

# Annual Report of Guardian

## Writing Suggestions

- ✓ Answer each question fully.
- ✓ Attach additional page(s,) as needed, to fully answer questions.
- ✓ Check spelling, grammar and wording.
- ✓ Write simply and clearly.
- ✓ Re-read the report before you save and print for signature.
- ✓ Do not leave any element blank.

### **1. Describe the incapacitated person's living arrangements:**

- Client lives
  - independently,
  - in an assisted living facility, name
  - in a nursing home, name
  - in a Group Home, name
  - in a Wavier Home, name
  - With family/friend, name
  - Other
- Describe the environment:
  - Client lives in a semi-private room.
  - Other relevant information.

### **2. Describe the current mental, physical and social condition of the incapacitated person. (Attach additional pages if necessary.)**

- **Mental** includes formal diagnoses, cognitive status, memory, judgment, orientation, reasoning, behavior.
- **Physical** includes formal medical diagnoses, significant medical history, ability or need for assistance to perform ADL's ( Bathing, dressing, eating/feeding, incontinence, mobility, toileting)
- **Social** includes individual or group activities, recreational events, outings, social contact with others (visiting with family or friends)

### **State any changes in the condition of the incapacitated person in the last year.**

- No significant changes during this reporting period.
- If significant changes did occur, provide details. (e.g., hospitalizations, injuries, new diagnosis, hospice care, change in placement, death, restored, released)

### **3. Describe all medical, educational, vocational and professional services provided to the incapacitated person for the period covered by this report, and state your opinion of the adequacy of the care received by the incapacitated person:**

- **Medical:** Routine medical care/ out-patient only; **or specify** hospitalization(s,) specialty care, out-patient procedures, OT, PT, significant dental care, other.
- **Vocational/Educational Services:** N/A for client needs **or specify** vocational/educational services provided and name of providers. (e.g., day program)
- **Professional Services:** Case Management Services provided by PGP, APS, Mental Health or other private provider, Day Program, Adult Daycare, PACE.

**4. State the number of times you visited the incapacitated person, the nature of the visits, describe your activities on behalf of the incapacitated person. (Guardians are required to visit the incapacitated person as often as necessary to know of his or her capabilities, limitations, needs and opportunities.)**

- State a number of times seen, not “monthly” or “weekly.”
- State the nature of your contacts: Monitor care, assess needs, and deliver personal items.

**5. State whether or not you agree with the current treatment or care plan:**

- PGP agrees with the current plan of care.
- PGP does not agree with the current treatment plan. When changes are needed, specify the steps or actions being taken to make the changes. (e.g., changing physician or facility)
- N/A if client is deceased.

**6. State your recommendation as to the need for continued guardianship, any recommended changes in the scope of the guardianship, and the steps taken to make those changes, and any other information useful, in your opinion, to a consideration of the guardianship:**

- PGP recommends continued guardianship with no changes to the scope of the authority.
- If changes are needed, specify what changes and action taken. (e.g., restoration or release.)
- N/A if client is deceased.

***If you incurred expenses in exercising your duties as a guardian and if you requested reimbursement or compensation for those expenses, itemize the expenses and list the person(s) from whom you requested reimbursement or compensation:***

- N/A or None
- Verify expenses due from Conservator Report if applicable

**Signature**

- Must be legible.
- Optional: Add printed name below signature.