



GUARDIANSHIP INTAKE FORM (WARD)

DATE: \_\_\_\_\_

ALLEGED INCAPACITATED PERSON ("AIP"):

Name: \_\_\_\_\_

Phone (Primary): \_\_\_\_\_

Address: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Age: \_\_\_\_\_

SSN: \_\_\_\_\_

Language (If not English): \_\_\_\_\_

Nature of Incapacity: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Specific Incidents  
Evidencing Incapacity: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Rights Incapable of Exercising:

- |  |  |  |                                       |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Marry             | <input type="checkbox"/> To Travel           | <input type="checkbox"/> Property Transactions | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Vote              | <input type="checkbox"/> Government Benefits | <input type="checkbox"/> Social Decisions      | _____                                 |
| <input type="checkbox"/> Medical Decisions | <input type="checkbox"/> Lawsuits            | <input type="checkbox"/> Residency             | _____                                 |
| <input type="checkbox"/> To Contract       | <input type="checkbox"/> License to Drive    | <input type="checkbox"/> Employment            |                                       |

Medical Care:

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Legal Documents:

Does the AIP have a Living Will?  YES

Does the AIP have a Durable Power of Attorney?  YES

Does the AIP have a Health Care Surrogate?  YES

Surrogate's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Next Of Kin (include D.O.B. for minors):

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Persons with Knowledge: (include physician but not petitioner):

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

PETITIONER:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Age: \_\_\_\_\_  
Relationship to AIP: \_\_\_\_\_

PROPOSED GUARDIAN:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Age: \_\_\_\_\_  
Relationship to AIP: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Application on File?:  YES

SUBJECT PROPERTY: (If Known)

CASH:

Bank:	_____	Account Type:	_____	Amount:	_____
Bank:	_____	Account Type:	_____	Amount:	_____
Bank:	_____	Account Type:	_____	Amount:	_____
Bank:	_____	Account Type:	_____	Amount:	_____
Bank:	_____	Account Type:	_____	Amount:	_____
Bank:	_____	Account Type:	_____	Amount:	_____

Stocks & Bonds:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Broker:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Real Estate:

Homestead Property: \_\_\_\_\_

How is it titled: \_\_\_\_\_

Other Real Estate: \_\_\_\_\_

How is it titled: \_\_\_\_\_

Income:

Social Security: \_\_\_\_\_

Pension: \_\_\_\_\_

Other: \_\_\_\_\_

Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_