PROPOSED GUARDIANSHIP QUESTIONNAIRE

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to the 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. ______________

Version of Software: ☐ WordPerfect ☐ Word ☐ Other ______________

B. PROTECTED PERSON

Name of Ward (person to be protected) ______________________

Permanent Address (domicile) ______________________

City ______________ State ______________ Zip ______________

Home Phone No. ______________ Date of Birth ______________

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

Is it anticipated that proposed Ward will remain at current address for the next six (6) weeks?

☐ Yes

☐ 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. **<u>PROPOSED GUARDIAN(S)</u>**

1. **<u>Proposed Guardian</u>**

(if same as Contact Person, complete date of birth and relationship to ward sections only)

Full Name ______________________________

Street Address ______________________________

City ______________ State ______________ Zip ______________

Home Phone No. ______________ Business Phone No. ______________

E-mail Address ______________ Fax No. ______________

Version of Software: ☐ WordPerfect ☐ Word ☐ Other ______________

Date of Birth ______________________________

Relationship to Ward or Interest in Proceedings ______________________________

2. **<u>Proposed Co-Guardian</u>**

Full Name ______________________________

Street Address ______________________________

City ______________ State ______________ Zip ______________

Home Phone No. ______________ Business Phone No. ______________

E-mail Address ______________ Fax No. ______________

Version of Software: ☐ WordPerfect ☐ Word ☐ Other ______________

Date of Birth ______________________________

Relationship to Ward or Interest in Proceedings ______________________________

D. **<u>REFERRAL</u>**

By Whom Were You Referred To This Office?

Full Name ______________________________

Street Address ______________________________

City ______________ State ______________ Zip ______________

Home Phone No. ______________ Business Phone No. ______________

E-mail Address ____________________ Fax No. ____________________

Have you visited our Website at www.hanulalaw.com? Yes ☐ No ☐

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. Ward's Spouse (if living)

Full Name ____________________

Street Address ____________________

City ____________________ State ____________ Zip ____________________

Home Phone No. ____________________ Business Phone No. ____________________

E-mail Address ____________________ Fax No. ____________________

Date of Birth ____________________

2. Ward'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. Ward'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. Ward's Children (if applicable)

Full Name of Ward's ☐ Son ☐ Daughter ____

Street Address____

City __________________________________ State ___________________ Zip __________________

Home Phone No. ________________________ Business Phone No. ________________________

E-mail Address ___________________________ Fax No. ___________________________________

Date of Birth____

Full Name of Ward's ☐ Son ☐ Daughter ____

Street Address____

City __________________________________ State ___________________ Zip __________________

Home Phone No. ________________________ Business Phone No. ________________________

E-mail Address ___________________________ Fax No. ___________________________________

Date of Birth____

Full Name of Ward's ☐ Son ☐ Daughter ____

Street Address____

City __________________________________ State ___________________ Zip __________________

Home Phone No. ________________________ Business Phone No. ________________________

E-mail Address ___________________________ Fax No. ___________________________________

Date of Birth____

Full Name of Ward's ☐ Son ☐ Daughter ______________________________

Street Address ______________________________

City ____________ State ____________ Zip ____________

Home Phone No. ____________ Business Phone No. ____________

E-mail Address ____________ Fax No. ____________

Date of Birth ______________________________

Full Name of Ward's ☐ Son ☐ Daughter ______________________________

Street Address ______________________________

City ____________ State ____________ Zip ____________

Home Phone No. ____________ Business Phone No. ____________

E-mail Address ____________ Fax No. ____________

Date of Birth ______________________________

Full Name of Ward's ☐ Son ☐ Daughter ______________________________

Street Address ______________________________

City ____________ State ____________ Zip ____________

Home Phone No. ____________ Business Phone No. ____________

E-mail Address ____________ Fax No. ____________

Date of Birth ______________________________

5. <u>Administrator of Nursing Home in Which Ward is Living</u> (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 WARD NEEDS A GUARDIAN**

Diagnosis ____________________

Date of Diagnosis ____________________

Examples of Incapacity ____________________

____

G. **MEDICAL**

Name of Physician Making Diagnosis ____________________

Street Address ____________________

City ____________________ State ____________________ Zip ____________________

Business Phone No. ____________________ Fax No. ____________________

E-mail Address ____________________

Name of Second Proposed Examining 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.

	Monthly Amounts	
	Ward	**Spouse**
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

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 ward receive Medicaid? ☐ Yes ☐ No

If so, provide date Medicaid benefits began ______________________________

M. LIFE INSURANCE

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

Make ______________________ Model ______________________

Year ______________ Estimated Resale Value $ ______________________

O. PERSONAL EFFECTS

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				
TOTALS				

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 Scott M. Hanula, Esquire that the information contained in this intake form is accurate and complete, and that the undersigned understands that Scott M. Hanula, Esquire will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

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