COURT OF COMMON PLEAS OF
ADAMS COUNTY PENNSYLVANIA
ORPHANS' COURT DIVISION

REPORT OF GUARDIAN OF THE PERSON

Estate of _____, an Incapacitated Person
Name of Incapacitated Person

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

4. Have you sent the Notice of Filing for this Report to those indicated in the court order appointing you as guardian? ☐ Yes ☐ No

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

PART II: PERSONAL INFORMATION ABOUT THE INCAPACITATED PERSON

1. Incapacitated Person's date of birth: _____/_____ /_____

2. Current address of the Incapacitated Person's residence:

_____

_____

Facility Name, if any: _____

3. Residence of the Incapacitated Person

a. Type of Residence/Facility:

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

☐ Your home

☐ Relative's home

Relative's name_____ Relationship _____

Address: _____

☐ Domiciliary Care

☐ Personal Care Boarding Home

☐ Assisted Living Facility

☐ Nursing Home Facility

☐ Other: _____

b. If in Personal Care Boarding Home, Assisted Living Facility or Nursing Home, is the incapacitated person in a Memory Support Facility? ☐ Yes ☐ No

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(s):	
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:

_____

_____

_____

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. If you do not live with the Incapacitated Person, how many times during the **Report Period** have you visited?

   ☐ 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 you participate in guardianship training? ☐ Yes ☐ No

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

Dates of Participation	Provider	Training Description

5. During this **Report Period**, were you charged or convicted of a crime?

☐ Yes - Please describe ☐ No

_____

_____

_____

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

☐ Yes - Please describe ☐ No

_____

_____

_____

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

_____

_____

_____

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.

_____ _____

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