NORTON
HEALTH LAW, PC

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GUARDIANSHIP/CONSERVATORSHIP INFORMATION SURVEY

[NOTE TO CLIENT: PLEASE COMPLETE HIGHLIGHTED PORTIONS OF DOCUMENT]

PETITIONER INFORMATION

Name: _____ SSN: ____-___-_____

Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Fax: _____ Email: _____

Relationship to Incapacitated Person: _____

Is it okay to communicate with you via email? Yes/No

Is it okay to communicate with you via text? Yes/No

Marital Status: □ Married: Date of Marriage: _____

□ Divorced: Date of Divorce: _____

Ex-spouse name: _____

Date of former marriage: _____

□ Widowed: Date of Spouse's death: _____

□ Single

INCAPACITATED PERSON'S INFORMATION

Full Name: _____ SSN: ____-___-_____

Date of Birth: _____ Height: _____ Weight: _____ Hair color: _____

Eye color: _____ Native language: _____ Race: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

If not living at home, provide current address of Incapacitated Person: _____

_____

_____

If applicable, list: (a) the date the Incapacitated Person was transferred to the current address, and (b) the reason for the transfer: (a) _____

(b) _____

Brief description of services currently being provided for the health care, safety, or rehabilitation of the Incapacitated Person: _____

_____

FAMILY OF INCAPACITATED PERSON

Spouse: [if spouse is deceased, list name and date of death]:

Name: _____ SSN: ____-___-_____

Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Fax: _____ Email: _____

Children: Name, address and phone of all living children of Incapacitated Person:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Telephone: _____ Date of Birth: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Telephone: _____ Date of Birth: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Telephone: _____ Date of Birth: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Telephone: _____ Date of Birth: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Telephone: _____ Date of Birth: _____

Other Family Members: If there are fewer than 3 family members listed above, then provide the next closest family members of the Incapacitated Person (IP):

Name: _____ Relationship to IP: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Telephone: _____ Date of Birth: _____

Name: _____ Relationship to IP: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Telephone: _____ Date of Birth: _____

Name: _____ Relationship to IP: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Telephone: _____ Date of Birth: _____

MEDICAL INFORMATION REGARDING INCAPACITATED PERSON

Primary physician for the Incapacitated Person (IP):

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Fax: _____ Date of most recent evaluation: _____

Physician practice specialty (if any): _____

Primary diagnosis treated: _____

Other treating physicians:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Fax: _____ Date of most recent evaluation: _____

Physician practice specialty (if any): _____

Primary diagnosis treated: _____

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Fax: _____ Date of most recent evaluation: _____

Physician practice specialty (if any): _____

Primary diagnosis treated: _____

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Fax: _____ Date of most recent evaluation: _____

Physician practice specialty (if any): _____

Primary diagnosis treated: _____

FINANCIAL INFORMATION (Required by Va. Code § 64.2-2002(b)):

Income: Sources and amounts (please state in monthly amounts):

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

ASSETS

[Please copy any pages as needed if additional space is required.]

CASH

*Checking Account (CA), Savings Account (SA), Certificates of Deposit (CD), Money Market Account (MM)

NAME OF INSTITUTION	TYPE*	ACCOUNT NUMBER	OWNER(S)+	BALANCE
				$ _____
				$ _____
				$ _____
				$ _____
				$ _____
			TOTAL:	$ _____

RETIREMENT PLANS

*Pension (P), Profit-Sharing (PS) , Keogh (K), Individual Retirement Account (IRA), or other (O)

**Husband (H), Wife (W), Other (O)

COMPANY	TYPE OF PLAN*	OWNER**	PRIMARY BENEFICIARY	CONTINGENT BENEFICIARY	CURRENT VALUE
					$ _____
					$ _____
					$ _____
					$ _____
				TOTAL:	$ _____

INVESTMENTS

(Other than Retirement Accounts)
Please attach copies of most recent statements.

Brokerage Firm: _____

Broker's Name and Phone: _____

Balance (less IRAs): $ _____ Acct. No.: _____

Exact Name(s) on Account: _____

Brokerage Firm: _____

Broker's Name and Phone: _____

Balance (less IRAs): $ _____ Acct. No.: _____

Exact Name(s) on Account: _____

MUTUAL FUNDS

Please list accounts held at mutual fund companies, e.g., Vanguard, Templeton, American Funds.

