

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?

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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**:

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:

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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.

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*Date*

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*Signature of Guardian of the Person*

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

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*Address*

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*City, State, Zip*

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*Home Phone Number*

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*Office Phone Number*

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*Cell Phone Number*

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*Email*

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*Date*

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

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

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*Address*

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*City, State, Zip*

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*Home Phone Number*

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*Office Phone Number*

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*Cell Phone Number*

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*Email*