FRANKLIN & KYLE
ELDER LAW

CONSERVATORSHIP INFORMATION PACKET

Your appointment with us is on: _____ in our Knoxville office at 4931 Homberg Drive, Knoxville, Tennessee 37919. Directions to our office are enclosed or available on our website.

We ask a lot of questions on this form because we need a lot of information in order to pursue a conservatorship. Do your best, but don't worry if some of the information you need to complete this form is not available to you.

Please call us at (865) 588-3700 if you have any questions or concerns about completing this form.

Date:_____ Referred by:_____

PERSONAL INFORMATION:

Your Name: _____

Address: _____

_____

County: _____

Phone: _____

Mobile: _____

Email: _____

Date of birth: _____

Place of birth: _____

SSN: _____

U. S. citizen? ☐ Yes ☐ No

Veteran? ☐ Yes ☐ No

_____

Disabled person's Name: _____

☐ Same

Address: ☐ Different: Note below

_____

_____

County: _____

Phone: _____

Mobile: _____

Email: _____

Date of birth: _____

Place of birth: _____

Your relationship: _____

SSN: _____

U. S. citizen? ☐ Yes ☐ No

Veteran? ☐ Yes ☐ No

If not you, who is your "Contact Person" (the person we should contact for appointments, for more information about you, etc.)?

_____

Relatives of Disabled Person: Please list the disabled person's spouse, children, (if an adult child is deceased, list that child and date of death). List that child's children if the deceased child left children. Also, if the disabled person has living parents and/or siblings, please list them below.

Name: _____
Relationship to disabled _____

Address: _____

_____

Phone: _____

Mobile: _____

Email: _____

Date of birth: _____

Date of death: _____

_____

Name/DOB of children: _____

_____

Name/DOB of children: _____

Name: _____
Relationship to disabled person: _____

Address: _____

_____

Phone: _____

Mobile: _____

Email: _____

Name: _____
Relationship to disabled person: _____

Address: _____

_____

Phone: _____

Mobile: _____

Email: _____

	_____		_____
Date of birth:	_____	Date of birth:	_____
Date of death:	_____	Date of death:	_____
	_____		_____
Name/DOB of children:	_____	Name/DOB of children:	_____
	_____		_____
Name/DOB of children:	_____	Name/DOB of children:	_____

**Please attach additional sheets as necessary for additional relative's information.*

Does the Disabled Person have any dependents (that is, someone who depends on him/her, in whole or in part, for their support)? ☐ Yes ☐ No

If yes, who? _____

Are any of the disabled person's children receiving Supplement Security Income, Social Security Disability; or, if not, do they have any major disabilities? ☐ Yes ☐ No

If yes, who? _____

DISABLED PERSONS MONTHLY INCOME:

SOURCE	INCOME
Social Security	
Retire Pension	
Wages	
VA Pension/Benefit	
IRA Distribution	
Annuity Payment	
Other:	
TOTAL	

PERSONAL RESIDENCE:

Address of property: _____

Names as they appear on deed: _____

Date Acquired: _____ Purchase Price: _____

Current Value: _____ Tax-Appraised Value: _____

Mortgage Company: _____ Mortgage Balance: _____

OTHER REAL ESTATE:

Address of property: _____

Names as they appear on deed: _____

Date Acquired: _____ Purchase Price: _____

Current Value: _____ Tax-Appraised Value: _____

Mortgage Company: _____ Mortgage Balance: _____

Anticipated maintenance needs to homestead (examples: roof, windows, painting, foundation repair, driveway, etc.)

Item	Cost
_____	_____
_____	_____
TOTAL:	_____

DISABLED PERSONS MONTHLY EXPENSES:

Item	Amount
Property tax	_____
Home maintenance and upkeep	_____
Homeowners insurance	_____
Utilities (gas, electric, water & sewer, security)	_____
Residential facility	_____
Private health care services	_____
Telephone	_____
Cable television	_____
Auto operation (gas and maintenance)	_____
Auto insurance	_____
Clothing	_____
Groceries and other household	_____
Hair cuts, personal grooming	_____
Laundry and cleaning	_____
Checking account charges/bank fees	_____
Newspapers and magazines	_____

Recreation, vacation, entertainment _____

Unreimbursed medical expense (such as for drugs) _____

Health Insurance (such as Medicare supplement) _____

Life insurance _____

Charitable contributions _____

Other: _____ _____

Other: _____ _____

Total Monthly Expenses: _____

OTHER ASSETS:

List the disabled person's bank accounts, CDs, annuities, stocks, retirement plans, etc.

Even though you will bring account statements and information, we still need for you to complete this page.

Type of Asset: _____ Value: _____

Company Name: _____

Name(s) on the account: _____

Type of Asset: _____ Value: _____

Company Name: _____

Name(s) on the account: _____

Type of Asset: _____ Value: _____

Company Name: _____

Name(s) on the account: _____

Type of Asset: _____ Value: _____

Company Name: _____

Name(s) on the account: _____

Total Value of Assets on this Page: _____

MONEY DISABLED PERSON OWES:

Creditor's Name	Amount Owed
TOTAL	

Does disabled person have a safe deposit box? ☐ Yes ☐ No
If yes, list name of bank, branch and box number: _____

PUBLIC BENEFITS & COMMUNITY SERVICES:

In addition to Social Security and Medicare, is disabled person receiving any other forms of assistance, whether from the government, charitable organizations or churches, or volunteer organizations? (Examples include: Veterans benefits, Section 8 housing and other subsidized housing, Medicaid, TennCare, CHAMPUS, TRICARE for Life, Meals-on-Wheels, subsidized regional transportation services, adult day care, support group services, property tax relief, home weatherization, and drug company discount card programs).

