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PROPOSED GUARDIAN QUESTIONNAIRE

NOTE: This form is extremely important. Your accuracy and completeness in responding will assist us in representing you. All information requested in this questionnaire must be included in the initial pleadings that we will file with the court. The court will reject and return any pleadings that have missing information. Therefore, please do not leave anything blank. If something does not apply, please write "N/A" next to it. If you do not know the requested information, please write "Unknown" next to it. Thank you!

IMPORTANT INFORMATION ABOUT PROPOSED GUARDIAN:

1. **FIRST NAME:**
2. **MIDDLE NAME:**
3. **LAST NAME:**
4. **EMAIL ADDRESS:**
5. **TELEPHONE NUMBER:**
6. **HOME ADDRESS:**
7. **DATE OF BIRTH: AGE:**
8. **RELATIONSHIP TO THE ALLEGED INCAPACITATED PERSON:**
9. **HAVE YOU EVER BEEN CONVICTED OF A CRIME, OTHER THAN A TRAFFIC VIOLATION?**
10. **HAS ANY CIVIL JUDGMENTS (INCLUDING BANKRUPTCY) EVER BEEN ENTERED AGAINST YOU?**
11. **DO YOU UNDERSTAND THAT YOU MUST WATCH THE INTRODUCTION TO GUARDIANSHIP TRAINING VIDEO FOR GUARDIANS, WHICH CAN BE FOUND AT www.njcourts.gov/courts/civil/guardianship.html?**
12. **HAVE YOU WATCHED THAT VIDEO?**

IMPORTANT INFORMATION ABOUT PROPOSED CO-GUARDIAN:

1. **FIRST NAME:**
2. **MIDDLE NAME:**
3. **LAST NAME:**
4. **EMAIL ADDRESS:**
5. **TELEPHONE NUMBER:**
6. **HOME ADDRESS:**
7. **DATE OF BIRTH:** **AGE:**
8. **RELATIONSHIP TO THE ALLEGED INCAPACITATED PERSON:**
9. **HAVE YOU EVER BEEN CONVICTED OF A CRIME, OTHER THAN A TRAFFIC VIOLATION?**
10. **HAS ANY CIVIL JUDGMENTS (INCLUDING BANKRUPTCY) EVER BEEN ENTERED AGAINST YOU?**
11. **DO YOU UNDERSTAND THAT YOU MUST WATCH THE INTRODUCTION TO GUARDIANSHIP TRAINING VIDEO FOR GUARDIANS, WHICH CAN BE FOUND AT www.njcourts.gov/courts/civil/guardianship.html?**
12. **HAVE YOU WATCHED THAT VIDEO?**

IMPORTANT INFORMATION ABOUT ALLEDGED INCAPACITATED PERSON:

1. **FIRST NAME:**
2. **MIDDLE NAME:**
3. **LAST NAME:**
4. **HOME ADDRESS:**
5. **DATE OF BIRTH:** **AGE:**
6. **SOCIAL SECURITY NUMBER:**
8. **DIAGNOSIS:**
9. **DATE OF DIAGNOSIS:**
10. **WHAT TASKS CAN HE OR SHE DO WITHOUT ASSISTANCE:**

11. WHAT TASKS DOES HE OR SHE NEED ASSISTANCE WITH:

12. EXAMPLES OF INCAPACITY:

13. DOES HE OR SHE HAVE AN INDIVIDUALIZED EDUCATION PROGRAM ("IEP")? IF SO, PLEASE ATTACH A COPY:

14. AMOUNT OF SOCIAL SECURITY BENEFITS:

15. AMOUNT OF PENSION BENEFITS:

16. IRA INCOME:

17. DISABILITY INCOME:

18. RENTAL INCOME:

19. INTEREST INCOME:

20. DIVIDENDS INCOME:

21. ANNUITY INCOME:

22. OTHER SOURCES OF INCOME:

23. MONTHLY MORTGAGE OR RENT:

24. MONTHLY REAL ESTATE TAXES:

25. MONTHLY UTILITIES:

26. ADDRESS, MUNICIPAL TAX ASSESSED VALUE, AND MARKET VALUE OF REAL ESTATE PROPERTY:

27. DOES HE OR SHE RECEIVE MEDICAID? IF SO, WHEN DID MEDICAID BENEFITS START?

28. VALUE OF LIFE INSURANCE POLICY:

29. MAKE, MODEL, YEAR, AND VALUE OF AUTOMOBILE:

30. NAME OF FINANCIAL INSTITUTION, ACCOUNT TYPE, NUMBER OF SHARES OR LAST FOUR DIGITS OF ACCOUNT, FACE VALUE, MARKET VALUE, AND DATE VALUE FIXED FOR ALL STOCKS:

31. NAME OF FINANCIAL INSTITUTION, ACCOUNT TYPE, NUMBER OF SHARES OR LAST FOUR DIGITS OF ACCOUNT, FACE VALUE, MARKET VALUE, AND DATE VALUE FIXED FOR ALL BONDS:

32. NAME OF FINANCIAL INSTITUTION, ACCOUNT TYPE, NUMBER OF SHARES OR LAST FOUR DIGITS OF ACCOUNT, FACE VALUE, MARKET VALUE, AND DATE VALUE FIXED FOR ALL MUTUAL FUNDS:

