

Date: _____

CONFIDENTIAL GUARDIANSHIP QUESTIONNAIRE

A. Incapacitated Person:

Full Legal Name: _____

Other names used: _____

Address of Present Residence: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different from residence): _____

City: _____ State: _____ Zip: _____

Phone Number: _____ E-mail: _____

Date of Birth: _____

B. Proposed Guardian(s):

Full Legal Name: _____

Other names used: _____

Relationship to Incapacitated Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Home / Cell Phone: _____ E-mail: _____

Date of Birth: _____

Full Legal Name: _____

Other names used: _____

Relationship to Incapacitated Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ E-mail: _____

Date of Birth: _____

C. Type of Guardianship (please circle)

Of Person and Estate / Of Person only / Of Estate only

(You may make this decision after your consultation.)

D. Standby (Alternate) Guardian

Full Legal Name: _____

Other names used: _____

Relationship to Incapacitated Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ E-mail: _____

Date of Birth: _____

E. Immediate Family Members (parents/siblings/children) not previously listed above:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Incapacitated Person: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Incapacitated Person: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Incapacitated Person: _____

F. Physical and Mental Status of Incapacitated Person.

1. Describe the nature and extent of the incapacity: _____

2. Describe services or programs the person receives: _____

3. Describe medical needs. (*i.e. Does the person take prescribed medications, need 24-hour care, etc.*) _____

4. Describe mental capacity:
a) Is the personal mentally stable? Yes No
If not, please explain: _____

b) Is the person able to be interviewed by a court-appointed person?
 Yes No
If not, please explain: _____

5. Does the person have the functional abilities to care for him/herself on a daily basis?

Describe his/her abilities and disabilities. _____

G. Personal Care of Incapacitated Person.

1. Intended place of residence after guardianship appointment: _____

2. Are services or programs to be used by the person different after appointment?

Yes

No

If yes, please describe: _____

3. Do you expect any changes in mental or physical status of the person after appointment?

Yes

No

If yes, please describe: _____

**** Please attach most recent comprehensive medical report. ****

H. Assets Owned by the Incapacitated Person

List the approximate value and the description of the person's property:

- A. Real Property: \$ _____
 - B. Stock, Mutual Funds and Bonds: \$ _____
 - C. Bank Accounts \$ _____
 - D. Furniture: \$ _____
 - E. Other Personal Property: \$ _____
- Total Approximate Value of Assets is: \$ _____

There are periodic compensation, pension, insurance, and allowances as follows:

- A. Social Security Benefits: \$ _____ /month
 - B. Veterans Benefits \$ _____ /month
 - C. Washington State Assistance \$ _____ /month
 - D. Other: \$ _____ /month
- Approximate Total Monthly Income: \$ _____

If assets total less than \$3,000, do you want to apply for waiver of court and third-party review fees? Yes No