ALLEGED INCAPACITATED PERSON (sometimes referred to as AIP)

Name: ____ also known as ___________________________________

Street: ____ City: _________________ State: _____ Zip: ________

Phones: Home: _____________________ Work _____________________ Other: ____________________

Birth Date: _________________________ S.S. No. _________________________ Religion: ________________

Race: _______________ Gender: _______________ Maiden Name: _________________________________

Marital Status: ________ Armed Forces Service (Branch): ____________ Discharge Date: ______________

Eye Color: ____________ Hair Color: ___________ Height: _________ Weight: _____________

Current Location if different from home address: ____

Contact name: ___________________________ Phone: ______________ Admission Date: _____________

General description of condition causing incapacity, including approximate onset date: _____________________

____

____

PETITIONER (First)

Name: ____ Relationship to AIP: _______________________

Street: __________________________________ City: ___________________ State: ____ Zip: ____________

Phones: Home: _________________ Work: ______________________ Other: ______________________

Email: Home: ____________________________________ Other: _____________________________________

PETITIONER (Second)

Name: ____ Relationship to AIP: _______________________

Street: __________________________________ City: ___________________ State: ____ Zip: ____________

Phones: Home: ___________________ Work: _____________________ Other: ______________________

Email: Home: ___________________________________ Other: ____________________________________

INDICATIONS OF INCAPACITY IN REGARD TO PERSONAL AFFAIRS
(Please place a check mark after each relevant problem area)

In regard to personal affairs, such as residential placement, medical decisions, relationships with family members and friends, management and participation in activities of daily living, have you observed:

Impaired memory ________ Impaired judgment ________ Impaired ability to recognize problems ________

Problems or a need for assistance with: Choosing safe and sanitary housing _______ Meal preparation ______

Bathing ____ Dressing _____ Eating ______ Taking Medications _____ Evaluating medical needs ________

Making and keeping medical care appointments ______Toileting and personal hygiene ______

Other observations which indicate the need for a guardian of the person:

____

____

____

____

INDICATIONS OF INCAPACITY IN REGARD TO FINANCIAL AFFAIRS
(Please place a check mark after each relevant problem area)

In regard to financial affairs, such as paying household bills, managing investments or real estate, making gifts or transferring or changing title to real estate, bank accounts or investments, have you observed:

Impaired memory ________ Impaired judgment ________ Impaired ability to recognize problems ________

Problems or a need for assistance with: Financial exploitation by family members or others ________

Paying bills ______ Managing investments ______ Changes to real estate or investment ownership _________

Sudden or unusual changes in a Will, Power of Attorney, Trust, Living Will or other estate planning ________

Acquiring benefits for income or care such as Medical Assistance, Social Security, PACE, Medicare, *etc*. _____

Other observations which indicate the need for a guardian of the estate:

____

____

____

PROPOSED GUARDIAN OF PERSON

Name: ____ Relationship to AIP: ______________________

Street: ______________________________ City: ___________________ State: ____ Zip: _____________

Phones: Home: ____________________ Work: ___________________ Other: _____________________

Email: Home: _________________________________ Other: _________________________________

Are you willing to provide annual reports to the Orphans' Court Division regarding you service as guardian of the person, including descriptions of medical care, residential placement, the AIP's general health and condition and your visitation schedule? Yes: ____________ No: ______________

Have you ever been arrested? __________ or convicted? __________ or filed bankruptcy? __________

Have you ever been sued? __________ Are you a party to any legal proceedings at this time? _____________

Do you have any addictions? _______ Have you ever undergone addiction counseling? _________________

If you answered yes to any of the above questions, please provide details, including court filing numbers and relevant dates on a separate page and return it with this form.

PROPOSED GUARDIAN OF ESTATE

Name: ____ Relationship to AIP: ______________________

Street: ______________________________ City: ___________________ State: ____ Zip: ____________

Phones: Home: ____________________ Work: ____________________ Other: _____________________

Email: Home: _________________________________ Other: _________________________________

Ever Arrested? _______ Ever Convicted? _______ Ever filed Bankruptcy? _______ Any Addictions? _______

Are you willing to provide annual reports to the Orphans' Court Division regarding you service as guardian of the estate, including an inventory of assets and annual reports of income and disbursements?

Yes: ____________ No: ______________

Have you ever been arrested? _______ or convicted? _______ or filed bankruptcy? _______

Have you ever been sued? __________ Are you a party to any legal proceedings at this time? _____________

Do you have any addictions? _______ Have you ever undergone addiction counseling? _________________

If you answered yes to any of the above questions, please provide details, including court filing numbers and relevant dates on a separate page and return it with this form.

