PROPOSED 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 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

Marital Status: ☐ Divorced ☐ Widowed - Date Of Death ____________________

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? 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 Father (if living)

Full Name ____

Street Address ____

City ______________________________ State ____________________ Zip ________________

Home Phone No. __________________________ Business Phone No. ____________________

E-mail Address ______________________________ Fax No. ______________________________

Date of Birth ____

2. 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 ____

3. 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 ____________________

4. 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) ____________________

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F. **REASON PROPOSED WARD NEEDS A GUARDIAN**

Diagnosis ____________________

Date of Diagnosis ____________________

Examples of Incapacity ____________________

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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 the Ward's estimated income and expenses for the current year 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

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)

J. MEDICAID

Does the proposed ward receive Medicaid? ☐ Yes ☐ No

If so, provide date Medicaid benefits began ______________________

K. 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 ______________________

L. AUTOMOBILE

Make ______________ Model ______________

Year ______________ Estimated Resale Value $ ______________

M. 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) 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		

N. 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).

O. 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:

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Rev. 1/16/2008