33. NAME OF FINANCIAL INSTITUTION, ACCOUNT TYPE, NUMBER OF SHARES OR LAST FOUR DIGITS OF ACCOUNT, FACE VALUE, MARKET VALUE, AND DATE VALUE FIXED FOR ALL SECURITIES:

34. NAME OF FINANCIAL INSTITUTION, ACCOUNT TYPE, NUMBER OF SHARES OR LAST FOUR DIGITS OF ACCOUNT, FACE VALUE, MARKET VALUE, AND DATE VALUE FIXED FOR ALL INVESTMENT ACCOUNTS:

35. NAME OF FINANCIAL INSTITUTION, ACCOUNT TYPE, LAST FOUR DIGITS OF ACCOUNT, VALUE, AND DATE VALUE FIXED FOR ALL MONEY ON HAND:

36. NAME OF FINANCIAL INSTITUTION, ACCOUNT TYPE, LAST FOUR DIGITS OF ACCOUNT, VALUE, AND DATE VALUE FIXED FOR ALL RETIREMENT ACCOUNTS:

37. DESCRIPTION AND VALUE OF ALL PERSONAL PROPERTY, VEHICLES, EMPLOYMENT BONUS OR AWARD, INTEREST IN A PARTNERSHIP OR UNINCORPORATED BUSINESS, ARTICLES OR COLLECTIONS, ETC.

38. DESCRIPTION AND AMOUNT OF ALL LIABILITIES/ENCUMBRANCES:

39. DOES HE OR SHE HAVE A WILL, POWER OF ATTORNEY, OR HEALTH CARE POWER OF ATTORNEY? IF SO, PLEASE ATTACH COPIES:

<u>IMPORTANT INFORMATION ABOUT ALLEDGED INCAPACITATED PERSON'S SPOUSE, IF APPLICABLE</u>:

1. FIRST NAME:

2. MIDDLE NAME:

3. LAST NAME:

4. EMAIL ADDRESS:

5. **TELEPHONE NUMBER:**

6. **HOME ADDRESS:**

7. **DATE OF BIRTH:** **AGE:**

IMPORTANT INFORMATION ABOUT ALLEDGED INCAPACITATED PERSON'S FATHER, IF NOT PROVIDED ABOVE AND IF LIVING:

1. **FIRST NAME:**

2. **MIDDLE NAME:**

3. **LAST NAME:**

4. **EMAIL ADDRESS:**

5. **TELEPHONE NUMBER:**

6. **HOME ADDRESS:**

7. **DATE OF BIRTH:** **AGE:**

IMPORTANT INFORMATION ABOUT ALLEDGED INCAPACITATED PERSON'S MOTHER, IF NOT PROVIDED ABOVE AND IF LIVING:

1. **FIRST NAME:**

2. **MIDDLE NAME:**

3. **LAST NAME:**

4. **EMAIL ADDRESS:**

5. **TELEPHONE NUMBER:**

6. **HOME ADDRESS:**

7. **DATE OF BIRTH:** **AGE:**

IMPORTANT INFORMATION ABOUT ALLEDGED INCAPACITATED PERSON'S CHILD, IF NOT PROVIDED ABOVE (Attach additional sheets if necessary to list all children):

1. **FIRST NAME:**
2. **MIDDLE NAME:**
3. **LAST NAME:**
4. **EMAIL ADDRESS:**
5. **TELEPHONE NUMBER:**
6. **HOME ADDRESS:**
7. **DATE OF BIRTH:** **AGE:**

IMPORTANT INFORMATION ABOUT ADMINISTRATOR OF FACILITY THE ALLEDGED INCAPACITATED PERSON CURRENTLY RESIDES, IF APPLICABLE:

1. **NAME OF FACILITY:**
2. **NAME OF ADMINISTRATOR:**
3. **NAME OF SOCIAL WORKER:**
4. **EMAIL ADDRESS:**
5. **TELEPHONE NUMBER:**
6. **ADDRESS:**
7. **DATE OF ADMISSION:**
8. **REASON FOR ADMISSION:**
9. **RESIDENCE BEFORE ADMISSION:**

IMPORTANT INFORMATION ABOUT THE PHYSICIAN OR PSYCHOLOGIST WHO WILL BE DOING THE REQUIRED EVALUATION AND CERTIFICATION:

1. **PHYSICIAN OR PSYCHOLOGIST'S FULL NAME:**
2. **NAME OF THE PRACTICE:**

3. EMAIL ADDRESS:

5. TELEPHONE NUMBER:

6. ADDRESS:

7. DATE YOU WILL BE TAKING THE ALLEDGED INCAPACITATED PERSON TO THE EVALUATION (We will be sending the certification for the person to fill out before the appointment):

IMPORTANT INFORMATION ABOUT THE SECOND PHYSICIAN OR PSYCHOLOGIST WHO WILL BE DOING THE REQUIRED EVALUATION AND CERTIFICATION:

1. PHYSICIAN OR PSYCHOLOGIST'S FULL NAME:

2. NAME OF THE PRACTICE:

3. EMAIL ADDRESS:

5. TELEPHONE NUMBER:

6. ADDRESS:

7. DATE YOU WILL BE TAKING THE ALLEDGED INCAPACITATED PERSON TO THE EVALUATION (We will be sending the certification for the person to fill out before the appointment):

BELOW PLEASE WRITE ANY ADDITIONAL INFORMATION YOU THINK WE SHOULD KNOW: