

GUARDIAN & CONSERVATOR DATA INTAKE FORM – 2006

NAME OF INCAPACITATED: _____

RESIDENCE ADDRESS: _____

COUNTY/CITY/ZIP: _____ **TELEPHONE #:** _____

DOB: _____ **AGE:** _____ **SSN:** _____ **MARITAL STATUS:** _____

PRESENT LOCATION: _____

RELATIVES (required by law to be given notice of the proceeding)

List ALL relatives of incapacitated, in following order: spouse, children, siblings, parents, aunt/uncles, grandchildren, nieces/nephews, cousins):

Name/Age	Relation	Full Mailing Address & Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL INFORMATION

Attending Physician: _____ **Date last visit:** _____

Address/Phone: _____

Psychiatrist: _____ **Date last visit:** _____

Address/Phone: _____

Hospital & Date of Admission: _____ **Phone:** _____

Hospital Social Worker: _____ **Phone:** _____

Nursing/Adult Home: _____ **Phone:** _____

Address: _____ **Contact Name:** _____

Please note that provision of this intake instrument or its review by any employee of Thompson and McMullan P.C., shall not of itself evince the existence of an attorney client relationship with Thompson and McMullan P.C.

DIAGNOSIS

INCOME

Social Security \$ _____ /month Type: _____

Retirement \$ _____ /month Source: _____

Interest \$ _____ /month Source: _____

Other \$ _____ /month Source: _____

ASSETS

Real Estate

Location: _____

Current Tax Assessed value \$ _____ Taxes due? _____

How Held/Ownership? _____

Mortgage/Liens? _____

Insurance carrier and policy number: _____

If the real estate is occupied, please explain in comments area below.

Motor Vehicles

Make/Model _____ Year _____ Value _____

Make/Model _____ Year _____ Value _____

Any other valuable personal property:

Describe _____ Value _____

Bank Accounts:

Location _____ Acct # _____ Value _____

Location _____ Acct # _____ Value _____

Location _____ Acct # _____ Value _____

Life Insurance

KIND	OWNER	BENEFICIARY	LIFE	FACE AMOUNT	CASH VALUE
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HEALTH INSURANCE

Medicare A _____ B _____ ID # _____

Secondary Supplement _____ ID # _____

Medicaid ID # _____ City/County _____

Eligibility Date: _____ Worker _____

PROPOSED GUARDIAN:

NAME: _____

ADDRESS: _____

COUNTY/CITY/ZIP: _____ TELEPHONE #: _____

DOB: _____ AGE: _____ SSN: _____ RELATION: _____

ANY CONVICTIONS or BANKRUPTCY: _____

EVER BEEN REFUSED BOND? _____

PROPOSED CONSERVATOR:

NAME: _____

ADDRESS: _____

COUNTY/CITY/ZIP: _____ TELEPHONE #: _____

DOB: _____ AGE: _____ SSN: _____ RELATION: _____

ANY CONVICTIONS or BANKRUPTCY: _____

EVER BEEN REFUSED BOND? _____

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PETITIONER / PERSON OR ENTITY BRINGING PETITION:

NAME: _____

ADDRESS: _____

COUNTY/CITY/ZIP: _____ TELEPHONE #: _____

DOB: _____ AGE: _____ RELATION: _____

ANY CONVICTIONS or BANKRUPTCY: _____

CURRENT AGENT UNDER POWER OF ATTORNEY (enclose copy), IF ANY: _____

ADDRESS: _____ COUNTY/CITY/ZIP: _____

TELEPHONE #: _____ DATE OF POA: _____ RELATION: _____

STATUS OF POA (CURRENT, REVOKED, ETC) _____

PERSON COMPLETING THIS FORM: _____ RELATION: _____

ADDRESS: _____ TELEPHONE #: _____

EMAIL ADDRESS: _____

HOW WERE YOU REFERRED TO US? _____

ADDITIONAL COMMENTS:

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Please note that most courthouses do not allow cell phones (or any type of weapon, etc) inside their building. Please do not bring such items to the hearing or qualification.

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