

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 E-mail Address _____
5. First Guardian Advocate's Phone Number: Home: _____ Office: _____ Cell _____
6. First Guardian Advocate's Date of Birth _____
7. First Guardian Advocate's Social Security # _____
8. Proposed Second Guardian Advocate's Name _____
9. Second Guardian Advocate's Mailing Address _____

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

11. Second Guardian Advocate's E-mail Address: _____
12. Second Guardian Advocate's Phone Number: Home: _____ Office: _____ Cell _____
13. Second Guardian Advocate's Date of Birth _____
14. Second Guardian Advocate's Social Security # _____
15. Proposed Standby Guardian Advocate's Name _____
16. Proposed Standby Guardian Advocate's Mailing Address _____

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

18. Proposed Standby Guardian Advocate's E-mail Address: _____
19. Proposed Standby Guardian Advocate's Phone Number:
Home: _____ Office: _____ Cell _____
20. Proposed Standby Guardian Advocate's Date of Birth _____
21. Proposed Standby Guardian Advocate's Social Security # _____

22. Name of developmentally disabled person _____
23. Disabled person's a/k/a, if any _____
24. Disabled Person's Mailing Address _____

25. Disabled Person's Residence (If different) _____

26. Disabled Person's E-mail Address: _____
27. Disabled Person's Phone Number:
Home: _____ Office: _____ Cell: _____
28. Disabled Person's Social Security # _____
29. Date of Birth of Person With a Disability _____
30. Place of Birth of Person With a Disability _____
31. Disabled Person's Marital Status _____
32. Disabled Person's Race _____ Height _____ Weight _____
33. Disabled Person's Length of Time in Florida _____
34. Is the disabled person a: U.S. Citizen? _____ a resident alien? _____
35. Identify the Employer of the person with a disability (include Name, Address, Phone Number and Title of Position With Employer): _____

36. Is the person with a disability enrolled in school? _____ Where? _____

37. Attending Physician _____
38. Physician's Address _____

39. Physician's Phone Number _____
40. Describe the diagnosis of the person with a 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, or handle finances:

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

42. Names and addresses of the next of kin of the person with a developmental disability(See note below):

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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.

43. Is the person with a developmental disability able to independently exercise the following rights:

Needs No Assistance	Needs Some Assistance	Cannot do at all	Activity/Right
			Initiate or make changes in residential abodes or environments
			Manage financial affairs or property
			Represent his/her interests with any governmental agency, including law enforcement authorities
			Give informed consent for medical, dental or surgical treatment
			Apply and qualify for public benefits
			Sue and defend lawsuits
			Marry
			Travel
			Make any gifts or dispositions of property
			Make decisions about his/her social environment or other social aspects of his/her life
			Arrange for educational needs
			Establish a Special Needs Trust (if needed), with Court approval, and direct the assignment of funds to the Special Needs Trust
			Make informed decisions regarding personal estate planning which may include a Last Will and Testament, Durable Power of Attorney and Health Care Surrogate

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

Print Name

Print Name

Signature of 1st Proposed Guardian

Date

Signature of 2nd Proposed Guardian

Date

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

- A. Checking Account _____

- B. Savings Accounts _____

- C. Certificate of deposit _____

- D. Money Market account _____

- E. Investment accounts _____

- F. Stocks/Securities _____

- G. IRA's / 401k _____

- H. Life Insurance _____

- I. Real estate _____

- J. Automobiles _____
- K. Annuities _____
- L. Special Needs Trust _____
- M. 529b plan _____
- N. College pre paid plan _____
- O. Funeral arrangements _____

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

- A. Pension _____
- B. Social Security _____
- C. Child Support _____
- D. Reparation _____
- E. Annuity _____

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

45. Name of Petitioner¹ _____

46. Address/Phone # of
Petitioner _____

47. Occupation/Title of Petitioner _____

48. Does the person with a developmental disability 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 (Do Not Resuscitate Order) Yes No
- Durable Power of Attorney Yes No

49. What health insurance and government benefits does the person with a developmental disability have (list names, policy #):

Medicare _____

Supplemental policy _____

HMO _____

TriCare _____

¹The 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.

Long term care _____

50. Is the 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	_____	_____	_____	_____
Food Stamps	_____	_____	_____	_____
HUD (subsidized) housing	_____	_____	_____	_____

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

Signature : _____

Print Name: _____

Date: _____