

**CONFIDENTIAL QUESTIONNAIRE  
GUARDIAN & CONSERVATOR**

**WILLIAMSON LAW OFFICE, PA**

1801 Old Trolley Road Suite 102 Summerville, SC 29485  
(843) 821-8884 (843) 821-9014-Fax

Email: [melvin@williamsonlawofficepa.com](mailto:melvin@williamsonlawofficepa.com)

MELVIN D. WILLIAMSON  
Attorney-CPA

GRANT A. WILLIAMSON  
Attorney

Certified Specialist in Estate Planning & Probate Law

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please answer each question completely. Place N/A in response to any question which does not apply to you.

**1. Person Completing Questionnaire. Please provide the following information about yourself:**

Full name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address (if different from mailing address: \_\_\_\_\_

Relationship to Incapacitated: \_\_\_\_\_

Home telephone number: \_\_\_\_\_ Cell phone number: \_\_\_\_\_

Work telephone number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Are you seeking appointment? Yes or No

By whom were you referred to this office: \_\_\_\_\_

**ACKNOWLEDGEMENT**

The undersigned states that the information provided to Williamson Law Office, PA in the questionnaire is true and correct to the best of their ability and will provide any updated information obtained to Williamson Law Office, PA prior to the submission of the Petition for Guardianship/Conservatorship.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Definitions and Terms:**

- 1. **Petitioner**-This is the person or persons asking the Court to appoint a guardian/conservator for the person in need (the Ward).
- 2. **Ward**-This is the person who is incapacitated, disabled otherwise in need of a guardian/conservator.
- 3. **Guardian**-This is the person to be appointed by the Probate Court to take care of the physical needs, living arrangements, and medical needs of the Ward. This person may or may not be the Petitioner.
- 4. **Conservator**-This is the person to be appointed by the Probate Court to take care of the financial assets of the Ward. This person may or may not be the Petitioner.
- 5. **Interested Party(ies)**-This is the person(s) entitled to notice of the filing of the Petition.

**2. Please provide the following information about the Incapacitated:**

Full name: \_\_\_\_\_

Other Names Known by: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address (if different from mailing address: \_\_\_\_\_

County of Residence: \_\_\_\_\_

Home telephone number: \_\_\_\_\_

Cell phone number: \_\_\_\_\_

Work telephone number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

SSN: \_\_\_\_\_

US Citizen? Yes or No

SC Resident? Yes or No

Veteran: Yes or No

If so, Branch of Service: \_\_\_\_\_

Dates of Service: \_\_\_/\_\_\_/\_\_\_ thru \_\_\_/\_\_\_/\_\_\_ Rank at Discharge: \_\_\_\_\_

Do you currently receive VA benefits? Yes or No Type: \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed

Please list all marriages

Spouse Name: \_\_\_\_\_ Date of Marriage: \_\_\_\_\_

Was this marriage ended by divorce? Yes or No Date of Divorce: \_\_\_\_\_

Was this marriage ended by death of spouse? Yes or No Date&Place of death: \_\_\_\_\_

**3. RELATIVES OF THE INCAPACITATED PERSON**

Please provide the following information including spouse, children, step-children, legally adopted children, parents, and adult siblings, or if none known, at least one relative of some degree.

Name	Date of Birth	Address	Relationship to Decedent

**4. MEDICAL INFORMATION FOR THE INCAPACITATED PERSON**

- 1. Most recent diagnosis: \_\_\_\_\_
- 2. Physical Conditions: \_\_\_\_\_
- 3. Cognitive Conditions: \_\_\_\_\_

4. Medications Prescribed: \_\_\_\_\_  
\_\_\_\_\_

**5. Activities of Daily Living**

Feeds Independently? Yes or No                      Dresses Independently? Yes or No  
Bathes Independently? Yes or No                    Transfers Independently? Yes or No  
Toilets Independently? Yes or No                   Requires Supervision? Yes or No

**6. Capacity**

Able to sign name? Yes or No                      Able to read & understand? Yes or No  
Been declared incompetent by court? Yes or No

7. Please provide the name of at least two physicians/examiners to complete a report for filing with  
The court to confirm the need for a guardian and/or conservator.

Primary Physician

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

Other Physician

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

**8. Nursing Home/Medical Facility Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_                      Date of Admission: \_\_\_\_\_

**9. HEALTH INSURANCE INFORMATION FOR THE INCAPACITATED PERSON**

Type	ID#/Insured	Carrier	Premium/Month
			\$

## 10. SUMMARY OF ASSETS

<u>Assets</u> (Estimate Current Fair Market Value)	<u>Fair Market Value</u>	<u>Account Name</u>
1. Principal Residence	\$	
2. Other Real Estate	\$	
	\$	
	\$	
	\$	
3. Mineral Interests	\$	
4. Checking Account(s)	\$	
5. Savings Account(s)	\$	
6. Certificates of Deposit(s)	\$	
7. Brokerage Account(s)	\$	
	\$	
	\$	
8. Other Securities	\$	
9. Business Interests	\$	
10. Notes Receivable	\$	
11. Personal Effects & Furnishings	\$	
12. Automobiles	\$	
13. Other	\$	
<b>Total Assets</b>	\$	

