Guardianship Questionnaire

MARRIED

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to the appointment.

Date_____ File No._____

A. CONTACT PERSON

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

E-mail Address _____ Fax No. _____

B. PROTECTED PERSON

Name of Ward (person to be protected) _____

Permanent Address (domicile) _____

City _____ State _____ Zip _____

Home Phone _____ Date of Birth _____

Current Place of Residence: G Home G Nursing Home G Hospital

Is it anticipated that proposed Ward will remain at current address for the next six (6) weeks?

G Yes G No (please provide the anticipated address below)

Facility Name (if applicable) _____

Street Address _____

City _____ State _____ Zip _____

Work Phone _____ Fax Number _____

C. PROPOSED GUARDIAN(S)

1. Proposed Guardian

(if same as Contact Person, complete date of birth and relationship to ward sections only)

Full Name _____

Address _____

City State Zip

Home Phone _____ Work Phone _____

E-mail Address _____ Fax Number _____

Date of Birth _____ Relationship to Ward or Interest in Proceedings _____

2. Proposed Co-Guardian

Full Name _____

Address _____

City State Zip

Home Phone _____ Work Phone _____

E-mail Address _____ Fax Number _____

Date of Birth _____ Relationship to Ward or Interest in Proceedings _____

D. REFERRAL

By Whom Were You Referred To This Office?

Full Name _____

Address _____

_____

City State

Zip

Home Phone _____ Work Phone _____

_____

E-mail Address _____ Fax Number _____

_____

E. NAMES AND ADDRESSES OF PERSONS ENTITLED TO NOTICE OF HEARING

1. Ward's Spouse

Full Name _____

_____

Address _____

_____

City State

Zip

Home Phone _____ Work Phone _____

_____

E-mail Address _____ Fax Number _____

_____

Date of Birth _____

_____

2. Ward's Father (if living)

Full Name _____

_____

Street Address _____

_____

City _____ State _____ Zip _____

_____

Home Phone _____ Work Phone _____

E-mail Address _____ Fax Number_____

Date of Birth _____

3. <u>Ward's Mother</u> (if living)

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

E-mail Address _____ Fax Number _____

Date of Birth _____

4. <u>Ward's Children</u> (if applicable)

Full Name of Ward's G Son G Daughter _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

E-mail Address _____ Fax Number _____

Date of Birth _____

Full Name of Ward's G Son G Daughter _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

E-mail Address _____ Fax Number _____

Date of Birth _____

Full Name of Ward's G Son G Daughter _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

E-mail Address _____ Fax Number _____

Date of Birth _____

Full Name of Ward's G Son G Daughter _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

E-mail Address _____ Fax Number _____

Date of Birth _____

Full Name of Ward's G Son G Daughter _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

E-mail Address _____ Fax Number _____

Date of Birth _____

5. <u>Name of Facility in Which Ward is Living</u> (if applicable)

Name of Facility G Assisted Living Facility or G Nursing Home or G Other: _____

_____

Name of Social Worker (if applicable)_____

Street Address (if other than as indicated in Section B) _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

E-mail Address _____

Date of Admission to Facility (if applicable) _____

Name of Hospital prior to Facility Admission (if applicable) _____

Date of admission to Hospital prior to Facility Admission (if applicable) _____

Reason for admission to Hospital (if applicable) _____

_____

F. REASON PROPOSED WARD NEEDS A GUARDIAN

Diagnosis _____

Date of Diagnosis _____

Examples of Incapacity _____

_____

G. MEDICAL

Name of Physician Making Diagnosis _____

Street Address _____

City _____ State _____ Zip _____

Work Phone _____ Fax Number _____

E-mail Address _____

Name of Second Proposed Examining Physician _____

Street Address _____

City _____ State _____ Zip _____

Work Phone _____ Fax Number _____

E-mail Address _____

H. SUMMARY OF INCOME

Please list estimated income and expenses for the current year from the following sources.

Monthly Amounts

	Ward	Spouse
Social Security		
Pension Benefits		
IRA Income		
Disability Income		
Rental Income		
Interest Income		
Dividends Income		
Annuity Income		
Other		
Other		
TOTAL		

I. REAL ESTATE

Please list any real estate in which ward has an ownership interest.

1. Address _____

City State Zip

Assessed Value $_____ Market Value $ _____

2. Address _____

City State Zip

Assessed Value $_____ Market Value $ _____

_____

3. Address _____

_____

City State Zip

Assessed Value $_____ Market Value $ _____

_____

J. MEDICAID

Does the proposed ward receive Medicaid? G Yes G No

If so, provide date Medicaid benefits began _____

_____

K. HEALTH INSURANCE

Name of Company _____

_____

L. LIFE INSURANCE

1. Name of Company_____

_____

Policy No. _____ Face Amount of Policy $ _____

_____

Beneficiary _____

_____

2. Name of Company _____

_____

Policy No. _____ Face Amount of Policy $ _____

_____

Beneficiary _____

_____

3. Name of Company _____

_____

Policy No. _____ Face Amount of Policy $ _____

_____

Beneficiary _____

M. AUTOMOBILE

Make_____
Model_____

Year _____ Estimated Resale Value $ _____

Name on Title _____

N. PERSONAL EFFECTS

Estimated Value $ _____

O. FINANCIAL SUMMARY

ASSETS/LIABILITIES

Please insert the value of each asset/liability in the appropriate space.

ASSETS	HUSBAND WIFE JOINT LIABILITIES			
PERSONAL EFFECTS				
AUTOMOBILE				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICATES OF DEPOSIT				
RESIDENCE (ASSESSED VALUE)				
OTHER REAL ESTATE				
ADDITIONAL AUTOMOBILES				
MUTUAL FUNDS				

STOCKS				
BONDS				
ANNUITIES				
CASH VALUE - LIFE INSURANCE				
IRA				
NURSING HOME DEPOSIT				
OTHER				
OTHER				
TOTALS				

P. CERTIFICATION

The undersigned hereby represents to The Law Offices of Evan J. Krame, P.C., and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client/Client Representative: _____