FAIRFAX, VIRGINIA OFFICE:
10640 Main Street, Suite 200
Fairfax, Virginia 22030
Phone: 703-691-1888
FREDERICKSBURG, VIRGINIA OFFICE:
511 Westwood Office Park
Fredericksburg, Virginia 22401
Phone: 540-479-1435

FARR LAW FIRM
A PROFESSIONAL CORPORATION
WWW.FARRLAWFIRM.COM
WWW.EVERYTHINGELDERLAW.COM
TOLL-FREE TEL: 800-399-FARR
FAX: 703-345-9999

DISTRICT OF COLUMBIA OFFICE:
1775 I St NW, Suite 350
Washington, DC 20006
Phone: 202-587-2797
ROCKVILLE, MARYLAND OFFICE:
1 Research Court, Suite 450
Rockville MD 20850
Phone: 301-519-8041

GUARDIAN & CONSERVATOR INTAKE FORM

LEGAL NAME OF INCAPACITATED PERSON: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____, _____ _____

TELEPHONE NUMBER: _____-_____-_____ **TYPE OF PHONE**_____

DOB: _____/_____/_____ **CURRENT AGE:** _____
Month Day Year

SOCIAL SECURITY NUMBER: _____ - _____ - _____ **MARITAL STATUS:** _____

PRESENT LOCATION (IF DIFFERENT FROM RESIDENCE, ABOVE):

STREET ADDRESS: _____

CITY/STATE/ZIP: _____, _____ _____

TELEPHONE NUMBER: _____-_____-_____

IS THE INCAPACITATED PERSON IN NEED OF AN EMERGENCY HEARING? ☐ **YES** ☐ **NO**

INFORMATION ABOUT THE INDIVIDUAL COMPLETING THIS FORM

LEGAL NAME: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____, _____ _____

TELEPHONE NUMBER: _____-_____-_____ **TYPE OF PHONE**_____

DOB: _____/_____/_____ **CURRENT AGE:** _____
Month Day Year

SOCIAL SECURITY NUMBER: _____ - _____ - _____ **MARITAL STATUS:** _____

YOUR RELATIONSHIP TO INCAPACITATED PERSON: _____

RELATIVES. Please provide the names and mailing addresses of the incapacitated person's spouse, all adult children, living parents, and all adult siblings. If no such relatives are known to you, please provide the names and mailing addresses of at least three other relatives of the incapacitated person (*e.g.* aunts or uncles, grandchildren, nieces or nephews, step-children, etc.). This information must be included on any Petition, for notice purposes. Attach additional pages as needed.

Name	Age	Relationship*	Mailing Address and Telephone Number
			*Street:*__________ *City, State, Zip:*__________ *Phone:* _____ - _____ - _____
			*Street:*__________ *City, State, Zip:*__________ *Phone:* _____ - _____ - _____
			*Street:*__________ *City, State, Zip:*__________ *Phone:* _____ - _____ - _____
			*Street:*__________ *City, State, Zip:*__________ *Phone:* _____ - _____ - _____
			*Street:*__________ *City, State, Zip:*__________ *Phone:* _____ - _____ - _____
			*Street:*__________ *City, State, Zip:*__________ *Phone:* _____ - _____ - _____
			*Street:*__________ *City, State, Zip:*__________ *Phone:* _____ - _____ - _____
			*Street:*__________ *City, State, Zip:*__________ *Phone:* _____ - _____ - _____
			*Street:*__________ *City, State, Zip:*__________ *Phone:* _____ - _____ - _____
			*Street:*__________ *City, State, Zip:*__________ *Phone:* _____ - _____ - _____

** Please state the relationship of the relative named to the incapacitated person.*

MEDICAL INFORMATION

PRIMARY PHYSICIAN
Name of Primary Physician:
Name of Practice/ Office:
Street Address: _____ City, State, Zip: _____ Telephone: _____-_____-_____. Email _____
Date of last office visit: _____/ _____/_____ *Month Day Year*

PSYCHIATRIST
Name of Psychologist:
Name of Practice/ Office:
Street Address: _____ City, State, Zip: _____ Telephone: _____-_____-_____. Email _____
Date of last office visit: _____/ _____/_____ *Month Day Year*

HOSPITAL OR NURSING HOME
Name of Facility:
Name of Contact at Facility:
Street Address: _____ City, State, Zip: _____ Telephone: _____-_____-_____. Email _____
Date of admission: _____/ _____/_____ *Month Day Year*

SOCIAL WORKER
Name of Social Worker:
Title of Social Worker:
Street Address: _____ City, State, Zip: _____ Telephone: _____-_____-_____. Email _____
Date of last visit: _____/_____/_____ *Month Day Year*

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 a medical certification form or letter.

