

# Special Needs Lawyers, PA

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Special Needs Trusts | Elder Law | Long Term Care Planning | Medicaid | Probate | Wills & Trusts  
Incapacity Planning | Guardianship | Developmental Disabilities | Veteran's Benefits

## CONFIDENTIAL GUARDIANSHIP QUESTIONNAIRE

*ALLEGED INCAPACITATED PERSON – “AIP”*  
*ALLEGED DEVELOPMENTALLY DISABLED PERSON – “ADDP”*

### A. Information about the AIP / ADDP:

1. Full Name: \_\_\_\_\_
2. Age: \_\_\_\_\_
3. Date of Birth: \_\_\_\_\_
4. Social Security Number: \_\_\_\_\_
5. Current Address: \_\_\_\_\_
6. Telephone Number: \_\_\_\_\_
7. Primary Spoken Language: \_\_\_\_\_
8. Description of alleged incapacity/developmental disability and reason for alleged incapacity/developmental disability: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Does the AIP/ADDP have any income? If yes, what kind and how much? \_\_\_\_\_  
\_\_\_\_\_
  - a. If AIP/ADDP is receiving SSI or will be receiving SSI, who is the Representative Payee? \_\_\_\_\_
10. Does the AIP/ADDP have any assets? If yes, what kind and value? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. List the name and address of person(s) known to the petitioner to have personal knowledge of facts through personal observation, of AIP/ADDP. (example: nurse at rehab facility or support coordinator) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B. Information about next of kin of AIP / ADDP:**

Please give the names, addresses and relationships of **all** known next of kin of the AIP/ADDP (give dates of birth of any who are minors.)

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_
2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_
3. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_
4. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_
5. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_
6. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_

**C. Information about AIP / ADDP's physician:**

Please give the name, address and phone number of the attending or family physician: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**D. Information about AIP / ADDP's physical disabilities:**

*Please indicate whether any of the following physical disabilities pertain to the AIP/ADDP:*

1. Impaired vision: \_\_\_\_\_
2. Impaired hearing: \_\_\_\_\_
3. Impaired ability to write: \_\_\_\_\_
4. Impaired ability to walk: \_\_\_\_\_
5. Impaired ability to physically maintain residence: \_\_\_\_\_
6. Impaired ability to clothe, bathe and/or feed self: \_\_\_\_\_
7. Bedridden: \_\_\_\_\_
8. Impaired ability to communicate: \_\_\_\_\_
9. Impaired ability to manage finances: \_\_\_\_\_
10. Other: \_\_\_\_\_

*Please indicate whether any of the physical disabilities associated with chronic or disabling conditions pertain to the AIP/ADDP:*

1. Heart Disease: \_\_\_\_\_
2. Cancer: \_\_\_\_\_
3. Lung Disorders: \_\_\_\_\_
4. Substance Abuse: \_\_\_\_\_
5. Stroke: \_\_\_\_\_
6. Diabetes: \_\_\_\_\_
7. Other: \_\_\_\_\_

*Please indicate if any of the following mental disabilities pertain to the AIP/ADDP:*

1. Senility: \_\_\_\_\_
2. Alzheimer's Disease: \_\_\_\_\_

3. Other Organic Brain Syndrome: \_\_\_\_\_
4. Psychiatric problems (i.e.: paranoia, depression, suicidal tendencies, violence, schizophrenia): \_\_\_\_\_
5. Hallucinations: \_\_\_\_\_
6. Confusion: \_\_\_\_\_
7. Poor judgment; no insight: \_\_\_\_\_
8. Memory Loss: \_\_\_\_\_
9. Disoriented as to time and place: \_\_\_\_\_
10. Other: \_\_\_\_\_

*Please indicate which rights you feel the AIP/ADDP is incapable of exercising:*

1. To marry: \_\_\_\_\_
2. To vote: \_\_\_\_\_
3. To enter into and perform contracts: \_\_\_\_\_
4. To travel: \_\_\_\_\_
5. To seek or retain employment: \_\_\_\_\_
6. To *personally* apply for governmental benefits: \_\_\_\_\_
7. To drive an automobile and have a driver's license: \_\_\_\_\_
8. To sue and defend lawsuits: \_\_\_\_\_
9. To maintain self in one's own residence without assistance: \_\_\_\_\_
10. To manage and control property: \_\_\_\_\_
11. To apply for governmental benefits: \_\_\_\_\_
12. To make informed decisions regarding medical treatment: \_\_\_\_\_
13. To make decisions about his or her social environment or other social aspects of his or her life: \_\_\_\_\_

