

<p>FAIRFAX, VIRGINIA OFFICE: 10640 Main Street, Suite 200 Fairfax, Virginia 22030 Phone: 703-691-1888</p> <p>FREDERICKSBURG, VIRGINIA OFFICE: 511 Westwood Office Park Fredericksburg, Virginia 22401 Phone: 540-479-1435</p>	<p>FARR LAW FIRM</p> <p>A PROFESSIONAL CORPORATION</p> <p>WWW.FARRLAWFIRM.COM WWW.EVERYTHINGELDERLAW.COM TOLL-FREE TEL: 800-399-FARR FAX: 703-345-9999</p>	<p>DISTRICT OF COLUMBIA OFFICE: 1775 I St NW, Suite 350 Washington, DC 20006 Phone: 202-587-2797</p> <p>ROCKVILLE, MARYLAND OFFICE: 1 Research Court, Suite 450 Rockville MD 20850 Phone: 301-519-8041</p>
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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: _____ / _____ / _____ <i>Month Day Year</i>	

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

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

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 Social Security Income	\$	Retirement / SSI / SSDI <i>(circle one)</i>
Private Retirement [IRA, 401(k), etc.]	\$	
Monthly Investment & Other Income	\$	
Interest	\$	
Other	\$	

ASSET SUMMARY TABLE

ASSET	VALUE
Equity in Virginia Real Estate	\$
Equity in Real Estate not in Virginia	\$
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

