Reset Form

# PROBATE COURT OF LUCAS COUNTY, OHIO

## JACK R. PUFFENBERGER, JUDGE

**GUARDIANSHIP OF** _____

**CASE NO.** _____

## GUARDIAN'S REPORT

**[R.C. 2111.49 and Sup.R. 66.05(B)(2)]**

NOTE: If allotted space is inadequate to respond, write "See Exhibit" in the space and add appropriate exhibit letter sequence, then attach exhibit containing information requested for that space.

1. This is the **(check one)** ☐ 1st, ☐ 2nd, ☐ 3rd, ☐ 4th, ☐ 5th, ☐ 6th, or _____, Guardian's Report.
2. Ward's present address: _____

   City _____ State _____

   Zip Code _____ Telephone Number (___) _____
3. Ward's living arrangements at the above address are best described as:

   ☐ a. His or her own apartment or home (includes assisted living facilities.)

   ☐ b. Private home or apartment of:

   ☐ (1) the ward's guardian

   ☐ (2) a relative of the ward, whose name is _____

   and relationship is _____

   ☐ (3) a non-relative whose name is _____

   ☐ c. A foster, group, or boarding home.

   ☐ d. A nursing home.

   ☐ e. A medical facility or state institution.

   ☐ f. Other (describe) _____

   _____

   g. If **c**, **d**, **e,** or **f** is checked, complete the following:

   ☐ (1) The name of the home, facility, or institution _____

   ☐ (2) The name of an individual at the home, facility, or institution who has knowledge and is authorized to give information to the court about the ward.

   Name _____

   Telephone Number (_____) _____
4. The ward will be at the address given in Item 2:

   ☐ a. Indefinitely.

   ☐ b. Temporarily. The new address and telephone number is:

   ☐ (1) Unknown. I will provide this information when known.

   ☐ (2) _____

   City _____ State _____

   Zip Code _____ Telephone Number (___) _____

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5. Guardian's contact with the ward.
   a. Approximate number of times the guardian had contact with the ward during the period covered by this report: _____
   b. The nature of those contacts (phone, personal, or other): _____
   c. Date the ward was last seen by the guardian: _____

6. Have you observed any **major** change in the ward's physical or mental condition during the period covered by this report? ☐ Yes ☐ No
   If "yes" is checked, briefly describe the changes. _____

7. The care given to the ward is ☐ Adequate ☐ Not Adequate
   If "Not Adequate" is checked, explain. _____

8. The guardianship should be ☐ Continued ☐ Not Continued
   If "Not Continued" is checked, explain. _____

9. During the period covered by this report, the ward ☐ has ☐ has not been seen by a physician. If the ward has been seen, the last date was _____ and for the purpose of _____

10. ☐ I currently serve as the guardian to ten or more wards and certify to the Court that I am unaware of any circumstances that may disqualify me from serving as guardian for this ward.

11. With regard to the continuing education requirement pursuant to Sup.R. 66.07:
    ☐ I have completed the continuing education requirement. (Attach Certificate of Completion if applicable)
    ☐ The continuing education requirement was waived.

Attached is a statement by a licensed physician, a licensed clinical psychologist, a licensed social worker, or a developmental disability team, that has evaluated or examined the ward within three months prior to the date of this report regarding the need for continuing the guardianship. [R.C. 2111.49(A)(1)(I)](Form 17.1)

If an attorney has been consulted on this report: Date _____

| | |
|---|---|
| _____ | _____ |
| Attorney for Guardian | Guardian's Printed Name |
| _____ | _____ |
| Street | Guardian's Signature |
| _____ | _____ |
| City State Zip Code | Street |
| _____ | _____ |
| Telephone Number (include area code) | City State Zip Code |
| _____ | _____ |
| Attorney Registration No. | Telephone Number (include area code) |

**(Knowingly giving false information on a Probate document is a criminal offense)**
**[R.C. 2921.13(A)(11)]**

**PROBATE COURT OF LUCAS COUNTY, OHIO**

**JACK R. PUFFENBERGER, JUDGE**

**IN THE MATTER OF THE GUARDIANSHIP OF** _____

**CASE NO.** _____

# STATEMENT OF EXPERT EVALUATION

**[Sup.R. 66 & R.C. 2111.49]**

Definition of Incompetent (R.C. 2111.01(D)): "Incompetent" means any person who is so mentally impaired, as a result of a mental or physical illness or disability, as a result of intellectual disability, or as a result of chronic substance abuse, that the person is incapable of taking proper care of the person's self or property or fails to provide for the person's family or other persons for whom the person is charged by law to provide, or any person confined to a correctional institution within this State. The examiner shall complete this statement using personal observations and prior history obtained during the examiners course of treatment / interaction with the individual.

The Statement of Evaluation does not declare the individual competent or incompetent. It is evidence to be considered by the Court. The Probate Court **WILL NOT** pay the fee for completing this evaluation, unless otherwise ordered by the Court. The evaluator should secure payment from the Applicant or Guardian.

1. This Statement of Expert Evaluation is to be filed with or attached to:

☐ A. Guardianship Application: [Evaluation must be completed before the filing of the attached application.]

Evaluation completed by: ☐ Licensed Physician ☐ Licensed Clinical Psychologist

☐ B. Application for Emergency Guardianship:

Evaluation completed by: ☐ Licensed Physician ☐ Licensed Clinical Psychologist

[NOTE: If this Statement relates to an emergency guardianship of the person, a Licensed Physician or a Licensed Clinical Psychologist must complete the Supplement for Emergency Guardian, Form 17.1A, specifying the details of the emergency, and why immediate action is required to prevent significant injury or death to the person. The Supplement must be signed by a Licensed Physician or a Licensed Clinical Psychologist, dated, and attached to this completed Statement.]

☐ C. Guardian's Report: [Evaluation must be conducted within three months before the date of this Report. R.C. 2111.49]

Evaluation completed by: ☐ Licensed Physician ☐ Licensed Clinical Psychologist
☐ Licensed Independent Social Worker ☐ Licensed Professional Clinical Counselor
☐ Developmental Disability Team ☐ Certified Nurse Practitioner ☐ Licensed Clinical Nurse Specialist

2. Statement completed by: (Please print clearly)
Name & Title/Profession: _____
Business Address: _____
Business Telephone Number: _____

3. Date(s) of evaluation: _____
Place(s) of evaluation: _____
Amount of time spent on evaluation: _____
Length of time the individual has been your patient: _____
Individual's language preference: _____

4. Is the individual presently taking medication? ☐ Yes ☐ No If yes, what is the medication, dosage, and purpose? [Continue comments on page 4]

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Are there any signs of physical and/or mental impairments caused by the medications themselves? _____

5. Is the individual mentally impaired? ☐ Yes ☐ No If yes, indicate the diagnosis below:

☐ Intellectual or Developmental Disabilities: *(Please check the severity)*
☐ Profound ☐ Severe ☐ Moderate ☐ Mild

☐ Mental Illness: Type and Severity _____

☐ Substance Abuse: Description _____

☐ Dementia: Type and Severity _____

☐ Other: Description, Type, and Severity _____
[Continue comments on page 4]

6. During the examination did you notice an impairment of the individual's:

| | | | |
|---|---|---|---|
| a) Orientation | ☐ Yes | ☐ No | ☐ Unknown |
| b) Speech | ☐ Yes | ☐ No | ☐ Unknown |
| c) Motor Behavior | ☐ Yes | ☐ No | ☐ Unknown |
| d) Thought Process | ☐ Yes | ☐ No | ☐ Unknown |
| e) Affect | ☐ Yes | ☐ No | ☐ Unknown |
| f) Memory | ☐ Yes | ☐ No | ☐ Unknown |
| g) Concentration | ☐ Yes | ☐ No | ☐ Unknown |
| h) Comprehension | ☐ Yes | ☐ No | ☐ Unknown |
| i) Judgment | ☐ Yes | ☐ No | ☐ Unknown |

7. Please describe any impairments identified in question six. [Continue comments on page 4].

8. Is the individual physically impaired? I.e. visual, mobility, hearing, etc. ☐ Yes ☐ No If yes, please describe: ___

9. Are there any special characteristics of the individual which should be considered in evaluating the individual for guardianship: ☐ Yes ☐ No If yes, please explain: _____

10. Is there any indication of abuse, neglect, or exploitation of the individual? ☐ Yes ☐ No If yes, please explain:

11. Do you believe the individual is capable of caring for his or her activities of daily living or making decisions concerning his or her own medical treatments, living arrangements, and diet?