Please attach copies of most recent statements.

* Incapacitated Person (PI) or Joint with other (J)

COMPANY	OWNER(S)* OF FUNDS	NUMBER OF SHARES	FAIR MARKET VALUE
			$ _____
			$ _____
			$ _____
			$ _____
	TOTAL:		$ _____

STOCKS

(Held in Certificate Form)

Please list all stocks in publicly owned corps. (stock traded on an exchange or over the counter).
Note: Stock owned in family or non-public companies listed in Business Interests section later.

* Incapacitated Person (IP) or Joint with other (J)

COMPANY	OWNER(S)* OF SHARES	NUMBER OF SHARES	CURRENT VALUE
			$ _____
			$ _____
			$ _____
			$ _____
	TOTAL:		$ _____

BONDS

Please list all U.S. Savings Bonds, corporate bonds and municipal bonds held.
* Incapacitated Person (IP) or Joint with other (J)

TYPE	OWNER(S)*	VALUE
		$ _____
		$ _____
		$ _____
		$ _____
	TOTAL:	$ _____

REAL ESTATE

Please list all deeds and land contract interests. (Land or buildings owned inside a separate entity should be listed under the Partnership section later).
* Incapacitated Person (IP) or Joint with other (J)
Please attach a copy of the Deed of Bargain and Sale for each parcel of real estate.

ADDRESS OR DESCRIPTION	OWNER(S)*	PURCHASE PRICE	TAX ASSESSED VALUE	FAIR MARKET VALUE	MORTGAGE BALANCE	EQUITY
Street: City/State:						
Street: City/State:						
Street: City/State:						
			TOTAL EQUITY:		$ _____	

PERSONAL EFFECTS AND OTHER ASSETS

Please list furniture, automobiles, jewelry, collectibles, and other personal assets of substantial value (in excess of $10,000 each) only. Please value all other household goods in one lump sum.

* Incapacitated Person (IP) or Joint with other (J)

ITEM	OWNER(S)*	VALUE
		$ _____
		$ _____
		$ _____
		$ _____
		$ _____
	TOTAL:	$ _____

NOTES RECEIVABLE

Please list all debts which others owe to you and attach copies of notes, deeds of trust, etc.
* Incapacitated Person (IP) or Joint with other (J)

NAME OF DEBTOR	DATE OF NOTE	DATE DUE	OWED TO*	CURRENT BALANCE
				$ _____
				$ _____
				$ _____
				$ _____
				$ _____
				$ _____
			TOTAL:	$ _____

LIFE INSURANCE POLICIES AND ANNUITIES

*Term, Whole Life, Universal Life, Variable Life, Split Dollar, Group Life, Annuity

+ Incapacitated Person (IP) or Other (O)

Policy Number	Face Amount: $ ________________
Company	Type*
Company Address:	
Insured	Owner
Primary Beneficiary	
Secondary Beneficiary	
Cash Value: $ ________________	Who Pays Premium +

Policy Number	Face Amount: $ ________________
Company	Type*
Company Address:	
Insured	Owner
Primary Beneficiary	
Secondary Beneficiary	
Cash Value: $ ________________	Who Pays Premium +

Policy Number	Face Amount: $ ________________
Company	Type*
Company Address:	
Insured	Owner
Primary Beneficiary	
Secondary Beneficiary	
Cash Value: $ ________________	Who Pays Premium +

Policy Number	Face Amount: $ ________________
Company	Type*
Company Address:	
Insured	Owner
Primary Beneficiary	
Secondary Beneficiary	
Cash Value: $ ________________	Who Pays Premium +

LONG-TERM HEALTH CARE INSURANCE

Company:	
Policy No.:	Date of Policy:
Owner:	
Daily Benefit:	
Term of Benefit:	
Home Health Rider: Yes ____ No ____	Premium:
Agent Name:	Agent's Company:
Address:	
Phone:	

BUSINESS INTERESTS

Please provide ownership interests in all privately owned, non-publicly traded corporations.
*If yes, please provide a copy of this agreement.
+Incapacitated Person (IP) or Joint with other (J)

COMPANY	NO. OF SHARES	% OWNERSHIP	OWNER(S)+	VALUE	BUY/SELL AGREEMENT*
				$ _____	
				$ _____	
				$ _____	
			TOTAL:	$ _____	