SPOUSE and NEXT OF KIN OF THE ALLEGED INCAPACITATED PERSON (This includes the AIP's living husband or wife, children, parents, grandparents, siblings, aunts and uncles, nephews and nieces and cousins). Add more pages if necessary. Please provide the age of all persons under 18 years of age.

1. Name: ______________________ Relationship: ____________
   Address: ______________________ Phone: ____________
2. Name: ______________________ Relationship: ____________
   Address: ______________________ Phone: ____________
3. Name: ______________________ Relationship: ____________
   Address: ______________________ Phone: ____________
4. Name: ______________________ Relationship: ____________
   Address: ______________________ Phone: ____________
5. Name: ______________________ Relationship: ____________
   Address: ______________________ Phone: ____________
6. Name: ______________________ Relationship: ____________
   Address: ______________________ Phone: ____________
7. Name: ______________________ Relationship: ____________
   Address: ______________________ Phone: ____________

MEDICAL AND SOCIAL SERVICE INFORMATION

Primary Care or Attending Physician:

Name: ______________________ Phone: ____________ Fax: ____________

Name of practice or health care facility:
____

Street: ____________________ City: ______________ State: ______ Zip: _______

Is there a Social Worker or Case Manager of any kind assisting the AIP at this time?

Name: ______________________________ Phone: ____________________

Agency or Health Care Provider: ______________________________________

EXISTING ALTERNATIVE PLANNING DOCUMENTS

Is there an existing Power of Attorney, Advance Directive for Health Care (Living Will), Trust or other document which allows another person to provide assistance to the AIP's with personal or financial affairs?

Power of Attorney Date: ___________________ Location of Original: _________________________________

Name of Agent: ____ Phone: ____________________________

Does the agent have authority to manage health care and personal affairs of the AIP: Yes _____ No ______

Does the agent have authority to manage financial affairs for the AIP: Yes _____ No ______

Living Will: Date: ___________________ Location of Original: _____________________________________

Name of Agent or Attorney in Fact: ____

Trust: Date: ___________________ Location of Original: ____

Name of Trust: ____

Trustee: ____ Phone: __________________________________

Is the trust revocable or irrevocable: ____

Does the trustee have authority to manage health care and personal affairs of the AIP: Yes _____ No ______

Does the trustee have authority to manage financial affairs for the AIP: Yes _____ No ______

DOES THE AIP HAVE ACCESS TO A SAFE DEPOSIT BOX OR SECURE STORAGE FACILITY?

Description:_______________________________________ Location:_______________________________

Box or Account No.: ________________________________ Phone: _________________________________

PRE-ARRANGED FUNERAL AND BURIAL PLANS

Is there a pre-existing funeral plan or burial reserve? Yes/No _______

What is the value of the funeral plan or burial reserve? ____

Name of funeral home or institution holding burial reserve: ____

Does the AIP own or have rights to a burial plot or crypt? Yes/No _______

Name and address of cemetery: ____

INCOME and PROPERTY Amount per month

Social Security: $______________________

Social Security Disability: $______________________

Supplemental Security Income (SSI): $______________________

Veteran's Benefits: (Include veteran's name) ________________ $______________________

Pension ______________________________________: $______________________

Other ______________________________________: $______________________

Other ______________________________________: $______________________

Real Estate Appraised or Assessed Value

1. Location/Address: ________________________________ $______________________

   Description of Property: ____

2. Location/Address: ________________________________ $______________________

   Description of Property: ____

Personal Property (Bank Accounts, Stocks, Bonds, Vehicles, Insurance, Collections, etc. Please include account numbers)

1. Description: ____ $______________
2. Description: ____ $______________
3. Description: ____ $______________
4. Description: ____ $______________
5. Description: ____ $______________
6. Description: ____ $______________

DEBTS and MONTHLY EXPENSES

1. Description: ____ $________________
2. Description: ____ $________________
3. Description: ____ $________________

OTHER PENDING MATTERS

Are there any other proceedings of any nature going on before or with any court, social service agency, government agency or private organization in Pennsylvania or elsewhere which relate to the care, custody, medical needs, residential needs, therapeutic needs, support, education or financial affairs of the alleged incapacitated person?

No _______ Yes _______ If yes, please give the name of the other matter, the court or other agency involved, any identifying file number and the names of other parties involved.

____

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