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Certified Elder Law Attorney
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CONFIDENTIAL QUESTIONNAIRE
GUARDIAN & CONSERVATOR
FOR INCAPACITATED PERSON

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please answer each question completely. Place N/A in response to any question which does not apply to you.

Person Completing Questionnaire _____

If not Client, Relationship to Incapacitated _____

Address _____

_____

Telephone _____ E-mail Address _____

By whom were you referred to this office _____

Are you seeking appointment? ☐ Yes ☐ No

Specific issues or questions to be addressed_____
_____
_____

CERTIFICATION

We understand that Clingman Law Firm, LLC will rely on the information supplied by us regarding guardianship and/or conservatorship. We also understand that inaccurate or incomplete information could negatively impact advice or recommendations. Consequently, we agree to provide updated, accurate and complete information as requested within this Questionnaire and Checklist of Documents.

Signature of Client Representative _____
Print Name _____
Date _____

PERSONAL INFORMATION ABOUT THE INCAPACITATED PERSON

Full Name _____
Address _____
City _____ County _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ E-mail Address _____
Age _____ Birth Date _____ SSN _____
U.S. Citizen? ☐ Yes ☐ No SC Resident? ☐ Yes ☐ No

Veteran? ☐ Yes ☐ No If so, Branch of Service_____
Dates of service ___/___/_____ thru ___/___/_____ Rank at Discharge _____
Were you a prisoner of war during service? ☐ Yes ☐ No
Do you currently receive VA benefits ☐ Yes ☐ No Type_____

Marital Status: ☐ Single ☐Married ☐ Separated ☐ Divorced ☐ Widowed
Please list all marriages
Spouse Name _____ Date of Marriage _____
Was this marriage ended by divorce? Date of divorce_____
Was this marriage ended by death of spouse? Date & Place of death _____

Spouse Name _____ Date of Marriage _____
Was this marriage ended by divorce? Date of divorce_____
Was this marriage ended by death of spouse? Date & Place of death _____

RELATIVES OF THE INCAPACITATED PERSON

Please provide the following information including spouse, children, step-children, legally adopted children, parents, and adult siblings. OR, if none known, at least one relative of some degree.

1. Relationship _____ Name _____ DOB __/__/____
   Address_____
   City_____ State _____ Zip Code _____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

2. Relationship _____ Name _____ DOB __/__/____
   Address_____
   City_____ State _____ Zip Code _____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

3. Relationship _____ Name _____ DOB __/__/____
Address_____
City_____ State _____ Zip Code _____
Home Phone_____ Work Phone _____
Cell Phone _____ E-mail _____

4. Relationship _____ Name _____ DOB __/__/____
Address_____
City_____ State _____ Zip Code _____
Home Phone_____ Work Phone _____
Cell Phone _____ E-mail _____

5. Relationship _____ Name _____ DOB __/__/____
Address_____
City_____ State _____ Zip Code _____
Home Phone_____ Work Phone _____
Cell Phone _____ E-mail _____

6. Relationship _____ Name _____ DOB __/__/____
Address_____
City_____ State _____ Zip Code _____
Home Phone_____ Work Phone _____
Cell Phone _____ E-mail _____

MEDICAL INFORMATION FOR THE INCAPACITATED PERSON

1. Most recent diagnosis

_____
_____

2. Physical Conditions

_____
_____

3. Cognitive Conditions

_____
_____

4. Medications Prescribed

_____ _____ _____
_____ _____ _____
_____ _____ _____

5. Activities of Daily Living

Feeds independently? ☐ Yes ☐ No Dresses independently? ☐ Yes ☐ No
Bathes independently? ☐ Yes ☐ No Transfers independently? ☐ Yes ☐ No
Toilets independently? ☐ Yes ☐ No Requires supervision? ☐ Yes ☐ No

6. Capacity

Able to sign name? ☐ Yes ☐ No Able to read & understand? ☐ Yes ☐ No
Been declared incompetent by court? ☐ Yes ☐ No

7. Please provide the names of at least two physicians/examiners to complete a report for filing with the court to confirm the need for a guardian and/or conservator.

Primary Physician

Name _____ Specialty_____
Address _____
City _____ State ___ Zip Code _____ Telephone _____

Other Physician

Name _____ Specialty_____
Address _____
City _____ State ___ Zip Code _____ Telephone _____

8. Nursing Home/Medical Facility Information

Name of Facility_____
Address _____
City _____ State _____ Zip Code_____
Telephone _____ Date of Admission _____

HEALTH INSURANCE INFORMATION

Type	ID#	Carrier	Insured	Premium/Month
Medicare Part A				$
Medicare Part B				$
Medicare Part C				$
Medicare Pat D				$
Medicare Supplement				$
Medicaid				$
Private Health Plan				$
Long Term Care Plan				$
Retiree Health Plan				$
Other				$
Other				$

MONTHLY INCOME & MONTHLY EXPENSES

MONTHLY INCOME

Social Security	$
Pension_____	$
Investment	$
IRA _____	$
Annuity_____	$
Rents	$
Business Interest	$
Gas Royalties	$
Other	$
Other	$
Other	$
TOTAL	**$**

MONTHLY EXPENSES

Medicare	$
Health Insurance	$
Taxes	$
Nursing Home or Other Facility	$
Caregivers	$
Prescriptions	$
Monthly Supplies	$
Other Costs	$
Other Costs	$
Other Costs	$
TOTAL	**$**

SUMMARY OF ASSETS

Nonretirement Accounts (Checking & Savings Accounts, CDs, Money Market Accounts, Brokerage Accounts, Stocks, Annuities or US Bonds)

Description	Account #	Value	In Whose Name?

