

THE LAW FIRM OF
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GUARDIAN & CONSERVATOR INTAKE FORM

NAME OF INCAPACITATED: _____

RESIDENCE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

DOB: _____ AGE: _____ SSN: _____

MARITAL STATUS: _____

PRESENT LOCATION:

ADDRESS: _____

CITY/STATE/ZIP: _____

PERSON COMPLETING THIS FORM

NAME: _____

RESIDENCE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

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

RELATION TO INCAPACITATED: _____

RELATIVES:

Please provide the names and mailing addresses of the respondent's spouse, adult children, parents and adult siblings or, if no such relatives are known to the petitioner, at least three other known relatives of the respondent, including step-children, must be included for notice. Please list all relatives of incapacitated, in following order: spouse, adult children, parents, and adult siblings, parents, aunt/uncles, grandchildren, nieces/nephews, cousins):

NAME	AGE	RELATIONSHIP TO INCAPACITATED	FULL MAILING ADDRESS & TELEPHONE NUMBER

MEDICAL INFORMATION

ATTENDING PHYSICIAN

NAME: _____

DATE LAST VISIT: _____

OFFICE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

EMAIL: _____

PSYCHIATRIST

NAME: _____

DATE LAST VISIT: _____

OFFICE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

EMAIL: _____

HOSPITAL OR NURSING HOME

ADDRESS: _____

CITY/STATE/ZIP: _____

CONTACT NAME: _____

TELEPHONE #: _____

EMAIL: _____

DATE OF ADMISSION: _____

HOSPITAL OR NURSING HOME SOCIAL WORKER

NAME: _____

DATE LAST VISIT: _____

OFFICE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

EMAIL: _____

DIAGNOSIS

The allegedly incapacitated person's physical and mental condition is an issue. Please state the most recent diagnosis which impairs the person. If you do not have a diagnosis, please describe the symptoms, or attach our medical certification form found at www.virginiaelderlawattorney.com/doctor-certificate-fillable.pdf.

HEALTH INSURANCE

Medicare

A _____ B _____ Id # _____

Secondary Supplement

Policy Number: _____

Company: _____

Agent: _____

Medicaid

Id #: _____

City/county: _____

Eligibility Date: _____

Worker Name: _____

Phone: _____

Email: _____

INCOME SUMMARY TABLE

	MONTHLY INCOME	TYPE/SOURCE
Monthly Social Security Income	\$	Old Age/ Retirement SSI SSDI (circle one)
Private Retirement (IRA, 401(k), etc.)	\$	
Monthly Investment & Other Income	\$	
Interest	\$	
Other	\$	

ASSET SUMMARY TABLE

	HUSBAND	WIFE	JOINT
Equity in Virginia Real Estate (Sched. A)	\$	\$	\$
Equity in Real Estate not in VA. (Sched.A)	\$	\$	\$
Investments - Non-Retirement (Sched. B)	\$	\$	\$
Ordinary Bank Accounts (Sched. C)	\$	\$	\$
Life Insurance - Death Benefit (Sched. D) (Include Accidental Death Benefit)	\$	\$	\$
Tangible Personal Property (Sched. E)	\$	\$	\$
Business or Trust Property (Sched. F)	\$	\$	\$
Vested Retirement Assets (Sched. G)	\$	\$	\$
Anticipated Inheritances (Sched. H)	\$	\$	\$
Powers of Appointment (Sched. J)	\$	\$	\$
Other Property (Sched. K)	\$	\$	\$
ASSET TOTALS:	\$	\$	\$
Liabilities, Excluding Mortgages (Sched. L)	\$	\$	\$

PROPOSED GUARDIAN/CONSERVATOR

FIRST CHOICE:

Name: _____

Residence Address: _____

City/State/Zip: _____

Telephone #: _____

DOB: _____ Age: _____ SSN: _____ Marital Status: _____

Email: _____

Relation to Incapacitated: _____

Attorney at Law, or Disbarred Attorney at Law? Yes No

Any Criminal Convictions or Bankruptcy Filings: Yes No

Ever Been Refused Bond? Yes No

SECOND CHOICE:

Name: _____

Residence Address: _____

City/State/Zip: _____

Telephone #: _____

DOB: _____ Age: _____ SSN: _____ Marital Status: _____

Email: _____

Relation to Incapacitated: _____

Attorney at Law, or Disbarred Attorney at Law? Yes No

Any Criminal Convictions or Bankruptcy Filings: Yes No

Ever Been Refused Bond? Yes No

PETITIONER (PERSON OR ENTITY BRINGING PETITION)

Name: _____

Residence Address: _____

City/State/Zip: _____

Telephone #: _____

DOB: _____ Age: _____ SSN: _____ Marital Status: _____

Email: _____

Relation to Incapacitated: _____

Attorney at Law, or Disbarred Attorney at Law? Yes No

Any Criminal Convictions or Bankruptcy Filings: Yes No

Ever Been Refused Bond? Yes No

POWER OF ATTORNEY INFORMATION

Does Incapacitated have (or did s/he ever have) a General Power of Attorney? Yes No

If Yes, Please Provide:

Name: _____

Residence Address: _____

City/State/Zip: _____

Telephone #: _____

Email: _____

DOB: _____ Age: _____ SSN: _____ Marital Status: _____

Relation to Incapacitated: _____

Status of POA (Circle One): Current Revoked Held in Escrow

Does Incapacitated have (or did s/he ever have) a Medical Power of Attorney? Yes No

If Yes, Please Provide:

Name: _____

Residence Address: _____

City/State/Zip: _____

Telephone #: _____

Email: _____

DOB: _____ Age: _____ SSN: _____ Marital Status: _____

Relation to Incapacitated: _____

Status of MPOA (Circle One): Current Revoked Held in Escrow

Date Intake Form completed: _____

Who may we thank for referring you to us: _____

ADDITIONAL COMMENTS
