

*The Law Office of
Catherine E. Davey, P.A.*

*Estate Planning · Probate
Guardianship · Special Needs Trusts*

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ADULT GUARDIANSHIP QUESTIONNAIRE

A. INFORMATION ABOUT THE ALLEGED INCAPACITATED PERSON:

1. Full name _____
2. Age _____ 3. Date of Birth: _____
4. Address _____
5. County of Residence: _____
6. Primary Spoken Language _____
7. Social Security Number _____
8. Race: _____ 9. Sex _____
10. Florida Driver's License No./Florida Identification Card No.: _____
11. Health Insurance Company/Policy No.: _____
12. Medicare _____ 13. Medicaid _____
14. Description of Alleged Incapacity and Reason for Alleged Incapacity _____

15. Is this an emergency (personally or financially)? _____

B. INFORMATION ABOUT PROPOSED GUARDIAN:

1. Name _____
2. Age _____
3. Date of Birth _____
4. Home Address _____
Mailing Address (If different from above) _____

5. Social Security Number _____
6. Place of Birth _____
7. U.S. Citizen _____
8. Employer's Name _____
9. Employer's Address _____
Employer's Telephone _____
10. Applicant's Position _____
11. Marital Status and Name of Spouse, if any: _____

12. Your home telephone number _____
13. Length of Residence in County in which application is to be filed _____
14. If currently serving as guardian for any other ward, list the names of each ward, court file number, circuit court in which the case(s) is/are pending and whether applicant is acting as the limited or plenary guardian of the person or property or both _____

15. Does applicant have any physical disabilities? _____
If "yes" was answered, please explain _____
16. Will any physical disability listed above affect ability to serve as guardian? _____

17. Has applicant ever been treated for the following?
- a. Mental condition _____
 - b. Alcohol _____
 - c. Drugs _____
 - d. Other _____
- Nature of Condition _____
- If "yes" was answered to any of the above, please state date, time, location of treatment and name of physician or professional involved _____

18. Has applicant ever been judicially determined to have committed abuse or neglect against a child as defined by the Florida Statutes? _____
If "yes" was answered, please give date and complete details _____

19. Has applicant ever been the subject of a confirmed report of abuse, neglect or exploitation which has been uncontested or upheld pursuant to the provisions of Sections 415.104 and 415.1075 of the Florida Statutes? _____

If "yes" was answered, please give date and complete details _____

20. Has applicant ever been charged with fraud, misrepresentation or perjury in a judicial or administrative proceeding? _____

If "yes" was answered, please give date and complete details _____

21. Has applicant ever been charged with, arrested for or convicted of a felony? _____

If "yes" was answered, please give date and complete details _____

22. Has applicant ever been charged with, arrested for or convicted of any other crimes? _____

If "yes" was answered, please give date and complete details _____

23. Has applicant ever held a position which required bonding? _____

If "yes" was answered, please describe position, date, amount of bond and name of surety _____

24. Has applicant, in the past, ever served as guardian of a person or of a person's property? _____

If "yes" was answered, please describe and include reason for termination of fiduciary position _____

25. Has applicant ever been held in contempt of court or removed as guardian? _____

If "yes" was answered, please describe _____

26. Has applicant ever filed for bankruptcy? _____

If "yes" was answered, please state date and location of court _____

27. Is applicant, or applicant's business, corporation or other business entity a creditor of or providing professional, personal or business services to the incapacitated person?

If "yes" was answered, please furnish details _____

28. Is applicant employed by a business, corporation or other business entity which is providing professional, personal or business services to the incapacitated person?

If "yes" was answered, please furnish details _____

29. Is applicant a health care provider for the alleged incapacitated person? _____

30. Educational History of the Applicant:

	<u>Name and Address</u>	<u>Degree</u>	<u>Date</u>
High School	_____	_____	_____
College	_____	_____	_____
Other	_____	_____	_____

31. List applicant's employment experience (position held, employer, address, reason for leaving) for the past ten (10) years beginning with the most recent date _____

32. Has applicant ever been discharged from employment? _____

If "yes", please furnish details _____

33. Has applicant ever been a member of the armed forces of the U.S.? _____
If "yes", what branch, dates and military serial number _____

34. Personal References: Please give the names, addresses and telephone numbers of three (3) responsible persons who have been closely associated with applicant and who have known applicant for five (5) years or more, not including relatives or spouse:

	<u>Name and Address</u>	<u>Telephone Number</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____

35. Does applicant possess any special educational qualifications (financial, business or otherwise) that uniquely qualifies applicant to be appointed as guardian? _____
If "yes", please describe _____

36. Has applicant received instruction and training which covered the legal duties and responsibilities of a guardian, the rights of an incapacitated person, the availability of local resources to aid a ward, and the preparation of habilitation plans and annual guardianship reports, including financial accounting for the ward's property?

