IN THE CIRCUIT COURT OF THE IN AND FOR COUNTY

Case Number:
Format Must Be PRCYYNNNNNNN
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: fac a					
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	☐
Second three months	☐
Third three months	☐
Fourth three months	☐

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 involuntary 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:

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?	☐ YES ☐ 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?	☐ YES ☐ 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?	☐ YES ☐ 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?	☐ YES ☐ NO
	Description of steps taken to identify and locate Order/Directive	

DECLARATION OF REMUNERATION RECEIVED BY GUARDIAN			
Instructions: List the total amounts of **all** prior remuneration (payment or other benefit made directly or indirectly, overtly or covertly, or in cash or in kind) received by the guardian from any source for services rendered to or on behalf of the Ward (Please list the type of remuneration, source, and amount)			
#	**Type**	**Source**	**Amount**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
Total Amount of Remuneration Received by Guardian			

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	
l. Having a Driver's License	

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: _____