***Thompson*McMullan, P.C.**
100 Shockoe Slip
Richmond, Virginia 23219
email: mbrawls@t-mlaw.com
804-698-6241 (direct dial)
804-649-0654 (fax)
www.t-mlaw.com
www.majette.net

GUARDIANSHIP & CONSERVATOR QUESTIONNAIRE

NAME OF INCAPACITATED _____

RESIDENCE ADDRESS: _____

COUNTY/CITY/ZIP: _____ **TELEPHONE #:** _____

DOB: _____ **AGE:**_____ **SSN:**_____ **MARITAL STATUS:** _____

PRESENT LOCATION (incl. room & floor for hosp): _____

Height (apx) _____ **Weight (apx)** _____ **Hair color** _____ **Eye color** _____ **Race** _____
(For State police form SP-237 reporting info for incapacitated adults)

RELATIVES OF INCAPACITATED PERSON:

Please list **ALL** of the incapacitated person's living relatives in this order: **spouse, adult children, parents, and adult siblings** or, if **no** such relatives are known, please list **THREE** other known living relatives, including step-children.

Name/Age	Relation	Full Mailing Address & Telephone Number

Please note that provision of this intake instrument or its review by any employee of *Thompson*McMullan P.C., shall not of itself evince the existence of an attorney client relationship with *Thompson*McMullan P.C.

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DIAGNOSIS

_____

_____

MEDICAL INFORMATION

Current Physician: _____ **Date last visit:** _____

Address/Phone: _____

Psychiatrist/Neurologist: _____ **Date last visit:** _____

Address/Phone: _____

Hospital: _____ **Date of Admission:** _____

Hospital Social Worker: _____ **Phone:** _____

Nursing/Adult Home: _____ **Phone:** _____

Address: _____ **Contact Name:** _____

INCOME

Social Security $_____**/month Type:** _____

Retirement $_____**/month Source:** _____

Interest $_____**/month Source:** _____

Other $_____**/month Source:** _____

ASSETS

Real Estate

Location: _____

Current Tax Assessed value $_____**Taxes due?** _____

How Held/Ownership?_____

Mortgage/Liens? _____

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ASSETS *(Real Estate continued):*

Insurance carrier and policy number: _____

If the real estate is occupied, please explain_____

Motor Vehicles

Make/Model_____ **Year**_____ **Value**_____

Make/Model_____ **Year**_____ **Value**_____

Any other valuable personal property:

Describe_____ **Value**_____

Bank Accounts

Location _____ **Acct #** _____ **Value** _____

Location _____ **Acct #** _____ **Value** _____

Location _____ **Acct #** _____ **Value** _____

Life Insurance

KIND whole/term	OWNER	BENEFICIARY	LIFE	FACE AMOUNT	CASH VALUE

HEALTH INSURANCE

Medicare A_____ **B**_____ **ID #** _____

Secondary Supplement _____ **ID#** _____ **Premium $**_____

Medicare D: _____ **ID#**_____ **Premium $**_____

Medicaid ID #_____ **City/County** _____

Eligibility Date: _____ **Worker** _____

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PROPOSED GUARDIAN:

NAME:_____

ADDRESS: _____

TELEPHONE: HOME: _____ **WORK:**_____ **CELL:**_____ **EMAIL:** _____

DOB: _____ **AGE:**_____ **SSN:**_____ **RELATION:** _____

ANY CONVICTIONS or BANKRUPTCY:_____

EVER BEEN REFUSED BOND? _____

PROPOSED CONSERVATOR (if different than Guardian):

NAME:_____

ADDRESS: _____

TELEPHONE: HOME: _____ **WORK:**_____ **CELL:**_____ **EMAIL:** _____

DOB: _____ **AGE:**_____ **SSN:**_____ **RELATION:** _____

ANY CONVICTIONS or BANKRUPTCY:_____

EVER BEEN REFUSED BOND? _____ **(to serve as conservator for an individual whose estate including real property OR annual income exceeds $15,000.00 you must be able to qualify for a fiduciary surety bond and a credit report will be requested from the surety company when applying for the bond)**

PETITIONER / PERSON OR ENTITY BRINGING PETITION:

NAME:_____

ADDRESS: _____

TELEPHONE: HOME: _____ **WORK:**_____ **CELL:**_____ **EMAIL:** _____

DOB: _____ **AGE:**_____ **SSN:**_____ **RELATION:** _____

ANY CONVICTIONS or BANKRUPTCY:_____

EVER BEEN REFUSED BOND? _____

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CURRENT AGENT UNDER POWER OF ATTORNEY OR MEDICAL DIRECTIVE (*ENCLOSE COPY*)

NAME:_____

ADDRESS: _____

TELEPHONE: HOME: _____ **WORK:**_____ **CELL:**_____ **EMAIL:** _____

DOB: _____ **AGE:**_____ **SSN:**_____ **RELATION:** _____

DATE OF POA: _____ **STATUS OF POA (CURRENT, REVOKED, RESIGNED, ETC.)** _____

PERSON COMPLETING THIS FORM:

NAME:_____

ADDRESS: _____

TELEPHONE: HOME: _____ **WORK:**_____ **CELL:**_____ **EMAIL:** _____

RELATION to incapacitated person: _____

HOW WERE YOU REFERRED TO US?_____

ADDITIONAL COMMENTS:

_____

MENTAL HEALTH OPTIONS FOR GUARDIANSHIP PETITION:

Va. Code §37.2-805 & § 37.2-1009: Ask for authority for guardian to consent to the admission of respondent to a facility & consent to medical and psychiatric treatment, including administration of anti-psychotic medications and administration of electro-convulsive therapy _____YES_____NO

Please note that courthouses do not permit cell phones or similar devices (or any weapon) inside their buildings. Please do not bring such items to the hearing or qualification or you may not be admitted in the court.

PLEASE RETURN COMPLETED FORM TO MARY BETH RAWLS, *THOMPSON*MCMULLAN, PC, 100 SHOCKOE SLIP, RICHMOND, VA 23219 OR VIA FAX 804-649-0654 OR VIA EMAIL MBRAWLS@T-MLAW.COM