GUARDIAN AND CONSERVATOR INTAKE FORM

The information requested on this form will help us properly advise you, and will provide the information necessary to prepare any pleadings that may be necessary.

If you need additional space for any question, please attach additional sheets.

CSRA PROBATE

BY HUGGINS PEIL, LLC

ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL

PERSONAL INFORMATION

PETITIONER'S LEGAL NAME _____

Prefer to be called_____ Date of Birth_____ Social Security Number _____

Street Address_____ City_____ State_____ Zip _____

Home Telephone_____ Cell phone_____ Business Telephone _____

E-mail Address_____ ☐ It is OK to communicate with me via my E-mail address.

Relationship to Incapacitated Person: _____

PROPOSED GUARDIAN/CONSERVATOR LEGAL NAME _____

Prefer to be called_____ Date of Birth_____ Social Security Number _____

Street Address_____ City_____ State_____ Zip _____

Home Telephone_____ Cell phone_____ Business Telephone _____

E-mail Address_____ ☐ It is OK to communicate with me via my E-mail address.

Relationship to Incapacitated Person: _____

PROPOSED CO-GUARDIAN/CONSERVATOR LEGAL NAME _____

Prefer to be called_____ Date of Birth_____ Social Security Number _____

Street Address_____ City_____ State_____ Zip _____

Home Telephone_____ Cell phone_____ Business Telephone _____

E-mail Address_____ ☐ It is OK to communicate with me via my E-mail address.

Relationship to Incapacitated Person: _____

INCAPACITATED PERSON'S LEGAL NAME _____

Prefer to be called_____ Date of Birth_____ Social Security Number _____ Home Address_____

_____ City_____ State Zip _____ Home Telephone

_____ Cell phone_____ Business Telephone _____

Place of birth: City/County_____ State_____ Native Language of Incapacitated Person _____

Is there any alternative mode of communication for the Incapacitated Person? _____

☐ Married: Date of Marriage_____ ☐ Divorced ☐ Widowed ☐ Single

INFORMATION REGARDING THE INCAPACITATED PERSON

SPOUSE *(if any)*

SPOUSE'S LEGAL NAME *(if married)* _____

Prefer to be called_____ Date of Birth_____ Social Security Number _____

Street Address_____ City_____ State_____ Zip _____

Date of marriage _____

SPOUSE'S LEGAL NAME *(if widowed)* _____

Date of marriage_____ Date of death _____

CHILDREN *(if any)*

Does he/she have children? ☐ *Yes* ☐ *No*

FULL LEGAL NAME **Date of Birth**

1. _____ _____

Address: _____

2. _____ _____

Address: _____

3. _____ _____

Address: _____

4. _____ _____

Address: _____

5. _____ _____

Address: _____

6. _____ _____

Address: _____

7. _____ _____

Address: _____

PARENTS *(if alive)*

Does he/she have a living parent? ☐ *Yes* ☐ *No*

MOTHER'S FULL LEGAL NAME

_____

Address: _____

FATHER'S FULL LEGAL NAME

_____

Address: _____

SIBLINGS *(if any)*

Does he/she have any living siblings? ☐ *Yes* ☐ *No*

FULL LEGAL NAME **Date of Birth**

1. _____ _____

Address: _____

2. _____ _____

Address: _____

3. _____ _____

Address: _____

4. _____ _____

Address: _____

5. _____ _____

Address: _____

6. _____ _____

Address: _____

7. _____ _____

Address: _____

OTHER RELATIVES

If the Incapacitated Person has no known spouse, children, parents, or adult siblings, then please state the name, date of birth, address and relationship of at least three known relatives, including step-children of the Incapacitated Person:

FULL LEGAL NAME **Date of Birth**

1. _____ _____

Address: _____

Relationship: _____

2. _____ _____

Address: _____

Relationship: _____

3. _____ _____

Address: _____

Relationship: _____

ESTATE PLANNING DOCUMENTS

Does the Incapacitated Person have any of the following documents?

If so, please bring the documents with you to our appointment.

Durable Power of Attorney?	☐ Yes	☐ No	Date signed: _____
Advance Medical Directive?	☐ Yes	☐ No	Date signed: _____
Last Will and Testament?	☐ Yes	☐ No	Date signed: _____

NATURE OF INCAPACITY AND GUARDIANSHIP PLAN

Please state the name, address and telephone number of the physician or other professional who can provide a written evaluation of the Incapacitated Person:

Name: _____ Professional Field: _____

Address: _____

Business Telephone: _____ Relationship: _____

Please describe the physical and mental condition of the Incapacitated Person, with particular reference to the alleged incapacity:

Please provide a brief description of the services currently being provided for the Incapacitated Person's health, care, safety and/or rehabilitation:

Please provide a recommendation for the Incapacitated Person's living arrangements and treatment plan:

FINANCIAL RESOURCES
(MONTHLY INCOME)

Salary:	$ _____
Social Security:	$ _____
SSI:	$ _____
SSDI:	$ _____
IRA account withdrawals:	$ _____
Retirement income:	$ _____
Dividends and interest:	$ _____
Other (identify source):	$ _____
	$ _____
Total income:	$ _____

FINANCIAL RESOURCES
(ASSETS)

Does the Incapacitated Person have an interest in any **real estate**? ☐ Yes ☐ No

If so, please identify:

Address:_____

Current fair market value:_____ Assessed value: _____

Mortgage or debt owed on property:_____

Please identify any other person(s) on the title:

Name:_____

Address:_____

Relationship to incapacitated person: _____

Does the Incapacitated Person own any **tangible personal property**,
such as motor vehicles, jewelry, or valuable collections? ☐ Yes ☐ No

If so, please list a description and current value of each item of personal property.

Description:_____ Current value: $_____

Description:_____ Current value: $_____

Description:_____ Current value: $_____

Description:_____ Current value: $_____

Description:_____ Current value: $_____

Description:_____ Current value: $_____

Does the Incapacitated Person have an interest in any **accounts at financial institutions**, such as checking accounts, savings accounts, investment accounts, or brokerage accounts? ☐ Yes ☐ No

If so, please list the type of account, the name of the financial institution, the account number, and the current value of each account.

Type of account:_______________ Current value: $____________
Financial institution:_________________ Account Number: ___________________

Please identify any other person(s) on the account:

Name:____
Address:____
Relationship to incapacitated person: ____

Type of account:_______________ Current value: $____________
Financial institution:_________________ Account Number: ___________________

Please identify any other person(s) on the account:

Name:____
Address:____
Relationship to incapacitated person: ____

Type of account:_______________ Current value: $____________
Financial institution:_________________ Account Number: ___________________

Please identify any other person(s) on the account:

Name:____
Address:____
Relationship to incapacitated person: ____

Type of account:_______________ Current value: $____________
Financial institution:_________________ Account Number: ___________________

Please identify any other person(s) on the account:

Name:____
Address:____
Relationship to incapacitated person: ____

DEBTS

Does the Incapacitated Person owe any debts to creditors? ☐ Yes ☐ No

If so, please list each debt and identify the nature of the debt (e.g., credit card, personal loan), the creditor, the purpose for which the debt was incurred (e.g., household goods, education expenses), and the total balance due on the debt.

Creditor:_____

Nature of debt:_____ Balance due: $_____

Purpose: _____

Creditor:_____

Nature of debt:_____ Balance due: $_____

Purpose: _____

Creditor:_____

Nature of debt:_____ Balance due: $_____

Purpose: _____

Additional Space

Use this space if there was a section with limited space.

Remember to save this PDF to your computer and upload the file using our secure upload referenced in your confirmation email.

Print this PDF for your own records as well.