

**STATE OF TENNESSEE**  
**DEPARTMENT OF INTELLECTUAL & DEVELOPMENTAL DISABILITIES**  
**OFFICE OF GENERAL COUNSEL**  
13TH FLOOR, SUITE 1310 - ANDREW JACKSON BUILDING  
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**CONSERVATORSHIP INFORMATION FORM**  
*PLEASE PRINT LEGIBLY*

**INFORMATION OF PERSON COMPLETING THIS FORM: (IT WILL BE NECESSARY FOR YOU TO ATTEND ALL COURT PROCEEDINGS)**

Date: \_\_\_\_\_

Regional Office Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**(Required)**

Your Name: \_\_\_\_\_ Your Title: \_\_\_\_\_

Your Address: \_\_\_\_\_ Your Phone: ( ) \_\_\_\_\_

\_\_\_\_\_ Alternate #: ( ) \_\_\_\_\_

Zip Code: \_\_\_\_\_ Your Fax: ( ) \_\_\_\_\_

**INFORMATION OF DISABLED PERSON:**

Full Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Level of Retardation: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_ Sex: Male Female (Circle one)

Other disabling conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WHERE DOES THE DISABLED PERSON RESIDE (Provide complete address and phone number):**

*If disabled person resides in a facility please complete the following:*

Name of Facility: \_\_\_\_\_ Building Name: \_\_\_\_\_

Phone # of Facility: ( ) \_\_\_\_\_ County: \_\_\_\_\_

Facility Director's Name: \_\_\_\_\_ Director's Phone: ( ) \_\_\_\_\_

*If disabled person lives at home, please complete the following:*

Home Address: \_\_\_\_\_ Person in most frequent contact with disabled  
\_\_\_\_\_ Person:  
\_\_\_\_\_ Name: \_\_\_\_\_

Zip Code/County: \_\_\_\_\_ Phone: \_\_\_\_\_

**FOR NOTICE PURPOSES YOU MUST LIST THE DISABLED INDIVIDUAL'S CLOSEST LIVING RELATIVES.** See the requirements from Tenn. Code Ann. § 34-3-104 (5):

The name, mailing address and relationship of the closest relative or relatives of the respondent and the name and mailing address of the person or institution, if any, having care and custody of the respondent or with whom the respondent is living. If the respondent has no then living spouse, child, parent or sibling, the petition shall so state and more remote relatives are not to be listed;

*(Aunts, uncles, and cousins do not need to be listed, unless they are the closest living relative.)*

Name & Address: \_\_\_\_\_  
\_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Name & Address: \_\_\_\_\_  
\_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Name & Address: \_\_\_\_\_  
\_\_\_\_\_ Phone: ( ) \_\_\_\_\_

*(If you have names and addresses of additional family members, please attach a sheet with this form.)*

**\*\*\* You must include dates of efforts to contact family members regarding their willingness and ability to serve as conservator if you are asking that a corporate conservator be appointed. This is not option! By submitting this form you are affirming that the information contained herein is true and correct to the best of your knowledge and belief. \*\*\***

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**PROPOSED CONSERVATOR(S)**

☛ Have you ever been convicted of a felony and sentenced to a penitentiary?  Yes  No

Please note that the State (Office of General Counsel) will **not** request that a conservator also be allowed to be a paid caregiver (or vice versa) due to the conflict of interest this situation presents.

Name: \_\_\_\_\_ (Full Name) SSN: \_\_\_\_\_  
DOB: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Relationship: \_\_\_\_\_  
\_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
\_\_\_\_\_ Work: ( ) \_\_\_\_\_

**If the proposed conservator is not the closest relative, explain why the closest relative is not recommended:** \_\_\_\_\_

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**PROPOSED STANDBY CONSERVATOR(S):**

☛ Have you ever been convicted of a felony and sentenced to a penitentiary?  Yes  No

Name of : \_\_\_\_\_ (Full Name) SSN: \_\_\_\_\_  
DOB: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Relationship: \_\_\_\_\_  
\_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
\_\_\_\_\_ Work: ( ) \_\_\_\_\_

**CURRENT CONSERVATOR**

**PLEASE NOTE: If the disabled individual has ever had a court-appointed conservator, please attach a copy of the appointment order:**

Appointment Order Number: \_\_\_\_\_

Date signed by the Judge: \_\_\_\_\_

**Explain why the previous / current conservator needs to be replaced:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
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**REMOVAL OF RIGHTS**

**Place a check by all the recommended rights to be removed from the disabled individual and entrusted to the Conservator:**

- \_\_\_\_\_ To acquire or dispose of property
- \_\_\_\_\_ To make purchases above \$30.00
- \_\_\_\_\_ To make purchases of any amount
- \_\_\_\_\_ To execute instruments and/or contracts or enter into any other contractual relationship
- \_\_\_\_\_ To give or withhold consent to medical and mental examinations, hospitalization, treatment and therapeutic or habilitative services or programs
- \_\_\_\_\_ To make other health care decisions
- \_\_\_\_\_ To give or withhold consent to custodial arrangements
- \_\_\_\_\_ To file or pursue litigation in vindication of rights

**DISABLED INDIVIDUAL'S FINANCIAL DATA**

Monthly Income: \_\_\_\_\_

Source of Income: \_\_\_\_\_

Current Account Balance: \_\_\_\_\_