For Official Use Only:

Annual Guardianship Plan

(Pursuant to F.S. 744.367, the Report with Original Signatures is due within 90 days after the last day of the anniversary month that the letters of guardianship were signed.)

In the Circuit Court, Sixth Judicial Circuit, Florida
County: Select County

IN RE: GUARDIANSHIP OF:			
Social Security Number:			
Case Number:			
For the period:		through	
Guardianship Inception Date:			
Guardian Name:			
Attorney Name:			

This Report, with original signatures, is due within 90 days after the last day of the anniversary month that the letters of guardianship were signed.

The Ward is living:

☐ In a private residence leased or owned by them (house, condo, apartment).
☐ In a private residence not leased or owned by them (such as family member).
☐ In a facility (Skilled Nursing, Assisted Living, etc)

Address and Phone Number where Ward is currently residing:

Address:
City, State, ZIP:
Phone:

Mailing Address for Ward (if different from above):

Mailing Address:
City, State, ZIP:

The guardian(s) submit(s) and propose(s) the following plan. Filed separately is the Annual Physician's Report. Together, these are the Annual Report of the Guardians(s) of the Person.

Annual Medical Report: A report of a physician who examined the Ward no more than 90 days before the beginning of the applicable reporting period is to be filed separately, but at the same time as this plan. The report must contain an evaluation of the Ward's condition and a statement of the current level of capacity of the Ward.

Note 1: The rights on the physician's report should match the Order Determining Incapacity and/or Order Appointing Guardian (signed when Letters were issued) or the guardian must either file a petition to remove or restore rights as appropriate, or provide an explanation for why no change should be made.

Ward Name: Case Number:

Note 2: Per Administrative Order 2009-036, you must file an updated Disaster Plan when you file the annual plan if the ward has changed residence or a new guardian has been appointed.

1. The places the ward has lived (resided) during the prior 12 months

	Facility's name or owner of the private residence's name (first line) Street Address (second line) City, State and Zip Code (third line) Phone Number (fourth line)	Type of Facility	Approximate Dates Of Residence
1			From To
2			From To
3			From To
4			From To
5			From To
6			From To
7			From To
8			From To
9			From To
10			From To

Ward Name: Case Number:

2. If the ward's address has changed since the last plan filed (check all that apply):

☐ N/A, the ward has not moved since the last plan was filed.
☐ The move was within this county and a change of address was provided to the court.
☐ The move was within this Circuit (Pinellas to Pasco or Pasco to Pinellas) and Notice was provided to the court within 15 days of the move. The notice stated the compelling reasons for, and expected duration of, the move.
☐ The move was not within this Circuit (Pasco/Pinellas) and prior court approval was obtained.
☐ The move was not within this Circuit (Pasco/Pinellas) and a petition to change venue is or has been filed with this plan. plan.

3. For the best welfare of the ward in a setting best suited for his/her needs, the undersigned guardian plans as follows:

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
☐ Specialized
☐ State Hospital
☐ Other (Please Explain Below)

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Explanation:

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. Provision for medical care services for the ward:
(Check all applicable boxes and provide explanation below)

☐ Routine examination by primary care physician
☐ Routine examination by dentist
☐ Routine examination by Ophthalmologist
☐ Routine examination by Specialist – area of specialty
☐ Physical Therapy
☐ Speech Therapy
☐ Occupational Therapy
☐ The ward retains the right to make their own decision
☐ None (Please Explain Below)
☐ Other (Please Explain Below)

Explanation:

D. Provision for mental health services for the ward:
(Check all applicable boxes and provide explanation below)

- ☐ Routine examination by Psychiatrist/Psychologist
- ☐ Ward retains the right to make own decisions
- ☐ Ongoing Treatment Outpatient
- ☐ Ongoing Treatment Inpatient
- ☐ None (Please Explain Below)
- ☐ Other (Please Explain Below)

Explanation:

E. Provision for the personal care of the ward, such as bathing, grooming and feeding:
(Check all applicable boxes and provide explanation below)

- ☐ Care Facility
- ☐ Nurses and Aides
- ☐ Family and Friends
- ☐ Ward does without assistance
- ☐ None; ward can provide own personal care
- ☐ Other(Please Explain Below)