☐ Yes ☐ No

If yes, please list them below:

Provider	Form of assistance
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

GIFTS & TRANSFERS:

Has the disabled person made any gifts or transfers, greater than $500.00, to any individuals or to a trust within the last 60 months? ☐ Yes ☐ No

If yes, please furnish the indicated information for each gift or transfer:

To whom:	_____	To whom:	_____
Date of gift:	_____	Date of gift:	_____
Item:	_____	Item:	_____
Value:	_____	Value:	_____

To whom: _____ To whom: _____
Date of gift: _____ Date of gift: _____
Item: _____ Item: _____
Value: _____ Value: _____

OTHER PROPERTY: List any large items of personal property the disabled person owns (I.e. cars, boats, RVs, farm equipment, etc.)

Personal Property (Item)	Value

**Attach a separate sheet if necessary*

LIFE INSURANCE: List all life insurance

Company Name: _____
Owner: _____
Insured: _____
Beneficiary: _____
Death Benefit (face value): _____
Cash surrender value: _____
Loan against policy: _____

Company Name: _____
Owner: _____
Insured: _____
Beneficiary: _____
Death Benefit (face value): _____
Cash surrender value: _____
Loan against policy: _____

Company Name: _____
Owner: _____
Insured: _____
Beneficiary: _____
Death Benefit (face value): _____
Cash surrender value: _____
Loan against policy: _____

OTHER INSURANCE:

Please complete the following health insurance information as it applies:

Medicare

Traditional Medicare Fee-for-Service? ☐ Yes ☐ No

OR

Medicare HMO, PSO, PPO, Private Plan? ☐ Yes ☐ No

Company: _____

Medicare Supplement ("Medigap")

Company: _____

Type (Plan A through J): _____

Medicare Prescription Drug Plan

Company: _____

Employer Retiree Health Plan

Company: _____

Private Health Insurance

Company: _____

Long Term Care Insurance

Company: _____

Daily Benefit Amount: _____ Length of Coverage: _____

Other Types of Insurance (Cancer, Accidental Death, Hospital Supplement, etc.)

Company: _____

Type: _____

Company: _____

Type: _____

Company: _____

Type: _____

INFORMATION ABOUT DISABLED PERSON'S HEALTH:

1. What medical or health problems does disabled person currently have?

_____

_____

_____

2. What medical problems has disabled person had in the past?

_____

_____

_____

3. Please list all of the medications disabled person is currently taking:

Medication	**Why Is Disabled Person Taking This Drug?**

**Attach a separate sheet, if necessary.*

4. Does the disabled person's family have a history of health problems (I.e. heart disease, cancer, or Alzheimer's disease)?

_____

_____

5. Tell us about disabled person's parents:

	Disabled person's Mother	**Disabled person's Father**
Age at Death:		
Cause of Death:		

Name of disabled person's personal Physician(s):

Name: _____
Address: _____
City/State: _____
Telephone: _____
Specialty: _____

Name: _____
Address: _____
City/State: _____
Telephone: _____
Specialty: _____

DISABLED PERSONS FUNCTIONAL LIMITATIONS & SUPPORT:

The term "activities of daily living" refers to the basic tasks of everyday life. When people are unable to perform these activities, they need help in order to cope, from either other human beings or mechanical devices (such as a walker or wheelchair) or both.

Why do we want this information? A conservatorship is for a person who suffers from a mental or physical disability (or both) and needs the court's assistance and protection.

Place an X in the box that most applies for each activity:

Activities of Daily Living			
Activity	**Need No Help**	**Need Some Help**	**Unable to Do At All**
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding Self			
Using the toilet			
Grooming			
Instrumental Activities of Daily Living			
Activity	**Need No Help**	**Need Some Help**	**Unable to Do At All**
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			

	Place Where Disabled Person Lives	**Since When?**
☐	Single-family home	
☐	Same, but someone assists you there with above activities	
☐	Apartment or retirement living community	
☐	Assisted-living facility	
☐	Other:	
☐	Nursing home	

List the names of all persons who provide assistance or caregiving for the disabled person:

_____

_____

Does the disabled person want to be buried or cremated? **Buried** ☐ **Cremated** ☐

Does the disabled person have a prepaid funeral or burial? ☐ Yes ☐ No

If yes, describe the arrangements: _____

If you, as the petitioner, have had past financial problems such as bad credit or a bankruptcy, you will need to notify the attorney at your first consultation.

Please also tell us if you have a past criminal history. This information will be important because a conservator must have a solid financial background and no criminal history in order to qualify for a bond. However, in some cases, a bond may not be necessary.

PLEASE BRING ALL FINANCIAL INFORMATION AVAILABLE RELATING TO THE DISABLED PERSON