

**GOLDSTEIN & CORNICK, LLP  
 210 EAST MAIN STREET  
 SOMERVILLE, NJ 08876  
 (908) 253-0404**

**GUARDIAN AND CONSERVATOR INTAKE FORM**

**Petitioner**

Name of Petitioner:		Telephone Number of Petitioner:	
Street Address of Petitioner:		Mailing Address of Petitioner , if different from street address:	
City		City	
State	Zip	State	Zip
Petitioner's date of birth:		Petitioner's Social Security Number:	
Petitioner's relationship to Incapacitated Person:			

**Incapacitated Person**

Name of Incapacitated Person:		Date of birth:		Social Security Number		
Description of the Incapacitated Person	Height	Weight	Color of Hair	Color of Eyes	Sex	

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

Marital Status	Married	Widow/Widower	Divorced	If married, spouse's name:
Spouse's date of birth:			Spouse's Social Security Number:	
Spouse's Street Address:				
City		State	Zip	

Names of Incapacitated Person's children:				
Name 1			Age	Relationship
Address		City		State   Zip
Name 2			Age	Relationship
Address		City		State   Zip
Name 3			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 yes, Mother's Address	City	State	Zip
If yes, Father's Address	City	State	Zip

Names of Incapacitated Person's Adult Siblings:			
Name 1		Age	Relationship

Address	City	State	Zip
Name <b>i</b>	Age	Relationship	
Address	City	State	Zip
Name <b>D</b>	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 relatives, including stepchildren of the Incapacitated Person:

Name <b>i</b>	Age	Relationship	
Address	City	State	Zip
Name <b>i</b>	Age	Relationship	
Address	City	State	Zip
Name <b>D</b>	Age	Relationship	
Address	City	State	Zip

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

Street Address	City	State	Zip
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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?


Please state the name, address, and telephone number of the two physicians who will provide an evaluation report:			
Names		Telephone Numbers	
â		â	
ã.		ã	
Addresses	City	State	Zip
â	â	â	â
ã	ã	ã	ã

<p>Please describe the physical and mental condition of the Incapacitated Person. Especially state the “alleged” incapacity:</p>
<p>Please provide a brief description of the services currently being provided for the Incapacitated Person’s health, care, safety, or rehabilitation:</p>
<p>Please provide a recommendation for the Incapacitated Person’s living arrangements and treatment plan:</p>

What is the native language of the Incapacitated Person?
Is there any alternative mode of communication?

**Estate Planning Documents**

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

**Real Property**

The following is a statement of the financial resources of the Incapacitated Person:		
Real Property	Address of Real Property	
City	State	Zip
Value, assessed or appraised: \$	Mortgage or debt owed: \$	
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 Balance
<b>Example:</b> 1998 Mercury Automobile	Husband & Wife	\$7,000	\$4,000


**Accounts at Financial Institutions**

<b>Type of Account</b>	<b>Name of Financial Institution</b>	<b>Account Number</b>	<b>Approximate Balance</b>
<b>Example:</b> checking	SunTrust	1234567009	\$1,500.00

**Annuities and Retirement Accounts**

<b>Type of Benefit</b>	<b>Financial Institution</b>	<b>Joint or Individual</b>	<b>Value or Balance</b>
<b>Example:</b> IRA	SunTrust	Individual	\$2,000.00
<b>Example:</b> Retirement plan through employer	ABC Corporation	Individual	\$15,000.00

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**Annual Income**

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

**Debts**

<b>Creditor</b>	<b>Joint or Individual</b>	<b>Purpose</b>	<b>Balance/Monthly Payment</b>
<b>Example:</b> Visa	Joint	Household	\$500/\$100 per month

**Life Insurance Policies**

Policy Number 1:	Address
Name of Company	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 _____

The undersigned hereby represents to Goldstein & Cornick, LLP, that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information which I am furnishing. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

Date:

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