

# GUARDIANSHIP QUESTIONNAIRE

Are you a member of any legal services insurance plan, such as ARAG? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please name the plan and your plan ID number: \_\_\_\_\_

Name of Alleged Incapacitated Person (AIP): \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Length of time at current residence: \_\_\_\_\_

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

\_\_\_\_\_

Phone: \_\_\_\_\_

Brief description of basis for belief that a guardianship is necessary: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there a durable power of attorney in place for the Alleged Incapacitated Person? \_\_\_\_\_

If yes, who has the power to act on the AIP's behalf? \_\_\_\_\_

AIP's Parents, if minor:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Deceased? Yes \_\_\_\_\_ No \_\_\_\_\_

Deceased? Yes \_\_\_\_\_ No \_\_\_\_\_

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

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

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

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

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

Name of Proposed Guardian(s): \_\_\_\_\_

Relationship to AIP, if any: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_

Fax Number: \_\_\_\_\_

\_\_\_\_\_

E-Mail: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are there any other residents in the home where the proposed Guardian would provide care for the AIP? (Each name listed below, including other family members, is subject to a criminal background check performed prior to placement or continued placement of the AIP in the home.)

Name: _____	Name: _____
Address: _____ _____	Address: _____ _____
Phone: _____	Phone: _____
Email: _____	Email: _____
Relationship: _____	Relationship: _____
Date of Birth: _____	Date of Birth: _____

Does proposed Guardian reside in Washington? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please provide name, address, phone number and e-mail address for resident agent:

Name: _____	Phone: _____
Address: _____ _____	Fax: _____
	E-Mail: _____

Does proposed Guardian have any felony convictions or other crimes of dishonesty on record that would prevent him/her from being bonded, if necessary? Yes \_\_\_\_\_ No \_\_\_\_\_

Is proposed Guardian a Professional Guardian? Yes \_\_\_\_\_ No \_\_\_\_\_

If you are the proposed guardian and are not a Certified Professional Guardian, do you have any background experience which may be helpful as a Guardian? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the gross estate of the AIP below \$3000? Yes \_\_\_\_\_ No \_\_\_\_\_ If the gross estate is below \$3000, or upon court review and order, the filing fee of \$230.00 may be waived and the County would pay for the services of the Guardian ad Litem appointed in the case.

List names, contact info and nature of the relationship of the persons in close contact with AIP:

Name: _____	Name: _____
Address: _____ _____	Address: _____ _____
Phone: _____	Phone: _____
Email: _____	Email: _____
Relationship: _____	Relationship: _____

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

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

\_\_\_\_\_

Phone: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

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

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

\_\_\_\_\_

Phone: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

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

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

\_\_\_\_\_

Phone: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

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

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

\_\_\_\_\_

Phone: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

Please indicate the name(s) of the treating physician / ARNP / psychologist or school counselor that may be able to attest to the AIP's competency or lack of capacity or developmental disability:

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

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

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

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

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

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

To secure the confidentiality of this information, please fax your completed questionnaire to my attention to (206) 723-3829, or send it by mail to:

Jeannie O'Brien  
Selander O'Brien Attorneys PLLC  
3829 C South Edmunds Street  
Seattle, WA 98118

Thank you for taking the time to complete this questionnaire.