EST. 2001

TEXAS PROBATE ATTORNEY PLLC

GUARDIANSHIP INTAKE FORM

NAME OF INCAPACITATED PERSON: _____

RESIDENCE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

DOB: _____ AGE: _____ SSN: _____
REQUIRED BY COURT

MARITAL STATUS: _____

PRESENT LOCATION: (IF DIFFERENT FROM RESIDENCE ADDRESS)

ADDRESS: _____

CITY/STATE/ZIP: _____

Driver's license # (if applicable) _____ _____
NUMBER **STATE**

PERSON COMPLETING THIS FORM

NAME : _____

RESIDENCE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

DOB: _____ SSN: _____ DL #_____
NUMBER & STATE

MARITAL STATUS: _____

RELATION TO INCAPACITATED PERSON: _____

RELATIVES:

Please provide the names and mailing addresses of the incapacitated person's **spouse, adult children, parents and adult siblings or, if no such relatives are known to the Applicant, at least three other known relatives of the incapacitated person, including step-children**, must be included for notice. Please list all relatives of incapacitated person, in following order: spouse, adult children, parents, and adult siblings (parents, aunts/uncles, grandchildren, nieces/nephews, cousins):
(attach additional sheets if necessary)

NAME	AGE	RELATIONSHIP TO INCAPACITATED PERSON	FULL MAILING ADDRESS TELEPHONE NUMBER & EMAIL ADDRESS

MEDICAL INFORMATION:

ATTENDING PHYSICIAN
NAME: _____

DATE LAST VISIT: _____

OFFICE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

EMAIL: _____

PSYCHIATRIST
NAME: _____

DATE LAST VISIT: _____

OFFICE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

EMAIL: _____

HOSPITAL OR NURSING HOME
NAME: _____

FACILITY ADMINISTRATOR'S NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

CONTACT NAME: _____

TELEPHONE #: _____

EMAIL: _____

DATE OF ADMISSION: _____

HOSPITAL OR NURSING HOME

NAME: _____

FACILITY ADMINISTRATOR'S NAME: _____

DATE LAST VISIT: _____

OFFICE ADDRESS: _____

CITY/STATE/ZIP: _____

CONTACT NAME: _____

TELEPHONE #: _____

EMAIL: _____

DIAGNOSIS

The incapacitated person's physical and mental condition is an issue. Please state the most recent diagnosis which impairs the person. If you do not have a diagnosis, please describe the symptoms.

_____

_____

_____

_____

_____

_____

_____

_____

HEALTH INSURANCE

MEDICARE

A _____ B _____ ID# _____

SECONDARY SUPPLEMENT

POLICY NUMBER: _____

COMPANY: _____

AGENT: _____

MEDICAID

ID#: _____

CITY/COUNTY: _____

ELIGIBILITY DATE: _____

WORKER NAME: _____

PHONE: _____

EMAIL: _____

INCOME SUMMARY TABLE

	MONTHLY INCOME	TYPE/SOURCE
Monthly Social Security Income	$	Old Age/Retirement SSI SSDI (circle one)
Private Retirement (IRA, 401(k), etc.)	$	
Monthly Investment & Other Income	$	
Interest	$	
Other	$	

ASSET SUMMARY TABLE

	HUSBAND	WIFE	JOINT
Equity in Texas Real Estate	$	$	$
Equity in Real Estate not in Texas	$	$	$
Investments – Non-Retirement	$	$	$
Ordinary Bank Accounts	$	$	$
Life Insurance – Death Benefit (Include Accidental Death Benefit)	$	$	$
Tangible Personal Property	$	$	$
Business or Trust Property	$	$	$
Vested Retirement Assets	$	$	$
Anticipated Inheritances	$	$	$
Powers of Appointment	$	$	$
Other Property	$	$	$
ASSET TOTALS:	$	$	$
Liabilities, Excluding Mortgages	$	$	$

PROPOSED GUARDIAN

FIRST CHOICE

NAME: _____

RESIDENCE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

DOB: _____ SSN: _____ DL #_____
NUMBER & STATE

MARITAL STATUS: _____ EMAIL: _____

RELATION TO INCAPACITATED PERSON: _____ _

ANY CRIMINAL CONVICTIONS OR BANKRUPTCY FILINGS? □ YES □ NO

IF YES, DESCRIBE: _____

_____

EVER BEEN REFUSED BOND? □ YES □ NO

IF YES, DESCRIBE: _____

_____

SECOND CHOICE

NAME: _____

RESIDENCE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

DOB: _____ SSN: _____ DL #_____
NUMBER & STATE

MARITAL STATUS: _____ EMAIL: _____

RELATION TO INCAPACITATED PERSON: _____

ANY CRIMINAL CONVICTIONS OR BANKRUPTCY FILINGS? □ YES □ NO

IF YES, DESCRIBE: _____

_____

EVER BEEN REFUSED BOND? □ YES □ NO

IF YES, DESCRIBE: _____

_____

APPLICANT (PERSON OR ENTITY BRINGING APPLICATION)

NAME: _____

RESIDENCE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

DOB: _____ SSN: _____ DL #_____
NUMBER & STATE

MARITAL STATUS: _____ EMAIL: _____

RELATION TO INCAPACITATED PERSON: _____

ANY CRIMINAL CONVICTIONS OR BANKRUPTCY FILINGS? □ YES □ NO

IF YES, DESCRIBE: _____

_____

EVER BEEN REFUSED BOND? □ YES □ NO

IF YES, DESCRIBE: _____

_____

POWER OF ATTORNEY INFORMATION

DOES INCAPACITATED PERSON HAVE (OR DID S/HE EVER HAVE) A GENERAL POWER OF ATTORNEY? □ YES □ NO

IF YES, PLEASE PROVIDE: *(ATTACH A COPY OF POA, IF YOU HAVE IT)*

NAME: _____

RESIDENCE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

DOB: _____ SSN: _____ DL #_____
NUMBER & STATE

MARITAL STATUS: _____ EMAIL: _____

RELATION TO INCAPACITATED PERSON: _____

STATUS OF POA: □ CURRENT □ REVOKED

DOES INCAPACITATED PERSON HAVE (OR DID S/HE EVER HAVE) A MEDICAL POWER OF ATTORNEY? □ YES □ NO

IF YES, PLEASE PROVIDE: *(ATTACH A COPY OF POA, IF YOU HAVE IT)*

NAME: _____

RESIDENCE ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE #: _____

DOB: _____ SSN: _____ DL #_____

NUMBER & STATE

MARITAL STATUS: _____ EMAIL: _____

RELATION TO INCAPACITATED PERSON: _____

STATUS OF POA: ☐ CURRENT ☐ REVOKED

COURT APPOINTED CONSERVATOR INFORMATION

DOES INCAPACITATED PERSON HAVE (OR DID S/HE EVER HAVE) A COURT APPOINTED CONSERVATOR? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE: *(ATTACH A COPY OF ORDER APPOINTING, IF YOU HAVE IT)*

NAME: _____

RESIDENCE ADDRESS: _____

CITY/STATE/ZIP: _____

STATUS OF CONSERVATORSHIP: ☐ CURRENT ☐ REVOKED

DATE INTAKE FORM COMPLETED: _____

WHO MAY WE THANK FOR REFERRING YOU TO US: _____