If "yes", indicate when and where training was received _____

- C. Names and addresses of all persons known to petitioner who have actual knowledge of such facts regarding the alleged incapacitated person's condition (Personal knowledge gained through personal observation of the individual.):

- D. Names, Addresses and Relationships of all known next of kin of the alleged incapacitated person (give dates of birth of any who are minors):

- E. Name, Address and Phone number of attending or family physician:

F. Which rights do you feel the alleged incapacitated person is incapable of exercising (Please mark with an "X"):

- | | |
|--|---|
| <input type="checkbox"/> to marry | <input type="checkbox"/> to vote |
| <input type="checkbox"/> to contract | <input type="checkbox"/> to travel |
| <input type="checkbox"/> to sue and defend lawsuits | <input type="checkbox"/> to have a driver's license |
| <input type="checkbox"/> to determine his or her residency | <input type="checkbox"/> to seek or retain employment |
| <input type="checkbox"/> to consent to medical treatment | <input type="checkbox"/> to personally apply for government benefits |
| <input type="checkbox"/> to manage property or to make any gift or disposition of property | <input type="checkbox"/> to make decisions about his or her social environment or other social aspects of his or her life |

INCOME/ASSETS of ALLEGED INCOMPETENT PERSON:

INCOME

Sources/Amounts/Frequency: _____

SAFE DEPOSIT BOX: YES: _____ NO: _____

LOCATION: _____

REAL ESTATE:

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ PRESENT VALUE: _____

HOW TITLED: _____

HOMESTEAD: YES: _____ NO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ PRESENT VALUE: _____

HOW TITLED: _____

HOMESTEAD: YES: _____ NO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ PRESENT VALUE: _____

HOW TITLED: _____

HOMESTEAD: YES: _____ NO: _____

STOCKS AND BONDS (please also provide copies of most recent statements, if available):

NAME OF COMPANY: _____

TYPE OF SECURITY: _____

HOW TITLED: _____

LOCATION OF CERTIFICATE: _____

PRESENT VALUE: _____

NAME OF COMPANY: _____

TYPE OF SECURITY: _____

HOW TITLED: _____

LOCATION OF CERTIFICATE: _____

PRESENT VALUE: _____

NAME OF COMPANY: _____

TYPE OF SECURITY: _____

HOW TITLED: _____

LOCATION OF CERTIFICATE: _____

PRESENT VALUE: _____

BANK ACCOUNTS (please also provide copies of most recent statements, if available):

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

PRESENT VALUE: _____

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

PRESENT VALUE: _____

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

PRESENT VALUE: _____

MONEY MARKET ACCOUNTS OR CERTIFICATES OF DEPOSIT (please also provide copies of most recent statements, if available):

NAME OF INSTITUTION: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

PRESENT VALUE: _____

NAME OF INSTITUTION: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

PRESENT VALUE: _____

NAME OF INSTITUTION: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

PRESENT VALUE: _____

U.S. GOVERNMENT SAVINGS BONDS (E, EE, H):

HOW TITLED: _____

LOCATION OF BONDS: _____

TO BE CASHED: YES _____ NO _____

IF YES, NAME OF TRANSFEREE: _____

PRESENT VALUE: _____

MORTGAGES AND NOTES (RECEIVABLE):

MORTGAGOR: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TERMS OF OBLIGATION: _____

PRESENT VALUE: _____

INSURANCE ON ALLEGED INCAPACITATED PERSON'S LIFE:

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

PRESENT VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

PRESENT VALUE: _

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

PRESENT VALUE: _____

ANNUITIES:

COMPANY NAME: _____ POLICY #: _____

BENEFICIARY NAMED: _____

LOCATION OF POLICY: _____

PRESENT VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARY NAMED: _____

LOCATION OF POLICY: _____

PRESENT VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARY NAMED: _____

LOCATION OF POLICY: _____

PRESENT VALUE: _____

VEHICLES:

MODEL: _____ YEAR: _____

HOW TITLED: _____

LOCATION OF TITLE: _____

PRESENT VALUE: _____

MODEL: _____ YEAR: _____

HOW TITLED: _____

LOCATION OF TITLE: _____

PRESENT VALUE: _____

MODEL: _____ YEAR: _____

HOW TITLED: _____

LOCATION OF TITLE: _____

PRESENT VALUE: _____

MISCELLANEOUS PERSONAL PROPERTY:

DOCUMENTS NEEDED BY THIS OFFICE:

_____ REAL ESTATE DEEDS (copies)

_____ BANK STATEMENTS (copies)

_____ VEHICLE TITLES (copies)

_____ BILLS/CREDITORS (copies)

_____ LAST WILL AND TESTAMENT (copy) (please indicate location of original, if any)

_____ DURABLE POWERS OF ATTORNEY (copy)

_____ LIVING WILL/HEALTH CARE SURROGATE (copy)

Under penalties of perjury, I declare that I have read the foregoing, and the facts set forth herein are true to the best of my knowledge and belief.

Print name: _____

Relationship to Ward: _____