_____

_____

_____

_____

HEALTH INSURANCE

Medicare

A_____ B_____ Identification Number _____

Secondary Insurance

Policy Number: _____

Company: _____

Agent: _____

Medicaid

Identification Number _____

City/County: _____

Eligibility Date: (MM/DD/YYYY) _____/_____/_____

Eligibility Worker's Name: _____

Eligibility Worker's Phone: _____

Eligibility Worker's Email: _____

INCOME SUMMARY TABLE

	MONTHLY INCOME	TYPE/SOURCE
Monthly Income	$	Retirement / SSI / SSDI *(circle one)*
Private Retirement [IRA, 401(k), etc.]	$	
Monthly Investment & Other Income	$	
Interest	$	
Other	$	

ASSET SUMMARY TABLE

ASSET	VALUE
Equity in Primary Real Estate	$
Equity in Other Real Estate	$
Investments - Non-Retirement	$
Ordinary Bank Accounts	$
Life Insurance - Death Benefit (Include Accidental Death Benefit)	$
Tangible Personal Property	$
Business or Trust Property	$
Vested Retirement Assets	$
Anticipated Inheritances	$
Other Property	$
ASSET TOTALS:	$
Liabilities, Excluding Mortgages	$

PETITIONER(S) (PERSON OR ENTITY WHO INITIATES THE PROCEEDINGS):

Petitioner #1's Full Name: _____
Street Address: _____
City/State/Zip: _____, _____ _____
Evening Phone: _____-_____-_____ Daytime Phone _____-_____-_____
Email: _____
DOB: _____/ _____/_____ Social Security Number: _____ - ____ - _____
Month Day Year
Relation to Incapacitated: _____ Marital Status _____
Attorney at Law? ❒Y ❒N Criminal Convictions or Bankruptcy Filings?❒Y ❒N
Ever Been Refused Bond? ❒Y ❒N

Petitioner #2's Full Name: _____
Street Address: _____
City/State/Zip: _____, _____ _____
Evening Phone: _____-_____-_____ Daytime Phone _____-_____-_____
Email: _____
DOB: _____/ _____/_____ Social Security Number: _____ - ____ - _____
Month Day Year
Relation to Incapacitated: _____ Marital Status _____
Attorney at Law? ❒Y ❒N Criminal Convictions or Bankruptcy Filings?❒Y ❒N
Ever Been Refused Bond? ❒Y ❒N

PROPOSED GUARDIAN(S)/CONSERVATOR(S)

Position (choose one) ☐ ***Guardian*** ☐ ***Conservator*** ☐ ***Guardian and Conservator***
Full Name: _____
Street Address: _____
City/State/Zip: _____, _____ _____
Evening Phone: _____-_____-_____ Daytime Phone _____-_____-_____
Email: _____
DOB: _____/ _____/_____ Social Security Number: _____ - ____ - _____
Month Day Year
Relation to Incapacitated: _____ Marital Status _____
Attorney at Law? ❒Y ❒N Criminal Convictions or Bankruptcy Filings?❒Y ❒N
Ever Been Refused Bond? ❒Y ❒N

Position (choose one) ☐ ***Guardian*** ☐ ***Conservator*** ☐ ***Guardian and Conservator***
Full Name: _____
Street Address: _____
City/State/Zip: _____, _____ _____
Evening Phone: _____-_____-_____ Daytime Phone _____-_____-_____
Email: _____
DOB: _____/ _____/_____ Social Security Number: _____ - ____ - _____
Month Day Year
Relation to Incapacitated: _____ Marital Status _____
Attorney at Law? ❒Y ❒N Criminal Convictions or Bankruptcy Filings?❒Y ❒N
Ever Been Refused Bond? ❒Y ❒N

POWER OF ATTORNEY INFORMATION

Has the Incapacitated Person ever signed a General Power of Attorney? ❒ Yes ❒ No
If Yes, Please Provide:
Agent's Full Name: _____
Street Address: _____
City/State/Zip: _____, _____ _____
Evening Phone: _____-_____-_____ Daytime Phone _____-_____-_____
Email: _____
DOB: _____/ _____/_____ Social Security Number: _____ - ____ - _____
Month Day Year
Relation to Incapacitated: _____ Marital Status _____
Date Power of Attorney was signed (if known) _____
Status of this Power of Attorney: ❒ *Current* ❒ *Revoked* ❒ *Held by someone else*

Has the Incapacitated Person ever signed a Medical Power of Attorney, Living Will, or Advance Medical Directive? ❒ Yes ❒ No
If Yes, Please Provide:
Agent's Full Name: _____
Street Address: _____
City/State/Zip: _____, _____ _____
Evening Phone: _____-_____-_____ Daytime Phone _____-_____-_____
Email: _____
DOB: _____/ _____/_____ Social Security Number: _____ - ____ - _____
Month Day Year
Relation to Incapacitated: _____ Marital Status _____
Date Power of Attorney was signed (if known) _____
Status of this Power of Attorney: ❒ *Current* ❒ *Revoked* ❒ *Held by someone else*

Additional Comments:

_____

_____

_____

_____