

IN THE CIRCUIT COURT OF THE

IN AND FOR

COUNTY

Case Number:

**Format Must Be
PRCYNNNNNNNN**

Division:

Amended Form?:

If yes, version of the Amended Form? :

Guardian Type :

IN RE: THE GUARDIANSHIP OF _____/

Note: Minors also need to have Annual Plan

ANNUAL GUARDIANSHIP PLAN

FOR THE PERIOD OF TIME TO

Guardianship Inception Date: _____ **Date of Order of Incapacity:** _____

_____, guardian of the person of _____ submits the following Annual Guardianship Plan for the Ward:

1. The Ward's present location is:

The name of the person/facility, address, and telephone number are:

Line 1

Line 2

Line 3

Line 4

2. The Ward during the preceding 12 months resided at the following locations:

| Facility Name, Address, and Phone Number | | | | Type of Facility | Start Date of Residence | Approximate Ending Date of Residence |
|--|----------------|--------|------|------------------|-------------------------|--------------------------------------|
| A | Facility Name: | | | | | |
| Street Address: | | | | | | |
| City: | | State: | Zip: | | | |
| Phone Number: | | | | | | |
| | | | | | | |
| B | Facility Name: | | | | | |
| Street Address: | | | | | | |
| City: | | State: | Zip: | | | |
| Phone Number: | | | | | | |
| | | | | | | |
| C | Facility Name: | | | | | |
| Street Address: | | | | | | |
| City: | | State: | Zip: | | | |
| Phone Number: | | | | | | |
| | | | | | | |
| D | Facility Name: | | | | | |
| Street Address: | | | | | | |
| City: | | State: | Zip: | | | |
| Phone Number: | | | | | | |
| | | | | | | |
| E | Facility Name: | | | | | |
| Street Address: | | | | | | |
| City: | | State: | Zip: | | | |
| Phone Number: | | | | | | |
| | | | | | | |
| F | Facility Name: | | | | | |
| Street Address: | | | | | | |
| City: | | State: | Zip: | | | |
| Phone Number: | | | | | | |
| | | | | | | |
| G | Facility Name: | | | | | |
| Street Address: | | | | | | |
| City: | | State: | Zip: | | | |
| Phone Number: | | | | | | |
| | | | | | | |
| H | Facility Name: | | | | | |
| Street Address: | | | | | | |
| City: | | State: | Zip: | | | |
| Phone Number: | | | | | | |
| | | | | | | |

3. A. The guardian states the place and kind of residential setting best suited for the needs of the Ward is:

- Assisted Living (ALF)
- Group Home
- Intermediate
- Private Residence
- Skilled Nursing/CP
- Specialized
- State Hospital
- Other

Explanation required only if other checked:

B. The guardian will ensure that the above is the best residential setting for the Ward by:

- Periodically Assessing Needs
- The Ward retains the right to decide
- No change, unless required by medical condition

C. The guardian states that every facility where the Ward resided was licensed, if licensing is required by law:

If no, please provide an explanation as to why the Ward resided in a non licensed facility:

4. Care plans were required to be prepared by any facility where the Ward resided during the preceding 12 months:

If yes, the number of care plan meetings the guardian attended or discussed with the facility on the Ward's behalf during the preceding 12 months:

Explanation required if answer 0 to care plan meetings:

5. The guardian visited the Ward during the preceding 12 months as follows:

Note: Please select all that applies and enter the number of visits

- | | |
|---------------------|----------------------|
| First three months | <input type="text"/> |
| Second three months | <input type="text"/> |
| Third three months | <input type="text"/> |
| Fourth three months | <input type="text"/> |

This applies to each quarter of the plan period for the last 12 months.

6. The following is a description of the medical and/or mental health treatment provided to the Ward during the preceding 12 months:

| Provider's Name Address, and Phone Number | | | Type of Provider | Number of Visits |
|---|--------|-----------|------------------|------------------|
| A | First: | MI: Last: | | |
| Street Address: | | | | |
| City: | State: | Zip: | | |
| Phone Number: | | | | |
| | | | | |
| B | First: | MI: Last: | | |
| Street Address: | | | | |
| City: | State: | Zip: | | |
| Phone Number: | | | | |
| | | | | |
| C | First: | MI: Last: | | |
| Street Address: | | | | |
| City: | State: | Zip: | | |
| Phone Number: | | | | |
| | | | | |
| D | First: | MI: Last: | | |
| Street Address: | | | | |
| City: | State: | Zip: | | |
| Phone Number: | | | | |
| | | | | |
| E | First: | MI: Last: | | |
| Street Address: | | | | |
| City: | State: | Zip: | | |
| Phone Number: | | | | |
| | | | | |
| F | First: | MI: Last: | | |
| Street Address: | | | | |
| City: | State: | Zip: | | |
| Phone Number: | | | | |
| | | | | |
| G | First: | MI: Last: | | |
| Street Address: | | | | |
| City: | State: | Zip: | | |
| Phone Number: | | | | |
| | | | | |

