Date:_____

Estimate:_____

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MATTHEW C. SUNDERLIN
Certified as an Elder Law Attorney through the National Elder Law Foundation

QUESTIONNAIRE FOR GUARDIANSHIP & CONSERVATORSHIP

PETITIONER(S)		
Full name:	Home phone number:	
	Work phone number:	
Address:		
City:	State:	Zip:
Email:	Home fax number:	
Date of Birth:	Work fax number:	
Relationship to Incapacitated Person:		
Social Security Number:		

Have you ever been convicted of a felony? ☐ Yes ☐ No If yes, explain on separate sheet.

Have you ever filed bankruptcy? ☐ Yes ☐ No If yes, explain on separate sheet.

Have you ever been licensed to practice law? ☐ Yes ☐ No If yes, explain on separate sheet.

INCAPACITATED PERSON						
Full name:						
Date of birth	Social Security Number:					
Physical Description: (required by VA State Police)	Height	Weight	Hair Color	Eye Color	Sex	Race
Physical Address:						
City:	State:		Zip:			
Mailing Address:						
City:	State:		Zip:			
Place of birth:						

INCAPACITATED PERSON'S SPOUSE		
Widow/Widower □ Divorced □	If married, spouse's name: Date of marriage:	
Spouse's date of birth:	Spouse's Social Security Number:	
Spouse's address:		
City	State:	Zip:

INCAPACITATED PERSON'S CHILDREN			
Full name: ①	Home Phone: Work Phone: Email:	Age	Relationship:
Address:			
Full name: ②	Home Phone: Work Phone: Email:	Age	Relationship:
Address:			
Full name: ③	Home Phone: Work Phone: Email:	Age	Relationship:
Address:			
Full name: ④	Home Phone: Work Phone: Email:	Age	Relationship:
Address:			
Full name: ⑤	Home Phone: Work Phone: Email:	Age	Relationship:
Address:			

INCAPACITATED PERSON'S PARENTS			
Father's full name:			
Address:	City:	State:	Zip:
Is the person's father alive? ☐ Yes ☐ No If deceased, date of death:			
Mother's full name:			
Address:	City:	State:	Zip:
Is the person's mother alive? ☐ Yes ☐ No If deceased, date of death:			

INCAPACITATED PERSON'S BROTHERS & SISTERS			
Full name: ①	Home Phone: Work Phone: Email:	Age	Relationship:
Address:			
Full name: ②	Home Phone: Work Phone: Email:	Age	Relationship:
Address:			
Full name: ③	Home Phone: Work Phone: Email:	Age	Relationship:
Address:			
Full name: ④	Home Phone: Work Phone: Email:	Age	Relationship:
Address:			
Full name: ⑤	Home Phone: Work Phone: Email:	Age	Relationship:
Address:			

INCAPACITATED PERSON'S OTHER RELATIVES

If the person has no known living spouse, children, parents, or adult siblings, please state the name, age, address and relationship of at least 3 known relatives, including step-children of the individual.

Full name: ①	Home Phone: Work Phone: Email:	Age	Relationship:
Address:			
Full name: ②	Home Phone: Work Phone: Email:	Age	Relationship:
Address:			
Full name: ③	Home Phone: Work Phone: Email:	Age	Relationship:
Address:			

INCAPACITATED PERSON'S RESIDENCE

Name of hospital, nursing home or other facility, if any:

Address:	City:	State:	Zip
How long has the person resided in the hospital, nursing home or other facility?			
Where did the person reside prior to entering the hospital, nursing home or other facility?			
Address:	City:	State:	Zip
How long did the person live at this address:			

INCAPACITATED PERSON'S PHYSICIAN(S)

Name of physician who will provide a written mental and physical evaluation of the person: ①			
Address:	City:	State:	Zip
Name of physician who will provide a written mental and physical evaluation of the person: ②			
Address:	City:	State:	Zip

INCAPACITATED PERSON'S CONDITION

Describe the person's physical and mental condition:
Describe the services currently provided for the person's health, care, safety and rehabilitation:
Provide a recommendation for the person's living arrangements and treatment plan:
Is the person's native language English? ☐ Yes ☐ No If no, what is it?
Is there any alternative mode of communication for the person? ☐ Yes ☐ No If yes, what is it?

INCAPACITATED PERSON'S ESTATE PLANNING DOCUMENTS

If the person has any of the following documents, please attach a copy:

Power of Attorney	Advance Medical Directive	Trust	Last Will & Testament
☐ Yes ☐ No	or Living Will ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

INCAPACITATED PERSON'S REAL ESTATE

Does the person own any real estate (jointly or individually)?			☐ Yes ☐ No
Property Address:	City:	State:	Zip:
Tax Assessed value: $	Appraised value, if any: $		
Does the property have a deed of trust or mortgage?			☐ Yes ☐ No
Is there more than one mortgage?			☐ Yes ☐ No
① Name of mortgage company:			
Address:	City:	State:	Zip
Balance due on the mortgage: $			
② Name of mortgage company:			
Address:	City:	State:	Zip
Balance due on the mortgage: $			
If the person owns other real estate interests, provide the information on a separate sheet.			

INCAPACITATED PERSON'S PERSONAL PROPERTY

Description	How titled or owned	Value	Amount Owed
Example: 2003 Ford	Incapacitated person	$9,500.00	$0.00

INCAPACITATED PERSON'S BANK ACCOUNTS			
Type of Account	Name of Bank & Account number	How owned or titled	Approximate Balance
Example: savings	Wachovia: 3656156546546	joint with mother	$6,500

INCAPACITATED PERSON'S STOCKS & BONDS			
Type of Account, Name of Stocks & Bonds, Number of Shares	Name of Financial Institution & Account Number	How Titled or Owned	Approximate Value

INCAPACITATED PERSON'S SAFE DEPOSIT BOX			
Financial Institution	Authorized Entrants	Location of Key	Content

INCAPACITATED PERSON'S ANNUITIES & RETIREMENT ACCOUNTS			
Type of Benefit	Financial Institution	How Titled	Value or Balance

INCAPACITATED PERSON'S ANNUAL INCOME	
Salary	
IRA account withdrawal	
Dividends & Interest	
Social Security	
Retirement Income	
Other	
TOTAL	

INCAPACITATED PERSON'S DEBTS			
Creditor	Name of Debtors	Purpose	Balance / Monthly Payment

INCAPACITATED PERSON'S LIFE INSURANCE POLICIES			
Policy Number:		Policy Number:	
Name of Company:		Name of Company:	
Address:		Address:	
City:		City:	
State	Zip	State	Zip
Name of Insured:		Name of Insured:	
Name of Owner:		Name of Owner:	
Premium: $_____ Paid how frequently: _____		Premium: $_____ Paid how frequently: _____	
Is insurance an employment benefit?		Is insurance an employment benefit?	
Who pays coverage?		Who pays coverage?	