**E. Information about the Proposed Guardian/Guardian Advocate (1):**

1. Full Name: \_\_\_\_\_
2. Social Security Number: \_\_\_\_\_
3. Date of Birth: \_\_\_\_\_
4. Place of Birth: \_\_\_\_\_
5. Current Address: \_\_\_\_\_  
\_\_\_\_\_
6. Mailing Address (if different from above): \_\_\_\_\_  
\_\_\_\_\_
7. Telephone Number: \_\_\_\_\_
8. Email Address: \_\_\_\_\_
9. U.S. Citizen? \_\_\_\_\_
10. Employer's name and address: \_\_\_\_\_  
\_\_\_\_\_  
Position: \_\_\_\_\_  
*(If not working, please specify if unemployed, retired or homemaker.)*
11. Marital status and name of spouse, if any: \_\_\_\_\_
12. Length of residence in county wherein application is filed: \_\_\_\_\_
13. What is the applicant's relationship to the AIP/ADDP? \_\_\_\_\_
14. If currently serving as guardian for any other ward, list the names of each ward, court file number, circuit court in which the case(s) is/are pending and whether applicant is acting as the limited guardian, guardian of the person, guardian of the property, plenary guardian, or guardian advocate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
15. Does the applicant have any physical disabilities? If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Will any physical disability listed above affect the ability to serve as guardian or guardian advocate? \_\_\_\_\_  
\_\_\_\_\_

17. Has applicant ever been treated for the following:

- a. Mental Condition: \_\_\_\_\_
- b. Alcohol: \_\_\_\_\_
- c. Drugs: \_\_\_\_\_
- d. Other: \_\_\_\_\_

If "yes" was answered to any of the above, please state the date, time, location of treatment, and name of physician or professional involved: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Has applicant ever been judicially determined to have committed abuse or neglect against a child as defined by the Florida Statutes? \_\_\_\_\_

If "yes" was answered, please give the date and complete details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. Has applicant ever been the subject of a confirmed report of abuse, neglect or exploitation which has been uncontested or upheld pursuant to the provisions of Sections 415.014 and 415.1075 of the Florida Statutes? \_\_\_\_\_

If "yes" was answered, please give the date and complete details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

20. Has applicant ever been charged with fraud, misrepresentation or perjury in a judicial or administrative proceeding? \_\_\_\_\_

If "yes" was answered, please give the date and complete details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. Has applicant ever been:
- a. Charged with a felony? \_\_\_\_\_
  - b. Arrested for a felony? \_\_\_\_\_
  - c. Convicted of a felony? \_\_\_\_\_
  - d. Entered a plea of guilty or no contest to a crime other than a felony? \_\_\_\_\_

If "yes" was answered to any above, please give complete details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

22. Has applicant ever held a position which required bonding? \_\_\_\_\_

If "yes" was answered, please describe the position, date, amount of bond and name of surety: \_\_\_\_\_  
\_\_\_\_\_

23. Has applicant, in the past, ever served as guardian of a person or of a person's property? \_\_\_\_\_

If "yes" was answered, please describe and include the reason for termination of fiduciary position: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

24. Has applicant even been held in contempt of court or removed as guardian? \_\_\_\_\_

If "yes" was answered, please give complete details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

25. Has applicant ever filed for bankruptcy? \_\_\_\_\_

If "yes" was answered, please state the date and location of the court: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

26. Is applicant, or applicant's business, corporation or other business entity a creditor of or providing, personal or business services to the alleged incapacitated person? \_\_\_\_\_