7. The guardian for the plan period proposes the following as to the provision of medical and rehabilitative services for the Ward:

- Physical Therapy
- Routine examination by Dentist
- Routine examination by Primary Care Physician
- Routine examination by Ophthalmologist
- Routine examination by Specialist _____
- Speech Therapy
- Occupational Therapy
- The Ward retains the right to make their own decision
- Other

Explanation required only if other checked:

8. The guardian for the plan period proposes the following as to the provision of mental health services for the Ward:

- Routine examination by Psychiatrist/Psychologist
- On going treatment outpatient
- On going treatment inpatient
- None
- Other

Explanation required only if other checked:

9. The Ward during the preceding 12 months was prescribed or took the following types of medications:

- Anti Anxiety
- Anti Depressant
- Cardiac
- Diabetic
- Memory Enhancement
- Over the counter
- Psychotropic
- Other Prescription

10. The guardian for the plan period proposes the following as to the provision of personal care services for the Ward:

- Care facility
- Nurses and Aides
- Family and Friends
- Other

Explanation required only if other checked:

11. The guardian for the plan period proposes the following as to the provision of social recreation for the Ward:

- Care facility
- Nurses and Aides
- Family and Friends
- The Ward retains the right to make their own decision
- Other

Explanation required only if other checked:

12. a. Baker Act – Was the Ward involuntarily placed or examined during the preceding 12 months under Chapter 394, F.S.?

If yes, the number of times the Ward was involuntarily placed or examined during the preceding 12 months:

- b. How the Ward was involuntarily placed in a treatment facility?
- Ex parte court order where petition filed by guardian or family or other interested person
 - An authorized mental health professional
 - Law Enforcement

13. The guardian provides the following statement as to the social condition of the Ward:

a. The guardian provides the following statement of the social skills of the Ward, including how well the Ward maintains interpersonal relationship with others:

- High Social Skills (maintains friendship)
- Moderate Social Skills (can carry on a conversation)
- Low Social Skills (inability to communicate)

b. The guardian provides the following description of the Ward's activities at communication and visitation:

- Highly Active Outside
- Moderately Active
- Low Activity
- Other

Explanation required only if other checked:

c. The guardian provides the following description of the unmet social needs of the Ward:

- No Unmet Needs
- The Ward does not care to socialize
- Unmet Needs

Explanation required only if Unmet Needs checked:

d. The guardian for the plan period proposes the following as to the provision of social services for the Ward:

- Adult Day Care
- Counseling
- Homemaker/Personal Care
- Home Delivered Meals
- Private Services
- Public Services
- Senior Center
- Sheltered Workshop
- Transportation
- Volunteer Services
- Other

Explanation required only if other checked:

14. The following activities were undertaken during the preceding 12 months in an effort to increase the capacity of the Ward:

- Encouragement to participate in social/recreational activities
- Occupational Therapy
- Physical Therapy
- Psychiatric Care
- Rehabilitation Services
- Speech Therapy
- Other

Explanation required only if Other checked:

15. The guardian during the preceding 12 months utilized the following health insurance, accident insurance, private benefits, or governmental benefits available to meet the costs of medical, mental health, or related services:

- Health Maintenance Organization (HMO)
- Institutional Care Program
- Optional State Supplement
- Medicare
- Medicaid
- Pension
- Social Security
- Social Security Disability Income (SSDI)
- Supplemental Insurance
- Supplemental Security Income (SSI)
- VA
- Other

Explanation required only if other checked:

16. Can any of the following rights be restored?

| Right To: | Answer |
|---|--------|
| a. Consent to Medical Treatment | |
| b. Contract | |
| c. Determine Residence | |
| d. Have a Driver's License | |
| e. Make decision about social environment or other aspects of social life | |
| f. Manage Property or make Gift of Disposition | |
| g. Marry | |
| h. Personally apply for Government Benefits | |
| i. Seek or Retain Employment | |
| j. Sue and be Sued | |
| k. Travel | |
| l. Vote | |

| 17. If you answered yes to any rights listed in question 16, or if the doctor has indicated on the attached physician's report that a right may be restored – will restoration be sought? | |
|---|---------------|
| Right To: | Answer |
| a. Consent to Medical Treatment | |
| b. Contract | |
| c. Determine Residence | |
| d. Have a Driver's License | |
| e. Make decision about social environment or other aspects of social life | |
| f. Manage Property or make Gift or Disposition | |
| g. Marry | |
| h. Personally apply for Government Benefits | |
| i. Seek or Retain Employment | |
| j. Sue and be Sued | |
| k. Travel | |
| l. Vote | |