PARTNERSHIP INTERESTS

*If yes, either separately or as part of a written part of a written partnership agreement. Please provide a copy of any partnership agreement.
+Incapacitated Person (IP) or Joint with other (J)

PARTNERSHIP NAME	GENERAL PARTNER	LIMITED PARTNER	OWNER(S)+	VALUE	BUY/SELL AGRMNT *
				$ _____	
				$ _____	
			TOTAL:	$ _____	

SOLE PROPRIETORSHIP BUSINESS INTERESTS

Please list all business interests in sole proprietorships
*Incapacitated Person (IP) or Joint with other (J)

NAME OF BUSINESS	DESCRIPTION	OWNER(S)*	VALUE
			$ _____
			$ _____
		TOTAL:	$ _____

LIABILITIES

Mortgage(s) on Real Property:

Name of Mortgage Company: _____ Acct No.: _____

Monthly Payment $: _____ Approximate Balance: $_____

Address of secured property: _____

Mortgage(s) on Real Property:

Name of Mortgage Company: _____ Acct No.: _____

Monthly Payment $: _____ Approximate Balance: $_____

Address of secured property: _____

Other Secured Loan(s):

Name of Creditor: _____ Acct No.: _____

Monthly Payment $: _____ Approximate Balance: $_____

Any collateral secured by loan: _____

Name of Creditor: _____ Acct No.: _____

Monthly Payment $: _____ Approximate Balance: $_____

Any collateral secured by loan: _____

Credit Card(s):

Name of Creditor: _____ Acct No.: _____

Monthly Payment $: _____ Approximate Balance: $_____

Name of Creditor: _____ Acct No.: _____

Monthly Payment $: _____ Approximate Balance: $_____

Name of Creditor: _____ Acct No.: _____

Monthly Payment $: _____ Approximate Balance: $_____

FINANCIAL SUMMARY

(TO BE COMPLETED BY ATTORNEY).

ASSETS

ASSETS		
	INCAPACITATED PERSON	JOINT
Liquid Assets	$ _____	$ _____
Retirement Plans	$ _____	$ _____
Brokerage Accts & Mutual Funds	$ _____	$ _____
Stocks & Bonds	$ _____	$ _____
Real Estate	$ _____	$ _____
Personal Effects & Other Assets	$ _____	$ _____
Notes Receivable	$ _____	$ _____
Anticipated Inheritances, Gifts & Lawsuit Judgments	$ _____	$ _____
Insurance & Annuities	$ _____	$ _____
Corporations, Partnerships or Sole Proprietorships	$ _____	$ _____
Other Assets (please describe under add'l notes)	$ _____	$ _____
TOTAL EACH COLUMN	$ _____	$ _____

LIABILITIES

LIABILITIES		
	INCAPACITATED PERSON	JOINT
Notes on Residence	$ _____	$ _____
Other Notes	$ _____	$ _____
Automobile Loans	$ _____	$ _____
Notes Payable	$ _____	$ _____
Loans Against Life Insurance	$ _____	$ _____
Credit Cards	$ _____	$ _____
Bills Due	$ _____	$ _____
Personal Loans	$ _____	$ _____
Other	$ _____	$ _____
TOTAL EACH COLUMN	$ _____	$ _____

NET WORTH

	INCAPACITATED PERSON	JOINT
TOTAL ASSETS	$ _____	$ _____
-TOTAL LIABILITIES	$ _____	$ _____
NET WORTH:	$ _____	$ _____

CURRENT ESTATE PLANNING DOCUMENTS

Please provide copies of all Powers of Attorney and Advance Medical Directives currently in effect

1. Is there a financial Power of Attorney in effect? Yes / No
2. Is there an Advance Medical Directive in effect? Yes / No

ADDITIONAL NOTES

_____
_____
_____
_____

QUESTIONS/CONCERNS/ISSUES FOR ATTORNEY

_____
_____

_____

_____

CLIENT ATTESTATION AND SIGNATURE

The information I have provided in this summary is accurate and complete to the extent of my knowledge and ability. I understand that it will be used by my attorney(s) in representing me and that, for advising me on petitioning the court for guardianship and/or conservatorship of the Incapacitated Person, my attorneys will rely on the information contained herein.

_____

(Signature)

_____

(Print Full Name)

_____

(Date)