<u>Liabilities</u>	<u>Your Name Only</u>	<u>Owed Jointly</u>
Home Mortgage	\$	
Other Mortgages	\$	
Other Loans	\$	
<i>Total Liabilities</i>	\$	

<b>NET ASSETS</b>	\$	\$
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**Profit Sharing, IRA, Pension Plans, 401k, Etc.**

OWNER	DESCRIPTION	BENEFICIARY	CURRENT VALUE
			\$
			\$
			\$
			\$

**TOTAL RETIREMENT BENEFITS:** \_\_\_\_\_

**Life Insurance**

Type (e.g., term, group, whole life, accidental )	Face Amount of Death Benefit	Approximate Cash Value	Owner	Insured	Primary Beneficiary	Secondary Beneficiary
			Client Trust Other	Client Other		

**TOTAL INSURANCE:** \_\_\_\_\_

$$\begin{array}{ccccccc}
 \text{_____} & + & \text{_____} & + & \text{_____} & = & \text{_____} \\
 \text{NET ASSETS} & & \text{COMBINED} & & \text{COMBINED} & & \text{TOTAL} \\
 & & \text{TOTAL} & & \text{TOTAL} & & \\
 & & \text{RETIREMENT} & & \text{INSURANCE} & & \\
 & & \text{BENEFITS} & & & & 
 \end{array}$$

**11. LEGAL ASSESSMENT OF THE INCAPACITATED**

Are the following estate planning documents in place?

Last Will & Testament? Yes or No    Date Made: \_\_\_\_\_ Location of Original \_\_\_\_\_

Health Care Power of Attorney? Yes or No

Living Trust? Yes or No

Durable Power of Attorney? Yes or No

Is the DPOA Recorded in ROD Office? Yes or No

Other important documents with location: \_\_\_\_\_

Lawsuit? Yes or No    Case Description: \_\_\_\_\_

Other legal concerns? \_\_\_\_\_

ADVISOR	NAME AND FIRM	ADDRESS / PHONE NUMBER
Attorney		
Financial Consultant		
Accountant		
Insurance Agent		
Trust Officer		
Other		



**12. INFORMATION ABOUT THE PROPOSED GUARDIAN**

Full name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address (if different from mailing address: \_\_\_\_\_

Relationship to Incapacitated: \_\_\_\_\_

Home telephone number: \_\_\_\_\_ Cell phone number: \_\_\_\_\_

Work telephone number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed

Convicted of a crime? Yes or No

Credit problems with the past 10 years? Yes or No

Do you serve as Attorney in Fact under DPOA for the Incapacitated? Yes or No

Do you serve as Attorney in Fact under HCPOA for the Incapacitated? Yes or No

**13. INFORMATION ABOUT THE PROPOSED CONSERVATOR (if different)**

Full name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address (if different from mailing address: \_\_\_\_\_

Relationship to Incapacitated: \_\_\_\_\_

Home telephone number: \_\_\_\_\_ Cell phone number: \_\_\_\_\_

Work telephone number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed

Convicted of a crime? Yes or No

Credit problems with the past 10 years? Yes or No

Do you serve as Attorney in Fact under DPOA for the Incapacitated? Yes or No

Do you serve as Attorney in Fact under HCPOA for the Incapacitated? Yes or No

**Please be advised that the Guardian/Conservator maybe requested to provide the following to the court:**

1. Social Security Card and Drivers License or other picture ID
2. Credit Report
3. Criminal Background Report from SLED or equivalent state agency
4. Bond, if applicable

\*\*All information provided on this form will be treated as privileged and confidential.

**14.** How did you first learn about our firm?

**CHECKLIST OF DOCUMENTS FOR INCAPACITATED PERSON**  
The following items may be needed for the Petition filed with the Probate Court.

- \_\_\_\_\_ COPY of health insurance cards for the alleged incapacitated person
- \_\_\_\_\_ COPY of social security and/or retirement annual award letter
- \_\_\_\_\_ COPY of military DD Form 214
- \_\_\_\_\_ COPY of most current tax notices for all real estate owned
- \_\_\_\_\_ COPY of deeds for all real estate owned
- \_\_\_\_\_ COPY of titles to all vehicles, boats, RVs, etc owned
- \_\_\_\_\_ COPY of life insurance policies
- \_\_\_\_\_ COPY of current statements for ALL financial assets
- \_\_\_\_\_ COPY of current health care power of attorney, financial power of attorney, last will, codicials, Trust agreements
- \_\_\_\_\_ COPY of prenuptial agreement, marriage license, seperation/divorcee decree for all marriages
- \_\_\_\_\_ COPY of adoption papers
- \_\_\_\_\_ COPY of business ownership agreements
- \_\_\_\_\_ COPY of pre-need funeral arrangements contract
- \_\_\_\_\_ COPY of past 3 years tax returns and any gift tax returns