GOLDSTEIN LAW FIRM, LLC
ATTORNEYS AT LAW
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GUARDIAN AND CONSERVATOR INTAKE FORM

Petitioner

Name of Petitioner:		Telephone Number of Petitioner:	
Street Address of Petitioner:		Mailing Address of Petitioner , if different from street address:	
City		City	
State	Zip	State	Zip
Petitioner's date of birth:		Petitioner's Social Security Number:	
Petitioner's relationship to Incapacitated Person:			

Incapacitated Person

Name of Incapacitated Person:		Date of birth:		Social Security Number		
Description of the Incapacitated Person	Height	Weight	Color of Hair	Color of Eyes	Sex	

Incapacitated Person's place of residence:					
City				State	Zip
Incapacitated Person's post office address:					
City				State	Zip
Place of birth: City				State	Zip
Marital Status	Married	Widow/Widower	Divorced	If married, spouse's name:	
Spouse's date of birth:				Spouse's Social Security Number:	
Spouse's Street Address:					
City				State	Zip

Names of Incapacitated Person's children:			
Name •	Age	Relationship	
Address	City	State	Zip
Name •	Age	Relationship	
Address	City	State	Zip
Name •	Age	Relationship	
Address	City	State	Zip

Are the parents of the Incapacitated Person alive? Yes ( ) No ( )	If yes, Mother's Name: Father's Name:		
If yes, Mother's Address	City	State	Zip
If yes, Father's Address	City	State	Zip

Names of Incapacitated Person's Adult Siblings:			
Name •	Age	Relationship	
Address	City	State	Zip
Name •	Age	Relationship	
Address	City	State	Zip

If the Incapacitated Person has no known spouse, children, parents, or adult siblings, then please state the name, age, address, and relationship of at least three known relatives, including stepchildren of the Incapacitated Person:			
Name •	Age	Relationship	
Address	City	State	Zip
Name •	Age	Relationship	
Address	City	State	Zip
Name •	Age	Relationship	
Address	City	State	Zip

Name of hospital, nursing home, or other facility, if any :			
Street Address	City	State	Zip
How long has the Incapacitated Person resided in the hospital, nursing home, or other facility?			
Where did the Incapacitated Person reside prior to entering the hospital, nursing home, or other facility?			

Please state the name, address, and telephone number of the two physicians who will provide an evaluation report:			
Names • •	Telephone Numbers • •		
Addresses • •	City • •	State • •	Zip • •

Please describe the physical and mental condition of the Incapacitated Person. Especially state the Aalleged@ incapacity:
Please provide a brief description of the services currently being provided for the Incapacitated Person's health, care, safety, or rehabilitation:
Please provide a recommendation for the Incapacitated Person's living arrangements and treatment plan:

What is the native language of the Incapacitated Person?
Is there any alternative mode of communication?

Estate Planning Documents

Does the Incapacitated Person have any of the following documents? If so, please attach a copy of each:		
Durable Power of Attorney Yes ( ) No ( )	Advance Medical Directive Yes ( ) No ( )	Last Will and Testament Yes ( ) No ( )

Real Property

The following is a statement of the financial resources of the Incapacitated Person:		
Real Property	Address of Real Property	
City	State	Zip
Value, assessed or appraised: $	Mortgage or debt owed: $	
If additional space is required to list the Incapacitated Person's real property, please provide this additional information on a separate sheet of paper attached to this Intake Form.		

Tangible Personal Property

Description	**How Titled or Owned**	**Value of Property**	**Amount Owed Balance**
Example: 1998 Mercury Automobile	Husband & Wife	$7,000	$4,000

Accounts at Financial Institutions

Type of Account	**Name of Financial Institution**	**Account Number**	**Approximate Balance**
Example: checking	SunTrust	1234567009	$1,500.00

Annuities and Retirement Accounts

Type of Benefit	**Financial Institution**	**Joint or Individual**	**Value or Balance**
Example: IRA	SunTrust	Individual	$2,000.00
Example: Retirement plan through employer	ABC Corporation	Individual	$15,000.00

Annual Income

Salary		Social Security	
IRA account withdrawal		Retirement income	
Dividends and interest		Other	
Total Annual Income			

Debts

Creditor	**Joint or Individual**	**Purpose**	**Balance/Monthly Payment**
Example: Visa	Joint	Household	$500/$100 per month

Life Insurance Policies

Policy Number 1: Name of Company	Address City State Zip
Name of Insured:	Name of Owner:
Amount paid for insurance $_____ per month?	Who pays coverage Wife ____ Husband ____
Is insurance an employment benefit? Yes ( ) No ( )	If yes, for Wife _____ or Husband _____
Policy Number 2: Name of Company	Address City State Zip
Name of Insured:	Name of Owner:
Amount paid for insurance $_____ per month	Who pays coverage Wife ____ Husband ____
Is insurance an employment benefit? Yes ( ) No ( )	If yes, for Wife _____ or Husband _____

The undersigned hereby represents to Goldstein Law Firm, LLC, and each of its attorneys, that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information which I am furnishing, but will **not** independently verify its accuracy . 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:

Date: