

COURT OF COMMON PLEAS  
COUNTY, PENNSYLVANIA  
ORPHANS' COURT DIVISION

**REPORT OF GUARDIAN OF THE PERSON**

Estate of: \_\_\_\_\_, an Incapacitated Person  
*Name of Incapacitated Person*

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 Guardian was discharged by a court order dated: \_\_\_\_\_

☐ Order for Adjudication of Capacity dated: \_\_\_\_\_

☐ Limited Duration Order Expired, 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. Where is the Incapacitated Person physically living?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Nature of Residence of the Incapacitated Person (Select One)

☐ 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

☐ Group 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: \_\_\_\_\_

6. What is the Gender of the Incapacitated Person?

☐ Female

☐ Male

☐ Unreported / Unknown

7. What is the Race of the Incapacitated Person?

☐ Asian

☐ Asian / Pacific Islander

☐ Black

☐ Multi-Racial

☐ Native American / Alaskan Native

☐ Native Hawaiian / Pacific Islander

☐ Unreported / Unknown

☐ White

8. What is the Ethnicity of the Incapacitated Person?

☐ Hispanic

☐ Non Hispanic

☐ Unknown

**PART III. MEDICAL INFORMATION**

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

**Medical Doctor**

**Dentist**

**Eye Doctor**

**Ear Doctor**

**Psychologist or Psychiatrist**

**Physical Therapist**

**Occupational Therapist**

**Social Worker**

**Geriatric Caseworker**

**Other**

Name

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

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

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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. Does the Incapacitated Person still require a guardian? Should the guardianship be:

- ☐ Continued  
☐ Continued with modifications  
☐ Discharged

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

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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		Provider	Training Description
	Starting	Ending		

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*

\_\_\_\_\_

\_\_\_\_\_

8. Did the Guardian receive compensation during the **Report Period**?

☐ Yes - Complete the table below

☐ No

Amount	Guardian Name	Is Amount Based on Hourly, Monthly or Annual Fee?	If Hourly, # of Hours

9. Was the compensation approved by the court?

☐ Yes - Date of Court Order: \_\_\_\_\_

☐ No - Explain why court approval was not obtained:

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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 Pa.R.O.C.P. 14.8(b). Service shall be in accordance with Pa.R.O.C.P. 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*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Co-Guardian of the Person (if applicable)*

\_\_\_\_\_  
*Name of Co-Guardian of the Person (type or print)*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*City, State, Zip*

\_\_\_\_\_  
*Home Phone Number*

\_\_\_\_\_  
*Office Phone Number*

\_\_\_\_\_  
*Cell Phone Number*

\_\_\_\_\_  
*Email*