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ELDER LAW
PLLC

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GUARDIANSHIP / CONSERVATORSHIP

PERSONAL AND FINANCIAL INFORMATION FORM
All information contained in this form is confidential and protected by attorney-client privilege.

For the individual requesting Guardianship (Petitioner):

Name _____

Address _____

Telephone Number _____

Relationship to individual wanting to have Guardianship of

_____

Qualifications for appointment (Why are you qualified to be appointed Guardian?)

_____

_____

_____

_____

For the individual to have Guardianship of (Respondent):

Full Name _____

Telephone Number _____

Date of Birth _____

Address of Respondent's Permanent, Full-Time Residence

_____

Respondent has resided at this address for the previous_____years and_____months.

Is this address a hospital, treatment facility, correctional facility, or long-term care facility?

Yes_____ **No** _____

Is respondent currently <u>physically</u> located at his or her permanent address above?

Yes_____ **No** _____

Nature of Respondent's Disability

_____

_____

_____

Names of individuals Respondent resides with

_____ _____

_____

Ownership of Respondent's estate, including government benefits insurance entitlements, and anticipated yearly income

ESTATE	**VALUE**
Real Property	**$**_____
Personal Property	**$**_____
Yearly Income	**$**_____
Source of Yearly Income	_____

Respondent's (check one)

- ☐ **Durable Power of Attorney**
- ☐ **Health Care Surrogate is**

Name _____

Address _____

Respondent's Next of Kin

Name_____

Relationship _____

Address_____

Respondent's Next of Kin

Name_____

Relationship _____

Address _____

Name of Person or Facility having custody of Respondent

_____

Address _____

Respondent's Identifiers:

Race_____ **Height**_____ **Weight** _____

Eyes _____ **Hair** _____

Social Security # _____

Drivers License #_____ **State** _____

Physician Information

Name of Hospital/Facility _____

Name of Physician _____

Hospital/Facility Address _____

Phone Number _____

Physician Information

Name of Hospital/Facility _____

Name of Physician _____

Hospital/Facility Address _____

Phone Number _____

Physician Information

Name of Hospital/Facility _____

Name of Physician _____

Hospital/Facility Address _____

Phone Number _____

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Phone Number _____