

**PROPOSED 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 No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Version of Software:  WordPerfect  Word  Other \_\_\_\_\_

**B. PROTECTED PERSON**

Name of Ward (person to be protected) \_\_\_\_\_

Permanent Address (domicile) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Current Place of Residence:  Home  Nursing Home  Hospital

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

Yes

No (please provide the anticipated address below)

Facility Name (if applicable) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

**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 No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Version of Software:  WordPerfect  Word  Other \_\_\_\_\_

Date of Birth \_\_\_\_\_

Relationship to Ward or Interest in Proceedings \_\_\_\_\_

**2. Proposed Co-Guardian**

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Version of Software:  WordPerfect  Word  Other \_\_\_\_\_

Date of Birth \_\_\_\_\_

Relationship to Ward or Interest in Proceedings \_\_\_\_\_

**D. REFERRAL**

By Whom Were You Referred To This Office?

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Have you visited our Website at [www.begleylawyer.com](http://www.begleylawyer.com)? Yes  No

Do you have any ideas for improving our Website? If so, please discuss.

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

**1. Ward's Spouse**

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth \_\_\_\_\_

**2. Ward's Father (if living)**

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth \_\_\_\_\_

**3. Ward's Mother (if living)**

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth \_\_\_\_\_

**4. Ward's Children (if applicable)**

**Full Name of Ward's**  **Son**  **Daughter** \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Full Name of Ward's**  **Son**  **Daughter** \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Full Name of Ward's**  **Son**  **Daughter** \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Full Name of Ward's**  Son  Daughter \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Full Name of Ward's**  Son  Daughter \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Full Name of Ward's**  Son  Daughter \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth \_\_\_\_\_

**5. Administrator of Nursing Home in Which Ward is Living (if applicable)**

Name of Nursing Home \_\_\_\_\_

Name of Administrator \_\_\_\_\_

Name of Social Worker \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

E-mail Address \_\_\_\_\_

Date of Admission to Nursing Home (if applicable) \_\_\_\_\_

Name of Hospital prior to Nursing Home Admission (if applicable) \_\_\_\_\_

Date of admission to Hospital prior to Nursing Home 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 \_\_\_\_\_

Business Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

E-mail Address \_\_\_\_\_

**Name of Second Proposed Examining Physician** \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

E-mail Address \_\_\_\_\_

**H. SUMMARY OF INCOME**

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

	<u>Monthly Amounts</u>	
	<u>Ward</u>	<u>Spouse</u>
<b>Social Security</b>	_____	_____
<b>Pension Benefits</b>	_____	_____
<b>IRA Income</b>	_____	_____
<b>Disability Income</b>	_____	_____
<b>Rental Income</b>	_____	_____
<b>Interest Income</b>	_____	_____
<b>Dividends Income</b>	_____	_____
<b>Annuity Income</b>	_____	_____
<b>Other</b>	_____	_____
<b>Other</b>	_____	_____
<b>TOTAL</b>	_____	_____

**I. MONTHLY SHELTER EXPENSES**

**(Please divide annual expenses by 12 and quarterly expenses by 3)**

Rent/Mortgage	\$ _____
Real Estate Taxes	\$ _____
Water	\$ _____
Sewer	\$ _____
Utilities (Heat, Electric & Telephone) (1/12th of last 12 months)	\$ _____
Homeowner's insurance premium	\$ _____
Condominium fees	\$ _____
<b>Total Monthly Housing Expenses</b>	<b>\$ _____</b>

**J. MONTHLY NON-SHELTER LIVING EXPENSES**

Food \$ \_\_\_\_\_  
Medical \$ \_\_\_\_\_  
Clothing \$ \_\_\_\_\_  
Transportation (including auto insurance) \$ \_\_\_\_\_  
Home Maintenance \$ \_\_\_\_\_  
Life Insurance Premiums \$ \_\_\_\_\_  
Health Insurance Premiums \$ \_\_\_\_\_  
Cable TV \$ \_\_\_\_\_  
Federal and State Income Taxes \$ \_\_\_\_\_  
Other \$ \_\_\_\_\_  
  
**Total Monthly Non-Shelter Living Expenses** \$ \_\_\_\_\_

**K. REAL ESTATE**

1. Tax Block \_\_\_\_\_ Lot \_\_\_\_\_  
Municipality \_\_\_\_\_ Assessed Value \$ \_\_\_\_\_  
Market Value \$ \_\_\_\_\_ (apply reciprocal of equalization ratio)

2. Tax Block \_\_\_\_\_ Lot \_\_\_\_\_  
Municipality \_\_\_\_\_ Assessed Value \$ \_\_\_\_\_  
Market Value \$ \_\_\_\_\_ (apply reciprocal of equalization ratio)

3. Tax Block \_\_\_\_\_ Lot \_\_\_\_\_  
Municipality \_\_\_\_\_ Assessed Value \$ \_\_\_\_\_  
Market Value \$ \_\_\_\_\_ (apply reciprocal of equalization ratio)

**L. MEDICAID**

Does the proposed ward receive Medicaid?       Yes       No

If so, provide date Medicaid benefits began \_\_\_\_\_

**M. 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 \_\_\_\_\_

**N. AUTOMOBILE**

Make \_\_\_\_\_ Model \_\_\_\_\_

Year \_\_\_\_\_ Estimated Resale Value \$ \_\_\_\_\_

**O. PERSONAL EFFECTS**

Estimated Value \$ \_\_\_\_\_

**P. 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) BLOCK# _____ LOT# _____ (Obtain from Tax Bill)				
OTHER REAL ESTATE				
ADDITIONAL AUTOMOBILES				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
CASH VALUE - LIFE INSURANCE				
IRA				
NURSING HOME DEPOSIT				
OTHER				
OTHER				
<b>TOTALS</b>				

**Q. MONTHLY COST OF NURSING HOME**

Monthly Nursing Home Cost           \$ \_\_\_\_\_

Monthly Prescription Cost               \$ \_\_\_\_\_

Monthly Incontinent Cost               \$ \_\_\_\_\_

Monthly Other Cost                       \$ \_\_\_\_\_

**Total Monthly Cost**                   \$ \_\_\_\_\_

The nursing home is paid through \_\_\_\_\_ (month/year).

**R. CERTIFICATION**

The undersigned hereby represents to Begley & Bookbinder, 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:

\_\_\_\_\_