

GUARDIAN AND CONSERVATOR INTAKE FORM

Petitioner

How did you hear about Oast & Hook?

Name of Petitioner:		Telephone Number (Home): Telephone Number (Work): Telephone Number (Cell):	
Street Address of Petitioner:		Mailing Address of Petitioner, if different from street address:	
City:		City:	
State:	Zip:	State:	Zip:
Fax Number Home:		Fax Number Work:	
Petitioner's e-mail address:		Petitioner's Social Security Number:	
Petitioner's date of birth:		Petitioner's relationship to Incapacitated Person:	
Have you ever been convicted of a felony?		Yes () No () If yes, please explain:	
Have you ever filed bankruptcy?		Yes () No () If yes, please explain:	
Are you now, or have you ever been, an attorney at law in Virginia or elsewhere?		Yes () No () If yes, please explain:	

Incapacitated Person

Name of Incapacitated Person:		Date of birth:		Social Security Number		
Description of the Incapacitated Person <small>(Required by Virginia State Police)</small>	Height	Weight	Color of Hair	Color of Eyes	Sex	Race

Incapacitated Person's place of residence:		
City	State	Zip
Incapacitated Person's post office address:		
City	State	Zip
Place of birth: City/County	State	

Marital Status	Married	Widow/Widower	Divorced	If married, spouse's name: Date of marriage:
Spouse's date of birth:			Spouse's Social Security Number:	
Spouse's Street Address:				
City			State	Zip
Veteran?			If Veteran, dates of service	
Was former spouse a Veteran?			If Veteran, dates of service	

Names of Incapacitated Person's living adult children:				
Name ①		Telephone	Age	Relationship
Address		City		State Zip
Name ②		Telephone	Age	Relationship
Address		City		State Zip
Name ③		Telephone	Age	Relationship
Address		City		State Zip

Are the parents of the Incapacitated Person alive? Yes () No ()	If yes, Mother's name: Father's name:		
If alive, mother's address	City		State Zip
If yes, father's address	City		State Zip

Names of Incapacitated Person's living adult siblings:			
Name ①	Telephone	Age	Relationship

Address	City	State	Zip
Name ②	Telephone	Age	Relationship
Address	City	State	Zip
Name ③	Telephone	Age	Relationship
Address	City	State	Zip

If the Incapacitated Person has no known spouse, children, parents, or adult siblings, then please state the name, age, address and relationship of at least three known living relatives, including step-children of the Incapacitated Person:

Name ①	Telephone	Age	Relationship
Address	City	State	Zip
Name ②	Telephone	Age	Relationship
Address	City	State	Zip
Name ③	Telephone	Age	Relationship
Address	City	State	Zip

Name of hospital, nursing home or other facility, if any :

Street Address	City	State	Zip
How long has the Incapacitated Person resided in the hospital, nursing home or other facility?			
Where did the Incapacitated Person reside prior to entering the hospital, nursing home or other facility?			
Address	City	State	Zip
How long did Incapacitated Person live at this address?			

Please state the name, address and telephone number of the physician ¹ who will provide a written evaluation of the Incapacitated Person:			
Name	Telephone Number		
Address	City	State	Zip

Please describe the physical and mental condition of the Incapacitated Person. Specially state the “alleged” incapacity:
Please provide a brief description of the services currently being provided for the Incapacitated Person’s health, care, safety or rehabilitation:
Please provide a recommendation for the Incapacitated Person’s living arrangements and treatment plan:
What is the native language of the Incapacitated Person?
Is there any alternative mode of communication for the Incapacitated Person?

Estate Planning Documents

Does the Incapacitated Person have any of the following documents? If so, please attach a copy of each such document:			
Durable Power of Attorney Yes () No ()	Advance Medical Directive Yes () No ()	Trust Agreement Yes () No ()	Last Will & Testament Yes () No ()

¹ Virginia Code § 37.2-1005 states: “The report shall be prepared by one or more licensed physicians or psychologists, or licensed professionals skilled in the assessment and treatment of the physical or mental conditions of the Ward as alleged in the petition.”

Real Property

Real Property	Address of Real Property	
City	State	Zip
Value, assessed or appraised: \$	Deeds of Trust or Mortgage	
Name of Mortgage Company	Mortgage or Debt owed: \$	
Name of Mortgage Company	Mortgage or Debt owed: \$	
For city assessments call:		
Virginia Beach 427-4601	Suffolk 923-2400	Portsmouth 393-8631
Chesapeake 382-6235	Norfolk 664-4732	
If additional space is required to list the Incapacitated Person's real property, please provide this additional information on a separate sheet of paper attached to this Intake Form.		

Tangible Personal Property

Description	How Titled or Owned	Value of Property	Amount Owed
Example: 1998 Mercury Automobile	Husband & Wife	\$7,000	\$4,000

Accounts at Financial Institutions

Type of Account	Name of Financial Institution and Account Number	How Titled or Owned	Approximate Balance
Example: checking	SunTrust 1234567890		\$1,500.00

Stocks and Bonds

Type of Account Name of Stocks and Bonds and Number of Shares	Name of Financial Institution and Account Number	How Titled or Owned	Approximate Value

Safe Deposit Box Information

Financial Institution	Authorized Entrants	Location of Key	Contents
Example: SunTrust	Daughter - Sara	Car key ring	Important papers, will, etc.

Annuities and Retirement Accounts

Type of Benefit	Financial Institution	How Titled	Value or Balance
Example: IRA	SunTrust	Incapacitated Person's name only	\$2,000.00
Example: Retirement plan through employer	ABC Corporation	Incapacitated Person's name only	\$15,000.00

Annual Income

Salary		Social Security	
IRA account withdrawal		Retirement income	
Dividends and interest		Other	
Total Annual Income			

Debts

Creditor	Name of Debtors	Purpose	Balance/Monthly Payment
Example: Visa	Capital One	Household	\$500/\$100 per month

Life Insurance Policies

Policy Number 1: Name of Company	Address City State Zip
Name of Insured:	Name of Owner:
Amount paid for insurance \$_____ per month?	Who pays coverage Wife ____ Husband ____
Is insurance an employment benefit? Yes () No ()	If yes, for Wife _____ or Husband _____
Policy Number 2: Name of Company	Address City State Zip
Name of Insured:	Name of Owner:
Amount paid for insurance \$_____ per month	Who pays coverage Wife ____ Husband ____
Is insurance an employment benefit? Yes () No()	If yes, for Wife _____ or Husband _____