Explanation:

F. Provision for socialization and/or recreational activities for the ward:
(Check all applicable boxes and provide explanation below)

- ☐ Care Facility
- ☐ Nurses and Aides
- ☐ Family and Friends
- ☐ The ward retains the right to make their own decision
- ☐ None (Please Explain Below)
- ☐ Other (Please Explain Below)

Explanation:

G. Description of health and accident insurance and any other private or governmental benefits to which the Ward is receiving to meet any part of the costs of medical, mental health or related services provided to the Ward.
(Check all applicable boxes and provide explanation below)

For	Eligible	Applied
Social Security	☐	☐
Social Security Disability Income (SSDI)	☐	☐
Health Maintenance Organization (HMO)	☐	☐

Supplemental Security Income (SSI)	☐	☐
Optional State Supplement	☐	☐
Institutional Care Program	☐	☐
Supplemental Insurance	☐	☐
(Continued Next Page)		
Pension	☐	☐
Medicare	☐	☐
Medicaid	☐	☐
VA	☐	☐
Trusts	☐	☐

☐ None (Please Explain Below)
☐ Other (Please Explain Below)

Explanation:

4. Professional Medical Treatment performed on the Ward during the prior 12 months

	Data Entry Format: 1st Line input: *Provider's first name, last name, and middle initial* 2nd Line input: *Street Address* 3rd Line input: *City, State and Zip Code* 4th Line input: *Phone Number*	Type of Provider	Number of Visits
1			
2			
3			
4			
5			
6			
7			

8			
9			
10			

5. Social Skills, Abilities and Activities of the Ward

A. Describe the social skills (abilities) of the Ward (i.e.: the Ward can communicate well; the Ward communicates with gestures; the Ward cannot communicate at all; etc…). In addition, please describe any changes from the previous plan period.

Explanation:

B. Describe the activities undertaken in an effort to increase the capacity of the Ward in the prior plan period (i.e.: encouragement; physical or mental therapy, rehabilitative services; etc…) In addition, please explain whether or not these activities were effective.

Explanation:

6. Is the Ward now capable of having some or all of the following rights restored?

Place a checkmark where applicable

	Yes	No	Not Removed	Needs to be Restored
A. Right to marry:	☐	☐	☐	☐
B. Right to Vote:	☐	☐	☐	☐
C. Right to personally apply for government benefits:	☐	☐	☐	☐
D. Right to have a driver's license:	☐	☐	☐	☐
E. Right to travel:	☐	☐	☐	☐
F. Right to seek or retain employment:	☐	☐	☐	☐
G. Right to contract:	☐	☐	☐	☐

Ward Name: Case Number:

H.	Right to sue and be sued	☐	☐	☐	☐
I.	Right to manage property or to make any gift of disposition:	☐	☐	☐	☐
J.	Right to determine residence:	☐	☐	☐	☐
K.	Right to consent to medical treatment:	☐	☐	☐	☐
L.	Right to make decisions about social environment or other aspects of social life:	☐	☐	☐	☐

7. If you answered "Yes" to any right in question 5, and the doctor has indicated on the physician's report that a right may be restored, you must file a petition to restore the right. If you do not agree with the physician's report, please provide an explanation.

Explanation:

8. Rate the following Activities of Daily Living (ADL's)

A.	Eating	Choose an item
B.	Prepare Meals:	Choose an item
C.	Heavy Chores (e.g., vacuuming)	Choose an item
D.	Light Housekeeping	Choose an item
E.	Managing Money:	Choose an item
F.	Dressing	Choose an item
G.	Transportation Ability	Choose an item
H.	Walking/Mobility:	Choose an item
I.	Toileting	Choose an item
J.	Climbing Stairs:	Choose an item
K.	Transferring (from wheelchair to char/bed):	Choose an item
L.	Doing Laundry:	Choose an item
M.	Shopping	Choose an item
N.	Bathing:	Choose an item
O.	Grooming	Choose an item
P.	Administration of medication	Choose an item

The rest of this page intentionally left blank

Ward Name: Case Number:

