

GUARDIANSHIP AND/OR CONSERVATORSHIP INTAKE

1. A. Full Name of Person to be Protected ("Respondent"): _____

B. SS#: _____ Date of Birth: _____
C. Address: _____

D. Telephone Number: _____
E. If in Care Facility, Contact Person and Title: _____

F. If in Hospital/Care Center, Where and When Admitted?: _____

2. Treating Physician for Respondent's Address and Telephone Number: _____

- A. Is any Doctor or Advisor recommending the Respondent be placed for treatment outside the home: _____ Yes _____ No
- B. If Yes, why?: _____

- C. Doctor's Statement Obtained: Yes No (Circle One)
- D. Diagnosis: _____

- E. Explain problems, i.e. wanders, suicidal, other deficits, including, but not limited to, memory loss, risk of falling, loss of eyesight/hearing, incontinence, self neglect, etc.... (Please be specific and give examples): _____

F. Brief description of the Respondent's mental condition: _____

G. Brief description of the Respondent's physical condition: _____

H. What is the incapacity plan for the Respondent: _____

3. A. Does an emergency exist requiring a Temporary Guardianship?

_____ Yes _____ No

If Yes, please explain the circumstances surrounding the need for an emergency: _____

B. Does the Respondent need to be placed in facility:

_____ Yes _____ No

If Yes, what type? _____

4. Is there a Health Care Representative: _____ Yes _____ No

If Yes, Whom is Appointed: _____

(Please provide a copy to the Lawyer if available)

5. Is there a financial Power of Attorney: _____ Yes _____ No

If Yes, Whom is Appointed: _____

(Please provide a copy to the Lawyer if available)

6. Is there a Trustee for the Respondent: _____ Yes _____ No

If Yes, Whom: _____

(Please provide a copy to the Lawyer if available)

7. Is there a Will for the Respondent: _____ Yes _____ No

(If Yes, please provide a copy to the Lawyer if available)

8. If there is a financial manager for the Respondent, is he/she having any trouble?: _____ Yes _____ No

If Yes, please describe: _____

9. Should there be any limits on the authority of the proposed Guardian and/or Conservator?: _____ Yes _____ No

If Yes, please described the limits suggested: _____

10. Benefits received (if applicable):

_____ VA ~ Amount \$ _____;
_____ Social Security ~ \$ _____;
_____ Medicaid ~ \$ _____.

11. Does the Respondent own any real property: _____ Yes _____ No
If Yes, please list the Real Property (Location and estimated Value): _____

12. Will any real property belonging to the Respondent need to be sold in order to fund care for the Respondent: _____ Yes _____ No

13. Estimated value of Respondent's estate: \$ _____

14. Does the Respondent have any assets that are held jointly with another other person? _____ Yes _____ No

If Yes, please describe and discuss with the Attorney: _____

15. Does the Proposed Guardian and/or Conservator owe money to the Respondent?: _____ Yes _____ No

If Yes, please explain: _____

16. Does the Proposed Guardian and/or Conservator receive money from the Respondent regularly?: _____ Yes _____ No
If Yes, please explain: _____

17. A. Who is the Person who will be signing the Petition ("Petitioner"): _____
B. Address: _____
C. Telephone Number: _____
D. Date of Birth: _____
E. Relationship to Respondent: _____

18. A. Who is the Proposed Guardian?: _____
B. Address: _____
C. Telephone Number: _____
D. Date of Birth: _____
E. Relationship to Respondent: _____
F. Is the proposed Guardian being paid to provide services to the Respondent?: _____ Yes _____ No
If Yes, please explain: _____

19. A. Who is the Proposed Conservator?: _____
B. Address: _____
C. Telephone Number: _____
D. Date of Birth: _____
E. Relationship to Respondent: _____
F. F. Is the proposed Guardian being paid to provide services to the Respondent?: _____ Yes _____ No
If Yes, please explain: _____

20. Has the proposed Guardian and/or Conservator had any of the following problems (there is no time limitation on these, it is to mean EVER):

_____ Conviction of a Crime

_____ Filed for Bankruptcy

_____ Revocation of an occupational or professional license

If Yes, please list who and give a brief description of dates and/or reason (i.e. filed for Bankruptcy due to...): _____

21. Please list the Name, Address and Telephone Number of any Spouse or Adult Children of the Respondent:

NAME, RELATIONSHIP & TELEPHONE NUMBER

ADDRESS

NAME, RELATIONSHIP & TELEPHONE NUMBER

ADDRESS

NAME, RELATIONSHIP & TELEPHONE NUMBER

ADDRESS

NAME, RELATIONSHIP & TELEPHONE NUMBER

ADDRESS

NAME, RELATIONSHIP & TELEPHONE NUMBER

ADDRESS

NAME, RELATIONSHIP & TELEPHONE NUMBER

ADDRESS

22. Does anyone NOT listed above live with the Respondent:

_____ Yes _____ No

If Yes, please explain whom (please also explain relationship): _____

23. Please list the Names, Telephone Numbers and Relationships of any persons you believe would have pertinent information that is not already listed:

NAME, TELEPHONE NUMBER & RELATIONSHIP

NAME, TELEPHONE NUMBER & RELATIONSHIP

NAME, TELEPHONE NUMBER & RELATIONSHIP

NAME, TELEPHONE NUMBER & RELATIONSHIP

CLIENT AGREEMENT

Payment of your account is due in full within thirty (30) days of billing. If an amount is not paid within 60 days of the billing date, we reserve the right to terminate representation of you without notice, unless acceptable, written payment arrangements are made before the 60th day and strictly abided by. In such a situation, client agrees that the matter can be turned over to collections.

NOTE: If our work is completed and you have not come in to sign documents within a thirty (30) day period, a bill for attorney fees will be sent as though the matter has been completed.

SIGNING BELOW MEANS YOU HAVE READ, FULLY UNDERSTOOD AND AGREED TO THE ABOVE.

DATE

SIGNATURE