The ProBono Project

Power of Attorney Questionnaire

Please provide the following information to the best of your ability and return either by email to jballard@probono-no.org or by mail to:
935 Gravier Street, Suite 1340
New Orleans, LA 70112

Please read each question fully and carefully and let us know if you have any questions. It is important that you fill out this document completely. We cannot continue with your case without the information contained in this questionnaire.

DATE: _____ /_____ /_____

CLIENT Please print your name below.	
APPEARER *This is the person who is giving legal authority to someone else. This decision MUST be voluntary. The APPEARER may be the same person as the CLIENT or different.* *If you are seeking Power of Attorney over someone else, then you are NOT the Appearer. Please complete the section "Are you seeking Power of Attorney over someone else?" below.*	
Appearer's name:	
Date of Birth:	Day: _____ Month: _____ Year: _____ Is this person a minor? YES ☐ / NO ☐ Is this person over the age of 65? YES ☐ / NO ☐
Appearer's Current Address:	Street address: _____ City, State: _____ ZIP: _____
Appearer's last 4 digits of social security number:	

The ProBono Project

Appearer's marital status:	MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ NEVER MARRIED ☐
Appearer's spouse:	Does the Appearer have a living spouse? YES ☐ / NO ☐
Your relationship to the Appearer:	
Does the Appearer have any previous Power of Attorney completed?	YES ☐ / NO ☐ If YES: When was it completed? _____ What type was it (circle all that apply)? GENERAL ☐ HEALTHCARE ☐ DURABLE ☐

AGENT *This is the person receiving legal authority over the Appearer. An alternative agent can be appointed in the event the first agent cannot act on behalf of the Appearer.*	
Please circle your preference: **AGENT ☐ AGENT AND ALTERNATIVE ☐**	
Agent 1 name:	
Date of Birth:	Day: _____ Month: _____ Year: _____
Agent's Current Address:	Street address: _____ City, State: _____ ZIP: _____
Your relationship to the Agent:	
Are you appointing an Alternative agent?	YES ☐ / NO ☐ If YES, Please complete the following:
Alternative Agent Name:	Day: _____ Month: _____ Year: _____
Alternative Agent Current Address:	Street address: _____ City, State: _____ ZIP: _____

The ProBono Project

Your relationship to the Alternative Agent:	

Are you seeking Power of Attorney over someone else? If YES, please complete below:	
Are you biologically related to the Appearer?	YES ☐ / NO ☐ If YES, please list your relationship: _____
Living Arrangement	Does this person live with you? YES ☐ / NO ☐ Does this person live in a healthcare or assisted care facility? YES ☐ / NO ☐ Does this person live independently? YES ☐ / NO ☐
Health and Wellness	Does this person have a disability? YES ☐ / NO ☐ Does this person have a serious illness? YES ☐ / NO ☐ If YES, is the illness: MENTAL ☐ / PHYSICAL ☐ Is this person over the age of 65? YES ☐ / NO ☐ Does this person have the ability to communicate? YES ☐ / NO ☐ IF YES: Are they able to communicate: VERBALLY ☐ / NON-VERBALLY ☐ Please list any additional comments regarding health and wellness: _____ _____ _____ _____ _____ _____

The ProBono Project

POWERS GIVEN TO THE AGENT:	
General Powers:	Does the Appearer wish to grant the Agent(s) with the following powers? Circle all that apply: Maintain all Property (including bills, taxes, etc.): YES ☐ / NO ☐ To Open and Answer Mail: YES ☐ /NO ☐ To write checks, pay bills, accept checks, etc. from bank account: YES ☐ / NO ☐ To represent the Appearer in any succession that may occur: YES ☐ / NO ☐
Healthcare Powers:	Does the Appearer wish to grant the Agent(s) power regarding healthcare matters? If YES, circle all that apply: Access to medical records: YES ☐ / NO ☐ Consent to medical care: YES ☐ / NO ☐ Hire, pay, and fire any healthcare professionals: YES ☐ / NO ☐ Admit the Appearer to any healthcare facility recommended by a qualified healthcare professional: YES ☐ / NO ☐ Consent to the following: TESTS ☐ /TREATMENT ☐ /MEDICATION ☐ /SURGERY ☐ /ORGAN TRANSPLANT ☐ Consent to treatment for chemical dependency: YES ☐ / NO ☐ Consent to pain relief procedures: YES ☐ / NO ☐ Release healthcare professionals/institutions from liability: YES ☐ / NO ☐
Additional Decisions	Please write any other decisions you would like the Agent to be able to make on your behalf. If NONE, leave this section blank: _____ _____ _____ _____ _____ _____

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Curator	If it becomes necessary for a curator to be appointed for the Appearer, should the agent(s) listed here assume that role? YES ☐ / NO ☐
Does the Appearer want assistance with any of the following:	Living will (Advance directive): YES ☐ / NO ☐ Will Preparation: YES ☐ / NO ☐

Please use this space to share important details or information:

_____

_____

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_____

FOR OFFICE USE ONLY **Reviewed by:** **Date:**	_____ _____