

# ANNE M. ZAUN, ESQ.

## CONFIDENTIAL QUESTIONNAIRE FOR PROPOSED GUARDIANSHIP (SINGLE)

**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 Number \_\_\_\_\_

### **A. CONTACT PERSON**

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

### **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

Marital Status: \_\_\_ Divorced \_\_\_ Widowed \_\_\_ / \_\_\_ / \_\_\_ Date Of Death

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. PROPOSED GUARDIAN(S)**

**1. Proposed Guardian**

**(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. \_\_\_\_\_

Date of Birth    /    /   

Relationship to Ward or Interest in Proceedings \_\_\_\_\_

**2. Proposed Co-Guardian**

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth    /    /   

Relationship to Ward or Interest in Proceedings \_\_\_\_\_

**D. REFERRAL**

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. \_\_\_\_\_

**E. NAMES AND ADDRESSES OF PERSONS ENTITLED TO NOTICE OF HEARING**

**1. 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 \_\_ / \_\_ / \_\_

**2. 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 \_\_ / \_\_ / \_\_

**3. Ward's Children (if applicable)**

**(1) Full Name of Ward's \_\_\_ Son \_\_\_ Daughter**

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth \_\_ / \_\_ / \_\_

**(2) Full Name of Ward's \_\_\_ Son \_\_\_ Daughter**

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth \_\_ / \_\_ / \_\_

**(3) Full Name of Ward's \_\_\_ Son \_\_\_ Daughter**

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth \_\_ / \_\_ / \_\_

**(4) Full Name of Ward's \_\_\_ Son \_\_\_ Daughter**

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

Date of Birth \_\_ / \_\_ / \_\_

**4. Administrator of Nursing Home in Which Ward is Living (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 the Ward's estimated income and expenses for the current year from the following sources.

**Monthly Amounts**

**Social Security** \_\_\_\_\_

**Pension Benefits** \_\_\_\_\_

**IRA Income** \_\_\_\_\_

**Disability Income** \_\_\_\_\_

**Rental Income** \_\_\_\_\_

**Interest Income** \_\_\_\_\_

**Dividends Income** \_\_\_\_\_

**Annuity Income** \_\_\_\_\_

**Other** \_\_\_\_\_

**TOTAL** \_\_\_\_\_

**I. 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) \_\_\_\_\_

**J. MEDICAID**

Does the proposed ward receive Medicaid? \_\_\_ Yes \_\_\_ No

If so, provide date Medicaid benefits began \_\_\_ / \_\_\_ / \_\_\_

**K. 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 \_\_\_\_\_

**L. AUTOMOBILE**

Make \_\_\_\_\_ Model \_\_\_\_\_

Year \_\_\_\_\_ Estimated Resale Value \$ \_\_\_\_\_

**M. FINANCIAL SUMMARY**

**ASSETS/LIABILITIES**

Please insert the value of each asset/liability in the appropriate space.

<u>ASSET/LIABILITY</u>	<u>ASSET TOTAL</u>	<u>LIABILITY TOTAL</u>
Personal Effects		
Checking Account		
Savings Account		
Money Market Account		
Certificates Of Deposit		
Residence (Assessed Value) Block# _____ Lot# _____ (Obtain from Tax Bill)		
Other Real Estate		
Automobile (s)		
Mutual Funds		
Stocks		
Bonds		
Annuities		
Cash Value - Life Insurance		
IRA		
Nursing Home Deposit		
Other		
Other		
<b>TOTAL</b>		

**N. 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).

**O. CERTIFICATION**

The undersigned hereby represents to Anne M. Zaun, Esq. that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm 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/Client Representative:

**X** \_\_\_\_\_