☐ Yes ☐ No If no, please explain: _____

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12 Do you believe this individual is capable of managing his or her finances and property? ☐ Yes ☐ No If no, please explain: _____

13. What is the recommended living situation for the individual?

☐ Independent living arrangement
☐ Assisted living facility or group home
☐ A nursing home
☐ A memory care facility or lockdown unit
☐ Other: _____

14. Prognosis of the individual:

A. Is the condition stabilized? ☐ Yes ☐ No ☐ Unknown
B. Is the condition reversible: ☐ Yes ☐ No ☐ Unknown

15. In my opinion a guardianship should be:
If this is a new application for appointment of guardian: ☐ Established ☐ Denied
If this is an existing guardianship: ☐ Continued ☐ Terminated

I certify that I have evaluated the individual on _____, 20_____.

Date:_____

_____
Signature of Evaluator

_____
Printed Name of Evaluator

## GUARDIAN'S REPORT ADDENDUM

(Not to be used with initial Application)

It is my opinion, based upon a reasonable degree of medical or psychological certainty that the mental capacity of this ward will not improve.

Date_____

_____
Signature – Licensed Physician/Clinical Psychologist

_____
Printed Name of Licensed Physician/Clinical Psychologist

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## ADDITIONAL COMMENTS

Date_____

_____
Signature of Evaluator

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# PROBATE COURT OF LUCAS COUNTY, OHIO

# JACK R. PUFFENBERGER, JUDGE

**GUARDIANSHIP OF** _____

**CASE NO.** _____

## ANNUAL GUARDIANSHIP PLAN - PERSON

**[Sup.R. 66.08 (G)]**

[Attach as addendum to Form 17.7-Guardian's Report.]

I am the guardian of the for the above-named Ward. I have identified the following goal(s) for the next year and how I intend the goal(s) to be met.

**For the Person**

**Goal** - (for example: address medication issues; obtain assistance devices; secure medical and rehab services; meet mental health service needs; secure personal care services; enhance nutrition; improve social skills, etc.)

_____

_____

_____

**Means to Meet the Goal –** (for example: educate on benefits of medications and compliance; obtain walker, wheelchair, hearing aid; schedule semi-annual checkups/exams; secure outpatient examinations and mental health counseling; arrange for shopping and/or meals on wheels; enroll in sheltered workshop/socialization programs, etc.)

_____

_____

_____

[Attach additional pages if necessary]

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_____ _____

Guardian's Printed Name Guardian's Signature

_____ _____

Street Telephone Number (include area code)

_____

City State Zip Code

# Lucas County Probate Court

700 ADAMS STREET, SUITE 200, TOLEDO, OHIO 43604-5660
TELEPHONE (419) 213-4775 FACSIMILE (419) 213-4764
e-mail address – info@lucasprobate.org
Web Site – www.lucasprobate.org





Date:

Case Number:

Ward's Name:

Dear:

There is a $5.00 fee for filing your **Guardian's Report and annual report**. Please return this letter with the **REPORT and annual report.** To obtain these forms, you may either come to the Probate Court or visit our website at www.lucasprobate.org.

If the ward or guardian is unable to pay this fee, please indicate below and return this letter to request a filing fee waiver.

Thank You,

_____
Deputy Clerk

1. ☐ $5.00 filing fee enclosed
2. ☐ The ward is on Medicaid and cannot pay the filing fee. Please waive costs.
3. ☐ The ward or guardian cannot pay and request that the costs be waived because

_____
_____

*** Signature required if box 2 or 3 is checked.

_____
Guardian

**Print Form**