

**ATLANTIC LAW PLC  
GUARDIAN AND CONSERVATOR INTAKE FORM**

So that Atlantic Law PLC can provide you with quality advice, it is important that you do your best to complete this questionnaire accurately and thoroughly and bring it with you to your appointment. Please understand that all information that you provide in this questionnaire will be kept confidential.

**Petitioner/Proposed Guardian and Conservator**

Full Name (First, Middle, Last) of Petitioner:	Telephone Number (Home): Telephone Number (Work): Telephone Number (Cell):
Address of Petitioner:	Mailing Address of Petitioner (if different from street address):
Petitioner's E-mail Address:	Petitioner's Social Security Number:
Petitioner's Date of Birth:	Petitioner's Relationship to Incapacitated Person:
Have you ever been convicted of a felony? Yes _____ No _____	If yes, please explain:
Have you ever filed bankruptcy? Yes _____ No _____	If yes, please explain:
Are you now, or have you ever been, an attorney at law in Virginia or elsewhere? Yes _____ No _____	If yes, please explain:

**Respondent/Incapacitated Person**

Full Name (First, Middle, Last):	Date of Birth:	Social Security Number:
Description of the Incapacitated Person (Required by the Virginia State Police)	Height:	Color of Eyes:
	Weight:	Sex:
	Color of Hair:	Race:
Incapacitated Person's place of residence:	City:	State:  Zip:
Incapacitated Person's Post Office Address:	City:	State:  Zip:
Place of Birth:	City/County:	State:
Marital Status:	If married, spouse's name:	Spouse's Social Security Number:

Married ___ Widow/Widower ___ Divorced ___		Spouse's Address:	Date of Marriage:  Spouse's Date of Birth:
Veteran? Yes ___ No ___  If Veteran, dates of service:		Is/Was spouse a Veteran? Yes ___ No ___  If Veteran, dates of service:	
Name of Incapacitated Person's living adult children  Name:  Relationship:		Address:  City:  State:                      Zip:	Telephone:  Age:
Name of Incapacitated Person's living adult children  Name:  Relationship:		Address:  City:  State:                      Zip:	Telephone:  Age:
Name of Incapacitated Person's living adult children  Name:  Relationship:		Address:  City:  State:                      Zip:	Telephone:  Age:
Are the parents of the Incapacitated Person alive? Yes ___ No ___	If yes, mother's name:  Mother's Address:  City:  State:                      Zip:	If yes, father's name:  Father's Address:  City:  State:                      Zip:	
Names of Incapacitated Person's living adult siblings:  1) Name:  Relationship:		Address:  City:  State:                      Zip:	Telephone:  Age:
2) Name:		Address:	Telephone:

Relationship:	City: State:            Zip:	Age:
3) Name:	Address:	Telephone:
Relationship:	City: State:            Zip:	Age:

If the Incapacitated Person has no known spouse, children, parents, or adult siblings (or if there are not at least 3 total of these individuals), then please state the name, age, address and relationship of at least three known living relatives, including step-children of the Incapacitated Person:

Name:	Address:	Telephone:
Relationship:	City: State:            Zip:	Age:
Name:	Address:	Telephone:
Relationship:	City: State:            Zip:	Age:
Name:	Address:	Telephone:
Relationship:	City: State:            Zip:	Age:

Name of hospital, nursing home or other facility, if any:	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?
Address:		Address:
City:		City:
State:            Zip:		State:            Zip:
		How long did the incapacitated person live at this address?

Please state the name, address and telephone number of the physician who will provide a written evaluation of the Incapacitated Person \*\*\*PLEASE COMPLETE THIS SECTION TO THE BEST OF YOUR ABILITIES.:

<u>Physician 1</u>  Name:  Telephone Number:	Address:  City:  State:                      Zip:
Please state the physical and mental condition of the incapacitated person.	
Specifically state the alleged 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 for the incapacitated person?	

**Estate Planning Documents**

Does the Incapacitated Person have any of the following documents? If so, please attach a copy of each such document:

Durable Power of Attorney            Yes \_\_\_ No \_\_\_  
 Advance Medical Directive            Yes \_\_\_ No \_\_\_  
 Trust Agreement                        Yes \_\_\_ No \_\_\_  
 Last Will & Testament                Yes \_\_\_ No \_\_\_

**Real Property**

Address of Real Property:  City:  State:                                  Zip:	Value, assessed or appraised:
Deeds of Trust or Mortgage?  Yes ___ No ___	Name of Mortgage Company 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:
<b>Example: 1996 Honda Civic</b>	<b>Husband and Wife</b>	<b>\$10,000</b>	<b>\$5,000.00</b>

**Accounts at Financial Institutions**

Type of Account:	Name of Financial Institution and Account Number:	How Titled or Owned:	Approximate Balance:
<b>Example: Savings</b>	<b>Wells Fargo 1234567890</b>	<b>Wife</b>	<b>\$2,000.00</b>

**Stocks and Bonds**

Type of Account and Name of Stocks and Bonds and Number of Shares	Name of Financial Institution and Account Number	How Titled or Owned	Approximate Value


### Safe Deposit Box Information

Financial Institution	Authorized Entrants	Location of Key	Contents
<b>Example: BB&amp;T</b>	<b>Son – Mike</b>	<b>Desk Drawer</b>	<b>Jewelry, Will, POA</b>

### Annuities and Retirement Accounts

Type of Benefit	Financial Institution	How Titled	Value or Balance
<b>Example: IRA</b>	<b>Fulton Bank</b>	<b>Husband's name alone</b>	<b>\$1,500</b>

### Annual Income

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

### Debts

Creditor:	Name of Debtors:	Purpose:	Balance/Monthly Payment:
<b>Example: Visa</b>	<b>Capital One</b>	<b>Household</b>	<b>\$200/month</b>



CERTIFICATION – By signing below, the undersigned hereby represents that the information provided to Atlantic Law PLC in this questionnaire is accurate and complete, and the undersigned understands that Atlantic Law PLC will rely upon this information. The undersigned understands that if the information contained herein is inaccurate or incomplete, then the advice provided by Atlantic Law PLC and its attorneys may not be accurate or appropriate. If you agree to hire me as your attorney and I agree to represent you, then we will both sign an Engagement Letter, which will state the terms and conditions under which I and Atlantic Law PLC will provide you with legal representation. The undersigned acknowledges that unless both client and attorney sign an Engagement Letter, that no attorney/client relationship has been formed and attorney and Atlantic Law PLC will take no action on behalf of the undersigned client.

\_\_\_\_\_  
Petitioner

\_\_\_\_\_  
Date



# Atlantic Law PLC

PLANNING FOR GENERATIONS. PLANNING FOR LIFE.

[www.AtlanticLawPLC.com](http://www.AtlanticLawPLC.com)

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