Guardianship Questionnaire

SINGLE

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 Number _____

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

Marital Status: G Divorced G Widowed - Date of Death _____

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 _____

Street 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 _____

Street 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 Father (if living)

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

E-mail Address _____ Fax Number _____

Date of Birth _____

2. Ward's Mother (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 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 _____

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

G Assisted Living Facility or G Nursing Home or G Other

Name of Facility _____

Name of Social Worker (if applicable) _____

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

City _____ State _____ Zip _____

Work Phone _____ Fax Number _____

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 the Ward's estimated income from the following sources:

	Monthly Amounts
Social Security	_____
Pension Benefits	_____
IRA Income	_____
Disability Income	_____
Rental Income	_____
Interest Income	_____
Dividends Income	_____
Annuity Income	_____
Other	_____
TOTAL	_____

I. REAL ESTATE

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

1. Address: _____

_____

City State Zip

Assessed Value $_____ Market Value $ _____

_____

2. 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 _____

4. Name of Company _____

Policy No. _____ Face Amount of Policy $ _____

Beneficiary _____

M. AUTOMOBILE

Make _____ Year _____

Model _____

Estimated Resale Value $ _____

Name Title _____

N. PERSONAL EFFECTS

Estimated Value $ _____

O. FINANCIAL SUMMARY – ASSETS & LIABILITIES

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

ASSET/LIABILITY	**ASSET TOTAL LIABILITY TOTAL**	
PERSONAL EFFECTS		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
MONEY MARKET ACCOUNT		
CERTIFICATES OF DEPOSIT		
RESIDENCE (ASSESSED VALUE)		
OTHER REAL ESTATE		
AUTOMOBILE(S)		
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
CASH VALUE - LIFE INSURANCE		
IRA		
FACILITY DEPOSIT		
OTHER		
OTHER		
TOTAL		

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: _____