRESENT ADDRESS OF RESPONDENT (If institutionalized, give name and address of institution.)
PETITIONER (Name, address, zip code, and telephone number)		RELATIONSHIP OF PETITIONER TO RESPONDENT (C.G.S. §45a-654)

SPOUSE (If not the petitioner), CLOSEST RELATIVES (If none, so state) and INTERESTED PARTIES as defined in Probate Practice book, Rule 3.1.02. [Give names, addresses, zip codes, and relationships to respondent. (C.G.S. §45a-649).]

Additional data (on Second Sheet, PC-180), if any, is made a part hereof.

THE PETITIONER REPRESENTS that the respondent is:

- incapable of managing his/her affairs
- incapable of caring for himself/herself AND
 - has has not designated a conservator as provided by C.G.S. §§45a-645, 45a-650.
 - has has not executed a living will.
 - has has not appointed a health care agent. (Include name and address. If unknown, so state.)
 - has has not executed a power of attorney for health care decisions. (Include name and address of person appointed to act. If unknown, so state.)
 - is is not able to request or obtain an attorney. (C.G.S. §45a-649)
 - is is not able to pay for the services of an attorney. [Submit affidavit of financial status. (C.G.S. §45a-649)]
 - is or is expected to become an inpatient or outpatient in a hospital, clinic, or other facility for the diagnosis, observation, or treatment

of mental illness. [Note: If this box is checked, AND if consent or other authorization is being sought for (a) psychiatric medication treatment and/or (b) shock therapy, special statutory requirements must be met. The applicable forms (CM-42 or CM-46 for psychiatric medication and CM-44 for shock therapy), together with all supporting documentation, MUST be attached to this form.

ALL of the documents filed in connection therewith will be recorded in a confidential volume.]

Irreparable injury to the mental or physical health or financial or legal affairs of the respondent will result if a temporary conservator is not appointed. (Briefly describe reasons. Use Second Sheet, PC-180, if additional space is needed.)

The Report signed by a Connecticut-licensed physician who has examined the respondent is attached hereto and made part of this application. (C.G.S. §45a-654(b)(1).)

THE PETITIONER FURTHER REPRESENTS that the contents of this application are true to the petitioner's best knowledge and belief and requests that this Court appoint the proposed temporary

- Conservator of the Person Conservator of the Estate

The representations contained herein are made under the penalties of false statement.

PETITIONER'S SIGNATURE	DATE
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PROPOSED TEMPORARY CONSERVATOR(S)

If appointed, I/we will accept said position(s) of trust, as temporary conservator(s) of the:

Person (Complete this section.)

Estate (Complete this section.)

SIGNATURE	SIGNATURE
TYPE OR PRINT NAME	TYPE OR PRINT NAME
ADDRESS	ADDRESS
TELEPHONE NUMBER	TELEPHONE NUMBER

ATTORNEY FOR THE PETITIONER (Name, address, zip code, telephone number, and juris number.)

ATTORNEY FOR THE RESPONDENT (Name, address, zip code, telephone number, and juris number.)