9. Disabilities:

A. Mental disabilities: (Check all applicable boxes and provide explanation below)

- ☐ Dementia
- ☐ Autism Spectrum Disorders
- ☐ Closed Head Injury
- ☐ Developmental Disabilities
- ☐ Schizophrenia or related disorders
- ☐ Depression
- ☐ Intellectual Disability
- ☐ Induced by substance abuse
- ☐ Alzheimer's type of Dementia
- ☐ Ward has no mental disabilities
- ☐ Other: (Please Explain Below)

Explanation:

B. The physical disabilities of the Ward are:
(Check all applicable boxes and provide explanation below)

- ☐ Mobility
- ☐ Blindness
- ☐ Deafness
- ☐ Diabetic
- ☐ Parkinson's disease
- ☐ Severe arthritis
- ☐ Ward has no physical disabilities
- ☐ Other (Please Explain Below)

Explanation:

C. The assistive devices used by the Ward are (*devices currently being used by the ward):*
(Check all applicable boxes and provide explanation below)

- ☐ Dentures
- ☐ Hearing Aid
- ☐ Wheelchair
- ☐ Walker/Cane
- ☐ Crutches
- ☐ Prosthetics
- ☐ Glasses
- ☐ None
- ☐ Other (Please Explain Below)

Explanation:

D. The assistive devices needed by the Ward are(devices needed but ward does not yet have them): (Check all applicable boxes and provide explanation below)

- ☐ Dentures
- ☐ Hearing Aid
- ☐ Wheelchair
- ☐ Walker/Cane
- ☐ Crutches
- ☐ Prosthetics
- ☐ Glasses
- ☐ None
- ☐ Other (Please Explain Below)

Explanation:

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Ward Name: Case Number:

CERTIFICATION AND SIGNATURE OF GUARDIAN(S)

(Check all that apply)
If the Ward's ability to exercise rights has changed since the Order Determining Capacity and/or Order Appointing Guardian, the guardian must either file a petition to remove or restore rights as appropriate, or provide an explanation as to why no change should be made.

- ☐ The Ward was declared totally incapacitated and has not been given a copy of this plan.
- ☐ The Ward is a minor and has not been given a copy of this plan.
- ☐ 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 other 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.
- ☐ In exercising his or her powers, the guardian shall recognize any rights retained by the ward [FS 744.363(6)].

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.

Guardian Signature	Guardian Name
Guardian SSN/EIN	Guardian Street Address
Guardian Phone Number	Guardian City/State/Zip
Date Signed	Guardian Relationship to Ward:

Co-Guardian Signature	Co-Guardian Name
Co-Guardian SSN/EIN	Co-Guardian Street Address
Co-Guardian Phone Number	Co-Guardian City/State/Zip
Date Signed	Co-Guardian Relationship to Ward

Ward Name: Case Number:

Co-Guardian Signature	Co-Guardian Name
Co-Guardian SSN/EIN	Co-Guardian Street Address
Co-Guardian Phone Number	Co-Guardian City/State/Zip
Date Signed	Co-Guardian Relationship to Ward

Co-Guardian Signature	Co-Guardian Name
Co-Guardian SSN/EIN	Co-Guardian Street Address
Co-Guardian Phone Number	Co-Guardian City/State/Zip
Date Signed	Co-Guardian Relationship to Ward

All guardians of person must sign and provide the most current address, telephone number, and ssn. Only reports with Original signatures will be audited by the Clerk of the Court.

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Ward Name: Case Number:

CERTIFICATION AND SIGNATURE OF GUARDIAN'S ATTORNEY

The undersigned hereby notifies the Court of the filing of the annual guardianship plan for the period through .

The undersigned hereby notifies the Court of the annual guardianship plan of the guardian of the person. This annual guardianship plan is the representation of the guardian. I have not audited the accompanying annual plan. The undersigned attorney represents that he/she has examined the contents of the annual guardianship plan and that it conforms to the requirements of the Florida Guardianship Law and the standards for the plans in Select County County.

Attorney Signature | Date Signed | Attorney Name

Attorney Bar Number | Attorney Address

Attorney Phone Number | Attorney City/State/Zip

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