Form G-04. Guardian's Inventory

COURT OF COMMON PLEAS OF

ORPHANS' COURT

DIVISION **INVENTORY**

ESTATE/GUARDIANSHIP OF _____

An Incapacitated Person

DOCKET NO. _____ DATE OF DECREE: _____

DUE DATE: _____ FILING FEE: _____

Inventory type: ☐ Initial ☐ Amended

PART I: ANNUAL INCOME

1. List all sources of income for the Incapacitated Person:

Does the Incapacitated Person receive any of the following as income?

Social Security Retirement benefits	☐ Yes	☐ No	$
Social Security Disability benefits	☐ Yes	☐ No	$
Supplemental Social Security Income benefits (SSI)	☐ Yes	☐ No	$
Public Assistance	☐ Yes	☐ No	$
Veterans Financial benefits	☐ Yes	☐ No	$
Trust income	☐ Yes	☐ No	$
Wages	☐ Yes	☐ No	$
Workman's Compensation benefits	☐ Yes	☐ No	$
Dividends	☐ Yes	☐ No	$
Interest income	☐ Yes	☐ No	$
Tax refund	☐ Yes	☐ No	$
Realized Gain on Other Asset	☐ Yes	☐ No	$

Does the Incapacitated Person receive any of the following as income?				Amount
Rental Income	☐ Yes	☐ No	$	
Pension	☐ Yes	☐ No	$	
Annuity Income	☐ Yes	☐ No	$	
Other: _____	☐ Yes	☐ No	$	
			TOTAL	$ 0.00

PART II. ASSETS

2. List all personal and real property below. If the property is owned by both the incapacitated person and others, indicate in the last column the name of the co-owner.

Asset	Value	Name of Co-Owner
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
TOTAL	$ 0.00	

3. Is any property co-owned by the Incapacitated Person and the guardian?

☐ Yes

☐ No

If **yes**:

3a. On what date was the property acquired? _____

3b. On what date was the guardian's name added? _____

3c. The guardian is:

☐ an individual having access or control over the account

☐ an owner of the account

4. Does the Incapacitated Person have a homeowners insurance policy for real property?

☐ Yes

☐ No

If **yes**:

4a. Carrier: _____

4b. Coverage period: _____

Attach a copy of insurance policy identifying coverage amounts

5. Does the Incapacitated Person have a homeowners insurance policy for personal property (jewelry, collectibles, etc.)?

☐ Yes

☐ No

If **yes**:

5a. Carrier: _____

5b. Coverage period: _____

Attach a copy of insurance policy identifying coverage amounts

6. Does the Incapacitated Person have an automobile insurance policy?

☐ Yes

☐ No

If **yes**:

6a. Carrier: _____

6b. Coverage period: _____

Attach a copy of insurance policy identifying coverage amounts

7. Does the incapacitated person have a safe deposit box?

☐ No

☐ Yes, in sole name

☐ Yes, in joint names _____

If **yes**:

7a. Location of safe deposit box: _____

7b. Are there plans to inventory the contents?

☐ Yes

☐ No

PART III. LIABILITIES/DEBTS

8. List all debts the Incapacitated Person owes, including mortgages, loans, credit card debt, etc.

Liabilities/Debts	Lender	Value
		$
		$
		$
		$
		$
		$
		$

TOTAL DEBTS: $ 0.00

PART IV. GUARDIAN COVERAGE

9. Was a surety bond required by the decree appointing you as guardian?

☐ Yes

☐ No

If **yes**, attach of copy of the bond

10. If you are a professional guardianship agency or an attorney serving as guardian, do you have professional liability coverage?

☐ Yes

☐ No

Not Applicable

If **yes**, attach copy of insurance policy

PART V. PERSONAL CARE PLAN

11. Reason for incapacity, as stated in the petition:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

12. Can the Incapacitated Person remain in their current residence with assistance, or in the home of a relative?

☐ Yes

☐ No

If **yes**:

12a. List the name of the responsible family member:

_____

12b. What services does the Incapacitated Person require?

☐ Services from local Area Agency on Aging

☐ Private Companion/Assistance Service

Number of days per week: _____

Number of hours per day: _____

☐ Assistance from family members

Will compensation be provided?

☐ Yes

☐ No

If **yes**, indicate compensation amount:

13. Will the Incapacitated Person be moved into a supervised residential setting?

☐ Yes

☐ No

If **yes**:

13a. Indicate the type of supervised residential setting:

☐ Domiciliary Care

☐ Personal Care

☐ Boarding Home

☐ Assisted Living Facility Nursing Home

☐ Other:_____

13b. Describe the steps that are being taken to move the Incapacitated Person into a supervised residential setting?

_____
_____
_____
_____

PART VI. FINANCIAL PLAN

14. Complete the following table using initial inventory or most recent amended inventory.

14a. Total Annual Income (Question 1)	$ 0.00	14b. Annual estimated expenses	
Net Income (14a minus 14b)	$ 0.00	14c. Total assets (principal) (Question 2)	$ 0.00

15. Is the net income listed above sufficient to care for the needs of the Incapacitated Person?

☐ Yes

☐ No, but assets (principal) are available based on petition to court requesting permission

☐ No, and assets (principal) are not available

16. Indicate any applications for government benefits that have been submitted:

Application type	Has an application been submitted?		Date of submission
Social Security Disability Insurance (SSDI)	☐ Yes	☐ No	
Supplemental Security Income (SSI)	☐ Yes	☐ No	
Social Security Retirement Benefits	☐ Yes	☐ No	
Veteran's Benefits	☐ Yes	☐ No	
Medical assistance, long term care	☐ Yes	☐ No	
Medical assistance, Home Waiver	☐ Yes	☐ No	
Other	☐ Yes	☐ No	

17. Describe all real estate included in the estate and how it will be maintained or sold:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

18. Prior to the appointment of a guardian, had an agent under a Power of Attorney been serving?

☐ Yes

☐ No

If **yes**, did that agent access the incapacitated person's property for the agent's personal use?

☐ Yes

☐ No

If **yes**, has an accounting ever been requested or filed with the court?

☐ Yes

☐ No

PART VII: MEDICAL INFORMATION

19. Is a "no-code" (Do Not Resuscitate) provision in place for the incapacitated person?

☐ Yes

☐ No

20. When still capacitated, did the Incapacitated Person execute a durable power of attorney for health care or some other health care directive (including, but not limited to, a POLST or a mental health care power of attorney)?

☐ Yes

☐ No

If **yes**, identify the authorized agent for making health care decisions:

_____

21. Are you aware of any will or trust executed by the Incapacitated Person, and/or any funeral or burial wishes of the Incapacitated Person?

☐ Yes

☐ No

If **yes**, describe:

_____
_____
_____
_____

22. Is the Certificate of Filing attached?

☐ Yes

☐ No

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

Name of Guardian (type or print)

Address

Telephone

Date

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

Name of Co-Guardian (type or print)

Address

Telephone