

**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 our initial 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. \_\_\_\_\_

**B. PROTECTED PERSON**

Name of Incapacitated Person (person to be protected) \_\_\_\_\_

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

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

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

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

Is it anticipated that proposed Incapacitated Person 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 \_\_\_\_\_

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 Incapacitated Person sections only)**

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

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

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

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

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

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

Relationship to Incapacitated Person 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. \_\_\_\_\_

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

Relationship to Incapacitated Person 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. \_\_\_\_\_

Have you visited our Website?      Yes G No G

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. Incapacitated Person's Spouse**

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

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

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

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

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

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

**2. Incapacitated Person'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. Incapacitated Person'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. Incapacitated Person's Children (if applicable)**

**Full Name of Incapacitated Person=s G Son G Daughter** \_\_\_\_\_

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

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

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

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

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

**Full Name of Incapacitated Person=s G Son G Daughter** \_\_\_\_\_

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

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

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

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

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

**Full Name of Incapacitated Person=s G Son G Daughter** \_\_\_\_\_

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

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

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

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

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

**Full Name of Incapacitated Person=s G Son G 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 Incapacitated Person 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 Incapacitated Person NEEDS A GUARDIAN**

Diagnosis \_\_\_\_\_

Date of Diagnosis \_\_\_\_\_

Examples of Incapacity \_\_\_\_\_

**G. INCAPACITATED PERSON=S DOCTOR**

**Name of Primary Physician** \_\_\_\_\_

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

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

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

E-mail Address

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Name of Second 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>Incapacitated Person</u>	<u>Spouse</u>
Social Security	_____	
Pension Benefits	_____	
IRA Income	_____	
Disability Income	_____	
Rental Income	_____	
Interest Income	_____	_____
Dividends Income	_____	
Annuity Income	_____	
Other	_____	
Other	_____	
TOTAL	_____	_____

**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 \$ \_\_\_\_\_

**Total Monthly Housing Expenses** \$ \_\_\_\_\_

**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 - Please list any real estate owned.**

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 Incapacitated Person receive Medicaid?      G Yes      G No

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

**M. LIFE INSURANCE - Please list any life insurance owned.**

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 - Please list any automobile owned.**

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

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

**O. PERSONAL EFFECTS - Please list any personal effects owned.**

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 the Law Offices of Douglas A. Fendrick, LLC., that the information contained in this intake form is accurate and complete. The undersigned is aware that the law firm will rely on this information and further understands that 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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