IN THE CIRCUIT COURT OF THE IN AND FOR COUNTY

Case Number:

Format Must Be PRCYYNNNNNNN

Division: Probate

Amended Form? :

If Yes, version of the Amended Form? :

Guardian Type:

IN RE: THE GUARDIANSHIP OF

_____/

INITIAL GUARDIANSHIP PLAN

PLAN PERIOD: TO

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

the guardian of the person of submits the following Initial 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 guardian for the plan period proposes the following as to the provision of medical services for the Ward:
   - ☐ Routine examination by Primary Care Physician
   - ☐ Routine examination by Dentist
   - ☐ Routine examination by Specialist Specialist Name:
   - ☐ Routine examination by Ophthalmologist
   - ☐ Physical Therapy
   - ☐ Speech Therapy
   - ☐ Occupational Therapy
   - ☐ The Ward retains the right to make his or her own decision
   - ☐ Other

   Explanation required only if “Other” option is checked:

3. 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
   - ☐ Ongoing treatment outpatient
   - ☐ Ongoing treatment inpatient
   - ☐ None
   - ☐ Other

   Explanation required only if “Other” option is checked:

4. The Ward presently is prescribed or takes the followings types of medications:
   - ☐ Anti Anxiety
   - ☐ Anti Depressant
   - ☐ Cardiac
   - ☐ Diabetic
   - ☐ Memory Enhancement
   - ☐ Over the Counter
   - ☐ Psychotropic
   - ☐ Other Prescription

5. 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” option is checked:

6. The guardian for the plan period proposes the following as to the provision of social/recreational services 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” option is checked:

7. 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” option is checked:

8. 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" option is checked:

   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

9. The Ward has 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
   - ☐ Pending Benefits, not yet received
   - ☐ Pension
   - ☐ Social Security
   - ☐ Social Security Disability Income (SSDI)
   - ☐ Supplemental Insurance
   - ☐ Supplemental Security Income (SSI)
   - ☐ VA
   - ☐ Other

   Explanation required only when "Pending Benefits, not yet received" or "Other" options are checked:

10. The guardian will secure the following physical/ mental examinations to determine the Ward's medical and mental health treatment needs:

Provider's Name, Address, and Phone Number				Type of Provider	Approximate Date of Exam
A	Name:				
Street Address:					
City:		State:	Zip:		
Phone Number					
B	Name:				
Street Address:					
City:		State:	Zip:		
Phone Number					
C	Name:				
Street Address:					
City:		State:	Zip:		
Phone Number					
D	Name:				
Street Address:					
City:		State:	Zip:		
Phone Number					
E	Name:				
Street Address:					
City:		State:	Zip:		
Phone Number					
F	Name:				
Street Address:					
City:		State:	Zip:		
Phone Number					
G	Name:				
Street Address:					
City:		State:	Zip:		
Phone Number					

11. To assist the Court with review of the initial 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	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all
ii. Bathing	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all
iii. Climbing Stairs	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all
iv. Doing Laundry	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all
v. Dressing	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all
vi. Eating	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all
vii. Grooming	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all
viii. Heavy Chores	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all

ix. Light Housekeeping	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all
x. Managing Money	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all
xi. Prepare Meals	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all
xii. Shopping	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all
xiii. Toileting	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all
xiv. Transferring	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all
xv. Walking Mobility	☐ Ward needs no help ☐ Ward needs some assistance ☐ Ward cannot do at all

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" option is 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" option is checked:

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

Explanation:

12. To assist the court in providing demographic information to private and public entities, please provide the following information:

a. Is the Ward a native Floridian?
- ☐ Yes
- ☐ No
- ☐ Not Yet Determined

b. If the Ward is not a native of Florida, the date of relocation to Florida:

c. The Ward's primary spoken language is:
- ☐ English
- ☐ Spanish
- ☐ Creole
- ☐ Portuguese
- ☐ Other _____

d. The Ward's race is:
- ☐ Asian or Pacific Islander
- ☐ Black (Non-Hispanic)
- ☐ Hispanic
- ☐ Native American
- ☐ White (Non-Hispanic)
- ☐ Other _____

e. The Ward's date of birth is:

CERTIFICATION AND SIGNATURE OF GUARDIAN(S)

(Check all that apply)

☐ The recommendations of the examining committee are incorporated into this plan.
☐ 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.

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 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 initial guardianship plan of the guardian of the person. This initial plan is the representation of the guardian. I have not audited the accompanying initial 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: _____