*** D R A F T ***

COURT OF COMMON PLEAS
CHESTER COUNTY, PENNSYLVANIA
ORPHANS' COURT DIVISION

REPORT OF GUARDIAN OF THE PERSON

Estate of:

Case File No:

DATE COURT APPOINTED YOU AS GUARDIAN:

PART I. INTRODUCTION

1. Name(s) of Guardian(s):
2. Is this a limited Guardianship? ☐ Yes ☐ No
3. Report Period

☐ This is the **Report** for the period from _____ to _____ (the **"Report Period"**);

or

☐ This is the **Final Report** for the period from _____ to _____ (the **"Report Period"**) and is filed for the following reason:

☐ The death of the Incapacitated Person.
Date of Death: _____
Name of Executor/Administrator: _____

☐ The Guardianship was terminated by a court order dated: _____

☐ Transfer of Guardianship to: _____
Date of court order approving transfer: _____

IF THIS IS A FINAL REPORT, ONLY COMPLETE PARTS I AND V.

PART II. PERSONAL INFORMATION ABOUT THE INCAPACITATED PERSON

1. Incapacitated Person's date of birth:

2. Incapacitated Person's Current Residence:

3. Residence of the Incapacitated Person

☐ Incapacitated Person's home (☐ with part-time home health care aide *or* ☐ 24/7 assistance)

☐ Your home

☐ Relative's home
Relative's Name: _____ Relationship: _____

☐ Domiciliary Care
Facility Name: _____
Is this a Memory Support Facility? ☐ Yes ☐ No

☐ Personal Care Boarding Home
Facility Name: _____
Is this a Memory Support Facility? ☐ Yes ☐ No

☐ Assisted Living Facility
Facility Name: _____
Is this a Memory Support Facility? ☐ Yes ☐ No

☐ Nursing Home Facility
Facility Name: _____
Is this a Memory Support Facility? ☐ Yes ☐ No

☐ Other: _____

4. The Incapacitated Person has been in the residence noted in question 3 since: _____

5. Has the Incapacitated Person moved during the **Report Period?**

☐ Yes

☐ No

If **yes**, date of move: _____

If **yes**, please provide:

Reason for move:

Previous residence/address:

PART III. MEDICAL INFORMATION

1. List the medical professionals who have seen the Incapacitated Person during the **Report Period**:

	Name
Medical Doctor	
Dentist	
Eye Doctor	
Ear Doctor	
Psychologist or Psychiatrist	
Physical Therapist	
Occupational Therapist	
Social Worker	
Geriatric Caseworker	
Other	

2. The major medical or psychiatric problems of the Incapacitated Person are as follows:

_____

_____

_____

3. Describe any social, medical, psychological and support services the Incapacitated Person is receiving:

_____

_____

_____

4. Has the Incapacitated Person been hospitalized during the **Report Period**?

☐ Yes

☐ No

If **yes**, date(s) of hospitalization: _____

5. Has the Incapacitated Person received a mental health assessment during the **Report Period**?

☐ Yes

☐ No

If **yes**, date(s) of evaluation: _____

PART IV. GUARDIAN'S OPINION

1. Should the guardianship be:

   ☐ Continued

   ☐ Continued with modifications

   ☐ Terminated

2. Provide the reasons for your opinion. List specific recommended modifications.

   _____

   _____

3. Have you filed a petition for modification or termination?

   ☐ Yes

   ☐ No

PART V. INFORMATION ABOUT THE GUARDIAN

1. On average, how often did you visit the Incapacitated Person during the **Report Period**?

   ☐ I live with the Incapacitated Person

   ☐ None

   ☐ Quarterly

   ☐ Monthly

   ☐ Weekly

   ☐ Daily

2. What is the average length of a visit?

   ☐ Less than 15 minutes

   ☐ Between 15 minutes and 1 hour

   ☐ Between 1 and 2 hours

   ☐ More than 2 hours

   ☐ Not applicable

3. Have you maintained a log of your activities as guardian?

   ☐ Yes - Attach a copy

   ☐ No

4. During this **Report Period**, did any guardian participate in guardianship training?

☐ Yes

☐ No

If **yes**, provide the following information:

Guardian Name	Dates of Training Starting	Ending	Provider	Training Description

5. During this **Report Period**, was any guardian charged with or convicted of a crime?

☐ Yes - Please describe ☐ No

Guardian Name *Description*

_____ _____

_____ _____

6. During this **Report Period**, was a Protection from Abuse Order or Protection from Sexual Violence or Intimidation Order entered against any guardian?

☐ Yes - Please describe ☐ No

Guardian Name *Description*

_____ _____

_____ _____

7. Is there any reason any guardian cannot continue to serve as guardian?

☐ Yes - Please describe ☐ No

Guardian Name *Description*

_____ _____

_____ _____

I verify that the foregoing information is correct to the best of my knowledge, information and belief; and that this verification is subject to the penalties of 18 Pa.C.S. §4904 relative to unsworn falsification to authorities.

I further acknowledge the Notice of Filing must be served within 10 days of the filing of this report, pursuant to proposed rule Pa. O.C. Rule 14.8(b). Service shall be in accordance with Pa. O.C. Rule 4.3.

_____
Date

_____
Signature of Guardian of the Person

_____
Name of Guardian of the Person (type or print)

_____
Address

_____
City, State, Zip

_____
Home Phone Number

_____
Office Phone Number

_____
Cell Phone Number

_____
Email