18. To assist the Court with review of the annual plan to determine if it is in the best interest of the Ward, please provide the following information:

a. Please rate the ability of the Ward to engage in activities of daily living or instrumental activities of daily living:

| Description | Rating |
|---|--------|
| i. Administration of Medication | |
| ii. Bathing | |
| iii. Climbing Stairs | |
| iv. Doing Laundry | |
| v. Dressing | |
| vi. Eating | |
| vii. Grooming | |
| viii. Heavy Chores | |
| ix. Light Housekeeping | |
| x. Managing Money | |
| xi. Preparing Meals | |
| xii. Shopping | |
| xiii. Toileting | |
| xiv. Transferring(from wheelchair to chair/bed) | |
| xv. Walking/Mobility | |

b. The diagnosed mental disabilities of the Ward are:

- Alzheimer's type of dementia
- Autism Spectrum Disorders
- Closed Head Injury
- Dementia
- Depression
- Developmental Disabilities
- Induced by substance abuse
- Schizophrenia or related disorders
- Other

Explanation required only if other checked:

c. The diagnosed physical disabilities of the ward are::

- Mobility
- Blindness
- Deafness
- Diabetic
- Parkinson's disease
- Severe arthritis
- Other

Explanation required only if "Other" option is checked:

d. The assistive devices used by the Ward are:

- Crutches
- Denture
- Glasses
- Hearing Aid
- Prosthetics
- Walker/Cane
- Wheelchair
- None
- Other

Explanation required only if other checked:

e. The plan for the next twelve (12) months for disaster preparedness for the Ward is:

Explanation:

ANNUAL PHYSICIAN'S REPORT OF EXAMINATION

(All items must be answered)

1. This report is based on an examination of the patient _____, which was made on:

Date: _____

2. DIAGNOSIS:

3. RECOMMENDED TREATMENT:

4. PROGNOSIS:

5. Current Level of Capacity: The Ward can make informed decisions as to: (answer: Yes or No)

a. Marrying

b. Voting

c. Personally applying for government benefits

d. Traveling

e. Seek or retaining employment

f. Contracting

g. Suing and being sued

h. Managing property or to making any gift of disposition

i. Determining residence

j. Consenting to medical treatment

k. Making decisions about social environment to social aspects

Doctor's Name: (Please Print) _____ Date: _____

Doctor's Signature: _____

Doctor's Address: _____

**CERTIFICATION AND SIGNATURE OF
GUARDIAN(S)**

(Check all that apply)

- The Ward was declared totally incapacitated.
- The Ward is a minor.
- The guardian has consulted with the Ward, to the extent reasonable, has honored the Ward's wishes, and to the maximum extent possible the plan is in accordance with the Ward's wishes or consistent with the rights retained by the Ward.
- The plan does not restrict the physical liberty of the Ward except as necessary to protect the Ward and others from serious physical injury, illness, or disease.
- The plan provides for the Ward's medical care and mental health treatment.
- The physician's statement of an examination of the Ward no more than 90 days before the beginning of the plan period is attached.

UNDER PENALTIES OF PERJURY, I declare that I have read and examined the foregoing plan, and the facts alleged are true, to the best of my knowledge and belief.

Date signed by Guardian _____

Guardian Signature

Guardian Name

Guardian Taxpayer Identification #

Guardian Telephone #

Guardian Mailing Address

_____,
Guardian City State, Zip

Guardian's Email Address: _____

-----**Co-Guardian**-----

Date signed by Co-Guardian _____

Co-Guardian Signature

Co-Guardian Name

Co-Guardian Taxpayer Identification #

Co-Guardian Telephone #

Co-Guardian Mailing Address

_____,
Co-Guardian City State, Zip

Co-Guardian's Email Address: _____

CERTIFICATION AND SIGNATURE OF PREPARER

The preparation of this form is based upon the information provided by the guardian(s) and/or attorney with no independent verification of the information contained herein. I have not audited or reviewed the guardianship plan or documents supporting the preparation of the guardianship plan and, accordingly, do not express an opinion or any other form of assurance as to the accuracy of the information contained in the plan.

Date signed by Preparer: _____

Preparer Signature

Preparer Name

Preparer Taxpayer Identification #

Preparer Telephone #

Preparer Mailing Address

Preparer City, State, Zip

Preparer's Email Address: _____

**CERTIFICATION AND SIGNATURE OF
GUARDIAN'S ATTORNEY**

The undersigned hereby notifies the Court of the filing of the annual guardianship plan of the guardian of the person. This annual plan is the representation of the guardian. I have not audited the accompanying annual guardianship plan. The undersigned attorney represents that he/she has examined the contents of this plan and that it conforms to the requirements of the Florida Guardianship Law.

Date signed by Attorney: _____

Attorney Signature

Attorney Name

Attorney Florida Bar Number

Attorney Telephone #

Attorney Mailing Address

Attorney City, State, Zip

Guardian's Attorney Email Address: _____