New Client Workbook

V.A.C.A.
Vulnerable Adult
Care Advocates, Inc.

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33 State St. Suite 311
New Albany, IN
47150
Telephone: 502.276.5292

CONFIDENTIAL LEGAL PLANNING INFORMATION

This information is important. Please take the time to complete and return the questionnaire before your appointment. If you need help completing this form, please feel free to call me at (812)800-9155.

Using this Workbook

You will not that this Workbook asks for a lot of information. I need this information in order to determine how to proceed with your care in the most appropriate manner. This Workbook will allow me to begin analyzing what the next steps are.

One I receive a completed Workbook, I will study it and then I will schedule time with you either over the telephone or in person, or both. At that time I will provide you a comprehensive list of information and documentation required to proceed with you case.

For now, I wish to assure you all of the information you provide in the workbook will be kept confidential.

I look forward to working with you.

Katie Morgan

Katie Morgan, NCG
Founder/Program Director

PERSON COMPLETING THIS FORM

Name _____

Residence, Street Address _____

City/State/Zip _____

Telephone _____

Relation to Incapacitated/Incompetent Person _____

INCOMPETENT PERSON (PROSPECTIVE WARD) INFORMATION

Full Name _____

Residence, Street Address _____

City/State/Zip _____

Telephone _____

Date of Birth _____ Age _____ SSN _____

Race_____ Hispanic Yes/No Gender_____ Eye Color _____

Hair Color _____ Height _____' _____" Weight _____

Scars, Marks, and Tattoos _____

Present Location, Street Address _____

City/State/Zip _____

Is this individual a veteran? _____ Yes _____ No Language Spoken _____

RELATIVES

Name	Age/Date of Birth	Relationship to Client	Address & Telephone

MEDICAL INFORMATION FOR PROSPECTIVE WARD

ATTENDING PHYSICIAN

Name: _____

Office Address: _____

_____

Telephone: _____

Email: _____

Date of Last Visit: _____

PSYCHIATRIST

Name:

Office Address:

Telephone:

Email:

Date of Last Visit:

HOSPITAL OR NURSING HOME

Name:

Office Address:

Telephone:

Email:

Date of Admission:

HOSPITAL OR NURSING HOME SOCIAL WORKER

Name:

Office Address:

Telephone:

Email:

Date of Last Visit:

DIAGNOSIS

The allegedly incapacitated person's physical and mental condition is an issue. Please state the most recent diagnosis which impairs the person. If you do not have a diagnosis, please describe the symptoms.

IN THE CIRCUIT COURT FOR FLOYD COUNTY
STATE OF INDIANA

IN RE THE MATTER OF THE
GUARDIANSHIP OF _____

CASE NO. 22C01- GU-

REPORT OF PHYSICIAN

_____, a physician licensed to practice medicine in all its branches in the State of Indiana, submits the following report on _____*(name)*, an alleged incapacitated person, based on an examination of _____*(name)* on_____*(date)*.

1. Describe the nature and type of the disability: _____

_____

2. Describe the mental and physical condition; and, when it is appropriate, describe educational condition, adaptive behavior and social skills: _____

_____

3. State whether, in your opinion, _____ *(name)* is totally or only partially incapable of making personal and financial decisions; and, if the latter, the kinds of decisions which he can and cannot make. Include the reason for this opinion. _____

_____

_____

4. What, in your opinion, is the most appropriate living arrangement for _____*(name)*; and, if applicable, describe the most appropriate treatment or rehabilitation plan. Include the reasons for your opinion_____

_____

5. Can he/she appear in court without injury to his or her health?_____

If the answer is no, explain the medical reasons for your answer._____

_____

I affirm, under penalties of perjury, that the foregoing representations are true:

_____
Signature of Physician

_____(Printed)

Address:_____
City/State/Zip:_____
Telephone:_____

THIS REPORT MUST BE SIGNED BY A PHYSICIAN. IF THE DESCRIPTION OF THE INCAPACITATED PERSON'S MENTAL, PHYSICAL OR EDUCATIONAL CONDITION, ADAPTIVE BEHAVIOR OR SOCIAL SKILLS IS BASED ON EVALUATIONS BY OTHER PROFESSIONALS, ALL PROFESSIONALS PREPARING EVALUATIONS MUST SIGN THE REPORT. EVALUATIONS MUST HAVE BEEN PERFORMED WITHIN THREE (3) MONTHS OF THE DATE OF THE FILING OF THE GUARDIANSHIP PETITION.

Names and addresses of other persons who performed evaluations upon which this report is based:

_____	_____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
_____	_____
Address	Address
_____	_____
Position/Employer	Position/Employer