NEW GUARDIAN ADVOCATE QUESTIONNAIRE (Adults)

1. Proposed First Guardian Advocate's Name _____

2. First Guardian Advocate's Mailing Address _____

_____

3. First Guardian Advocate's Residence
(If different) _____

_____

4. First Guardian Advocate's Phone Number _____

5. First Guardian Advocate's Date of Birth _____

6. First Guardian Advocate's Social Security # _____

7. Proposed Second Guardian Advocates Name _____

8. Second Guardian Advocate's Mailing Address _____

_____

9. Second Guardian Advocate's Residence
(If different) _____

_____

10. Second Guardian Advocate's Phone Number _____

11. Second Guardian Advocate's Date of Birth _____

12. Second Guardian Advocate's Social Security # _____

13. Proposed Standby Guardian Advocate's Name _____

14. Proposed Standby Guardian Advocate's Mailing Address _____

_____

15. Proposed Standby Guardian Advocate's Residence
(If different) _____

_____

16. Proposed Standby Guardian Advocate's Phone Number _____

17. Proposed Standby Guardian Advocate's Date of Birth _____

18. Proposed Standby Guardian Advocate's Social Security #_____

19. Name of developmentally disabled person_____

20. Disabled person's a/k/a, if any _____

21. Disabled Person's Mailing Address _____

_____

22. Disabled Person's Phone Number_____

23. Disabled Person's Residence
(if different) _____

_____

24. Disabled Person's Social Security #_____

25. Date of Birth of Person With a Disability_____

26. Place of Birth of Person With a Disability_____

27. Disabled Person's Marital Status _____

28 Disabled Person's Race _____ Height_____Weight_____

29. Disabled Person's Length of Time in Florida_____

30. Is the disabled person a: U.S. Citizen? _____ a resident alien?_____

31. Identify Disable Person's Employer, Name, Address, Phone Number and Disable Person's Title of Position With Employer: _____

_____

32. Attending Physician _____

33. Physician's Address _____

_____

34. Physician's Phone Number _____

35. Describe the disabled person's developmental disability and **attach any recent reports/evaluations**. Please include your observations of why this person is unable to give informed medical consent or, make health care decisions on their own behalf:

_____

36. Does the proposed Guardian Advocate have a blood, marital or other prior relationship with the disabled person? If so, describe the relationship:

37. Names and addresses of the disabled person's next of kin (See note below):

NOTE: Florida law defines "next of kin" to be the heirs at law. Therefore, you should list the spouse and children, or grandchildren if child who was their parent is dead; if none, then list siblings, or nieces and nephews if the sibling who was their parent is dead; if none, then list aunts, uncles or cousins; if none or if relatives unknown, then state NO KNOWN RELATIVES.

IDENTIFY ALL ASSETS OF THE DISABLED PERSON (Include financial institution, branch location, account number, account balance, and names of all owners)

1. Checking Account
2. Savings Accounts
3. Certificate of deposit
4. Money Market account
5. Investment accounts
6. Stocks/Securities

7. IRA's _____

8. Life Insurance _____

_____

9. Real estate _____

_____

10. Automobiles _____

11. Annuities _____

12. Special Needs Trust _____

INCOME (include source of income, frequency of payment, amount of payment, address of payor)

1. Pension _____

2. Social Security _____

3. Reparation _____

4. Annuity _____

38. Name & address of bank we want to use as the court depository: _____

_____

39. Name of Petitioner[1] _____

40. Address/Phone # of Petitioner _____

_____

[1]The term "petitioner" is the legal word that means the person who has personal knowledge of the person's disability, and signs the petition to begin the guardian advocate proceeding.

41. Occupation/Title of Petitioner_____

42. Does the ward have any of the following documents? Please provide copies to our office:

Last Will & Testament __ Yes __ No Codicil __ Yes __ No Living Will __ Yes __ No

Designation of Health Care Surrogate __ Yes __ No Trust __ Yes __ No

Advance Directive __ Yes __ No Durable Power of Attorney __ Yes __ No

43. What health insurance does the incapacitated person have (list names, policy #):

Medicare _____

Supplemental policy _____

HMO _____

Long term care _____

Food Stamps _____

HUD Housing _____

44. Is the incapacitated person currently receiving or, has he/she applied for the following public assistance:

	YES	**NO**	**Gross Monthly Amount**	**Date Applied**
Medicaid				
Private Disability benefits				
Supplemental Security Income				
Supplemental Security Disability				

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____

Print Name: _____

Date: _____

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