If "yes" was answered, please give complete details: \_\_\_\_\_  
\_\_\_\_\_

27. Is applicant a health care provider for the AIP/ADDP? \_\_\_\_\_

28. Educational history of the applicant:

High School: \_\_\_\_\_

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

Dates attended: \_\_\_\_\_

Diploma: \_\_\_\_\_

College: \_\_\_\_\_

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

Dates attended: \_\_\_\_\_

Degree: \_\_\_\_\_

Other: \_\_\_\_\_

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

Dates attended: \_\_\_\_\_

Degree: \_\_\_\_\_

29. List applicant's employment experience for the past ten (10) years beginning with the most recent:

1. Name: \_\_\_\_\_

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

Dates: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

2. Name: \_\_\_\_\_

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

Dates: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

3. Name: \_\_\_\_\_

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

Dates: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

4. Name: \_\_\_\_\_

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

Dates: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

30. Has applicant ever been discharged from employment? \_\_\_\_\_

If "yes" was answered, please furnish details: \_\_\_\_\_

\_\_\_\_\_

31. Has applicant ever been a member of the armed forces of the U.S.? \_\_\_\_\_  
 If "yes" was answered, what branch, dates and military serial number: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
32. Personal References – Please give the names, addresses and telephone numbers of three (3) responsible persons who have been closely associated with applicant and who have known applicant for five (5) years or more, not including relatives or spouse:
1. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_
  2. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_
  3. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_
33. Does applicant possess any special educational qualifications (financial, business or otherwise) that uniquely qualifies the applicant to be appointed as guardian or guardian advocate? \_\_\_\_\_  
 If "yes" was answered, please describe: \_\_\_\_\_  
 \_\_\_\_\_
34. Has applicant received instruction and training which covered the legal duties and responsibilities of a guardian, the rights of an incapacitated person, the availability of local resources to aid a ward, and the preparation of habilitation plans and annual guardianship reports, including financial accounting for the ward's property? \_\_\_\_\_  
 If "yes" was answered, indicate when and where training was received.  
 When: \_\_\_\_\_  
 Where: \_\_\_\_\_

**ADDITIONAL INFORMATION TO PROVIDE WITH QUESTIONNAIRE**

- Document providing diagnosis. This can be an Individual Education Plan (IEP), Psychological Evaluation, Physician's letter stating diagnosis, or Support Plan. *(For ADDP Only, Guardian Advocacy Cases)*
- Credit Report for each Guardian *(Hillsborough County Cases Only)*

**F. Information about the Proposed Guardian/Guardian Advocate (2):**  
(Complete only if there is more than one proposed guardian/guardian advocate.)

1. Full Name: \_\_\_\_\_
2. Social Security Number: \_\_\_\_\_
3. Date of Birth: \_\_\_\_\_
4. Place of Birth: \_\_\_\_\_
5. Current Address: \_\_\_\_\_  
\_\_\_\_\_
6. Mailing Address (if different from above): \_\_\_\_\_  
\_\_\_\_\_
7. Telephone Number: \_\_\_\_\_
8. Email Address: \_\_\_\_\_
9. U.S. Citizen? \_\_\_\_\_
10. Employer's name and address: \_\_\_\_\_  
\_\_\_\_\_  
Position: \_\_\_\_\_  
*(If not working, please specify if unemployed, retired or homemaker.)*
11. Marital status and name of spouse, if any: \_\_\_\_\_
12. Length of residence in county wherein application is filed: \_\_\_\_\_
13. What is the applicant's relationship to the AIP/ADDP? \_\_\_\_\_
14. If currently serving as guardian for any other ward, list the names of each ward, court file number, circuit court in which the case(s) is/are pending and whether applicant is acting as the limited guardian, guardian of the person, guardian of the property, plenary guardian, or guardian advocate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
15. Does the applicant have any physical disabilities? If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Will any physical disability listed above affect the ability to serve as guardian or guardian advocate? \_\_\_\_\_  
\_\_\_\_\_

17. Has applicant ever been treated for the following:

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- b. Alcohol: \_\_\_\_\_
- c. Drugs: \_\_\_\_\_
- d. Other: \_\_\_\_\_

If "yes" was answered to any of the above, please state the date, time, location of treatment, and name of physician or professional involved: \_\_\_\_\_  
\_\_\_\_\_  
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18. Has applicant ever been judicially determined to have committed abuse or neglect against a child as defined by the Florida Statutes? \_\_\_\_\_

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  - d. Entered a plea of guilty or no contest to a crime other than a felony? \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_

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Dates attended: \_\_\_\_\_

Degree: \_\_\_\_\_

Other: \_\_\_\_\_

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

Dates: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

2. Name: \_\_\_\_\_

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

Dates: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

3. Name: \_\_\_\_\_

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

Dates: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

4. Name: \_\_\_\_\_

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

Dates: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

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\_\_\_\_\_

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 Address: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_
  2. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_
  3. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_
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