Retirement Plans (IRAs, vested pension plans, annuities, or other assets that would pass on your death to a particular beneficiary that you have designated)

Description	Account #	Value	Beneficiary

Real Estate (Please list personal residence first; also list mineral/oil rights)

Description/address	Purchase Date	Purchase Price	Current Value	In Whose Name?

Life Insurance

Insured	Company	Face Value	Cash Value	Policy No	Beneficiary

Other Business Interests

Description	Value	In Whose Name?

Personal Property (Autos, Boats, RVs)

Description	Value	In Whose Name?

Money Owed to Incapacitated (promissory notes)

Type	Security	Repayment terms

Burial, Pre-Need Funeral Arrangements

Description	Company	

TOTAL ASSET VALUES **$**_____

Liabilities

Description	Balance	Monthly Payment	Secured?
Mortgage			
Other Mortgages			
Vehicle Loans			
Personal Loans			
Business Loans			
Credit Card Balances			
Other			
Other			
Other			

TOTAL LIABILITIES **$**_____

RECAP:

TOTAL ASSETS **$**_____
TOTAL LIABILITIES **- $**_____
NETWORTH **$**_____

LEGAL ASSESSMENT OF THE INCAPACITATED

Are the following estate planning documents in place?

	Date Made	Location of Original
• Last Will & Testament	_____	_____
• Health Care Power of Attorney	_____	_____
• Living Trust	_____	_____
• Durable Power of Attorney	_____	_____

Is DPOA Recorded in County ROD Office? ☐ Yes ☐ No

Location of other important papers _____
I am involved in a lawsuit _____
Other legal concerns _____
_____
_____
_____
_____
_____
_____
_____

INFORMATION ABOUT THE PROPOSED GUARDIAN

Name _____ Age _____ DOB ___/___/_____
Address_____
City_____ State _____ Zip Code _____
Home Phone_____ Work Phone _____
Cell Phone _____ E-mail _____
Relationship to Incapacitated:_____ SSN _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Have you ever been convicted of a crime? ☐ Yes ☐ No
Have you had credit problems within the past 10 years? ☐ Yes ☐ No
Do you serve as Attorney in Fact under DPOA for the Incapacitated? ☐ Yes ☐ No
Do you serve as Attorney in Fact under HCPOA for the Incapacitated? ☐ Yes ☐ No

INFORMATION ABOUT THE PROPOSED CONSERVATOR (if different)

Name _____ Age _____ DOB ___/___/_____
Address_____
City_____ State _____ Zip Code _____
Home Phone_____ Work Phone _____
Cell Phone _____ E-mail _____
Relationship to Incapacitated:_____ SSN _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Have you ever been convicted of a crime? ☐ Yes ☐ No
Have you had credit problems within the past 10 years? ☐ Yes ☐ No
Do you serve as Attorney in Fact under DPOA for the Incapacitated? ☐ Yes ☐ No
Do you serve as Attorney in Fact under HCPOA for the Incapacitated? ☐ Yes ☐ No

Please be advised that <u>when requested</u> you must provide the following to the court:

1. Social Security Card and Drivers License or other picture ID
2. Credit Report
3. Criminal Background Report from SLED or equivalent state agency
4. Bond, if applicable

Checklist of Documents

Please submit the following items prior to your consultation appointment along with your completed questionnaire and consultation fee.

- ☐ COPY of driver's license/ID card and social security card for the
  - ☐ Proposed Guardian
  - ☐ Proposed Conservator
- ☐ COPY of health insurance cards for the alleged incapacitated person
- ☐ COPY of social security and/or retirement annual award letters
- ☐ COPY of military DD Form 214
- ☐ COPY of most current tax notices for all real estate owned
- ☐ COPY of deeds for all real estate owned
- ☐ COPY of titles to all vehicles, boats, RVs etc owned
- ☐ COPY of life insurance policies
- ☐ COPY of current statements for ALL financial assets (checking, savings, CD accounts, investment and brokerage accounts, and retirement accounts)
- ☐ COPY of current health care power of attorney, financial power of attorney, last will and testament/codicils, trust agreements
- ☐ COPY of pre-nuptial agreement, marriage license, separation/divorce decree – for all marriages
- ☐ COPY of adoption papers
- ☐ COPY of business ownership agreements
- ☐ COPY of pre-need/funeral arrangements contract
- ☐ COPY of the past 3 years tax returns and any gift tax returns