



GUARDIANSHIP/CONSERVATORSHIP QUESTIONNAIRE

This confidential questionnaire is designed to help our firm best represent you. Please return the completed questionnaire prior to your appointment via mail, email, or fax.

Date _____

A. Contact Person:

Full Name _____

Relationship to Incapacitated person: _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Cell Phone No. _____

E-mail Address _____

How did you hear about our firm? _____

B. Incapacitated Person (person for whom you are seeking guardianship and/or conservatorship):

Name of Incapacitated person (person to be protected) _____

Home Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Date of Birth _____

Current Place of Residence: _ Home _ Nursing Home _ Hospital _ Group Home _ Other (please explain _____)

Is it anticipated that the incapacitated person will remain at current address for the next six (6) weeks? ___ Yes ___ No If no, please provide anticipated address: _____

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

Native Language of incapacitated person _____

Can incapacitated person communicate verbally? _____

C. Reason Incapacitated person needs a Guardian and/or Conservator:

Diagnosis of the incapacitated person:

Briefly describe the behaviors and physical/mental needs of the incapacitated person:

Briefly describe the types of services the incapacitated person is currently receiving:

Is the incapacitated person receiving any government benefits (For example, social security disability income, Medicaid, supplemental security income)? If so, please describe.

**Do you have an evaluation report or physician statement stating the person is incapacitated? __ No
__ Yes *If yes, please provide a copy.***

In your opinion, do you think the incapacitated person's attendance at the court hearing would be harmful to his/her health care, mental status or safety? ___ yes ___ no

D. Medical Information for Incapacitated Person:

1. Name of Physician Making Diagnosis _____

Specialty of Physician Making Diagnosis (ex. Neurologist, primary doctor)

Date last seen: _____

Street Address _____

City _____ **State** _____ **Zip** _____

Business Phone No. _____ **Fax No.** _____

2. Name of Second Proposed Examining Physician (If the person does not currently have a current evaluation report.) _____

Specialty of Physician Making Diagnosis (ex. Neurologist, primary doctor)

Street Address _____

City _____ State _____ Zip _____

Business Phone No. _____ Fax No. _____

E. Legal Documents of Incapacitated Person:

Does the incapacitated person have any of the following documents? *If so, please provide a copy.*

1. Durable General Power of Attorney (financial matters) ___ Yes ___ No
2. Medical Power of Attorney ___ Yes ___ No
3. Advance Medical Directive (living will) ___ Yes ___ No
4. Will ___ Yes ___ No
5. Trust _____

F. Summary of Income:

Please list the Incapacitated Person's estimated monthly income for the current year.

Monthly Amounts (if applicable)

Social Security _____

Pension Benefits _____

IRA Income _____

Disability Income _____

Rental Income _____

Interest Income _____

Dividends Income _____

Annuity Income _____

Other _____

G. Assets/Liabilities:

Real Estate Owned

Address _____

County _____ Tax Assessed Value \$ _____

Market Value \$ _____ Mortgage? _____ If so, how much is owed? _____

Please insert the value of each asset, if applicable, and how the asset is titled (ex. jointly with spouse, individually, etc.) in the appropriate space.

ASSETS	Asset Value	How titled?
PERSONAL EFFECTS		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
MONEY MARKET ACCOUNT		
CERTIFICATES OF DEPOSIT		
RESIDENCE (ASSESSED VALUE) BLOCK# _____ LOT# _____ (Obtain from Tax Bill)		
OTHER REAL ESTATE		
AUTOMOBILE(S)		
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
CASH VALUE - LIFE INSURANCE		
IRA		
NURSING HOME DEPOSIT		
OTHER		
OTHER		
TOTAL		

Does the incapacitated person have any debt? (ex. Promissory notes, credit card debt, car loan, etc.). If so, please indicate amount owed, to whom the amount is owed, and what type of debt.

H. Proposed Guardian and/or Conservator

1. Proposed Guardian

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Business Phone No. _____

E-mail Address _____

Relationship to Incapacitated Person _____

Any convictions or bankruptcy? No Yes Good credit? No Yes

2. Proposed Conservator (if different than proposed Guardian):

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Business Phone No. _____

E-mail Address _____

Relationship to Incapacitated Person _____

Any convictions or bankruptcy? No Yes Good Credit? No Yes

I. Petitioner/Person or Entity Bringing Petition:

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Business Phone No. _____

E-mail Address _____

Relationship to Incapacitated Person _____

J. Relatives of Incapacitated Person:

Please list ALL of the incapacitated person's living relatives in this order: spouse, adult children, parents, and adult siblings, or if NO such relatives are known, please list 3 other known relatives, including step-children. Attach additional sheets if needed.

Name	Relation	Full Mailing Address & Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

K. Nursing Home or Hospital in Which Incapacitated person is currently (if applicable):

Name of Nursing Home or Hospital _____

Name of Social Worker/Nurse Case Manager _____ Phone _____

Date of Admission to Nursing Home or Hospital (if applicable) _____

Reason for admission to Nursing Home or Hospital (if applicable) _____

L. Mental Health Options for Guardianship Petition:

Virginia Code Section 37.2-805 and 64.2-1009: Do you want to ask for authority for a guardian to consent to the admission of the incapacitated person to a facility and consent to medical and psychiatric treatment, including administration of anti-psychotic medications and administration of electro-convulsive therapy?

___ yes ___ no

M. Certification:

This information is true and accurate to the best of my knowledge and belief.

Signature of Client: _____