

IN THE CIRCUIT COURT OF THE IN AND FOR COUNTY

Case Number:

**Format Must Be
PRCYNNNNNNN**

Division:

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:

<p>3. The guardian for the plan period proposes the following as to the provision of mental health services for the Ward:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Routine examination by Psychiatrist/Psychologist <input type="checkbox"/> Ongoing treatment outpatient <input type="checkbox"/> Ongoing treatment inpatient <input type="checkbox"/> None <input type="checkbox"/> Other <p>Explanation required only if "Other" option is checked:</p>
<p>4. The Ward presently is prescribed or takes the followings types of medications:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anti Anxiety <input type="checkbox"/> Anti Depressant <input type="checkbox"/> Cardiac <input type="checkbox"/> Diabetic <input type="checkbox"/> Memory Enhancement <input type="checkbox"/> Over the Counter <input type="checkbox"/> Psychotropic <input type="checkbox"/> Other Prescription
<p>5. The guardian for the plan period proposes the following as to the provision of personal care services for the Ward:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Care Facility <input type="checkbox"/> Nurses and Aides <input type="checkbox"/> Family and Friends <input type="checkbox"/> Other <p>Explanation required only if "Other" option is checked:</p>
<p>6. The guardian for the plan period proposes the following as to the provision of social/recreational services for the Ward:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Care Facility <input type="checkbox"/> Nurses and Aides <input type="checkbox"/> Family and Friends <input type="checkbox"/> The Ward retains the right to make their own decision <input type="checkbox"/> Other <p>Explanation required only if "Other" option is checked:</p>
<p>7. The guardian for the plan period proposes the following as to the provision of social services for the Ward:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Adult Day Care <input type="checkbox"/> Counseling <input type="checkbox"/> Homemaker/Personal Care <input type="checkbox"/> Home Delivered Meals <input type="checkbox"/> Private Services <input type="checkbox"/> Public Services <input type="checkbox"/> Senior Center <input type="checkbox"/> Sheltered Workshop <input type="checkbox"/> Transportation <input type="checkbox"/> Volunteer Services <input type="checkbox"/> Other <p>Explanation required only if "Other" option is checked:</p>

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	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all
ii. Bathing	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all
iii. Climbing Stairs	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all
iv. Doing Laundry	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all
v. Dressing	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all
vi. Eating	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all
vii. Grooming	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all
viii. Heavy Chores	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all

ix. Light Housekeeping	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all
x. Managing Money	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all
xi. Prepare Meals	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all
xii. Shopping	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all
xiii. Toileting	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all
xiv. Transferring	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> Ward cannot do at all
xv. Walking Mobility	<input type="checkbox"/> Ward needs no help <input type="checkbox"/> Ward needs some assistance <input type="checkbox"/> 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:

PREEXISTING ORDERS NOT TO RESUSCITATE AND ADVANCE DIRECTIVES

Instructions (*For adult wards only): List any preexisting orders not to resuscitate executed under s. 401.45(3) or preexisting advance directives, as defined in s. 765.101. Include the date an order or directive was signed, whether such order or directive has been suspended by the court, and a description of the steps taken to identify and locate the preexisting order not to resuscitate or advance directive (attach additional pages if necessary).

1	Title of Order/Directive	
	Date Order/Directive signed	
	Order/Directive suspended by the court?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	Description of steps taken to identify and locate Order/Directive	
2	Title of Order/Directive	
	Date Order/Directive signed	
	Order/Directive suspended by the court?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	Description of steps taken to identify and locate Order/Directive	
3	Title of Order/Directive	
	Date Order/Directive signed	
	Order/Directive suspended by the court?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	Description of steps taken to identify and locate Order/Directive	
4	Title of Order/Directive	
	Date Order/Directive signed	
	Order/Directive suspended by the court?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	Description of steps taken to identify and locate Order/Directive	

**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: _____