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. <u>Proposed Guardian and/or Conservator</u>

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. <u>Petitioner/Person or Entity Bringing Petition</u>:

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 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: ____