GUARDIAN'S CARE PLAN/REPORT	Docket No.	Commonwealth of Massachusetts The Trial Court Probate and Family Court

In the Interests of:

_____ First Name _____ Middle Name _____ Last Name

Incapacitated Person

_____ **Division**

INSTRUCTIONS TO GUARDIAN:

Fill this Report out completely, then sign and date on the last page. Attach separate sheets if needed to complete your response to the numbered questions. File original Report with the Court and serve the Incapacitated Person in hand or by certified mail, return receipt requested. Complete the Certificate of Service at the end of this Report.

(Check one box)

Age of Incapacitated Person _____

☐ **INITIAL 60 DAY CARE PLAN**

Your relationship to Incapacitated Person _____

☐ **ANNUAL REPORT**

☐ **OTHER:**

Current Reporting Period From: _____ (date) to _____ (date)

CURRENT CONDITION OF THE INCAPACITATED PERSON

1. Describe the Incapacitated Person's mental, physical, and social condition.

LIVING ARRANGEMENTS

1a. List the name, type of facility and address of each place where the Person currently resides and where the person stayed or resided during the reporting period, and include the dates each stay or residence began and ended.

Dates of Stay or Residency	Address	If facility, list name and type of facility and answer Q1b. below

click to add click to remove

1b. Please explain whether you consider the current living arrangements or habilitation plan and level of care and treatment to be in the Incapacitated Person's best interest.

The Guardian's Care Plan/Report was acknowledged on _____ . **Date**

CONDITIONS AND SERVICES

2. SERVICES PROVIDED TO THE INCAPACITATED PERSON

Describe the medical, educational, vocational and other services provided to the Incapacitated Person during the reporting period.

Do you believe that the current care and services are adequate to meet the Person's needs? ☐ Yes ☐ No

Please explain your opinion about the adequacy of care and services.

3. ANTIPSYCHOTIC MEDICATION

Is the Incapacitated Person taking and/or receiving antipsychotic medication(s)? ☐ Yes ☐ No

If **Yes** and you are also the Court appointed Rogers Monitor, you may attach a **Rogers Monitor Supplemental Report**, in lieu of a Roger's Monitor Report.

4. PROTECTION OF INCAPACITATED PERSON

Have any criminal charges or reports of abuse or neglect involving the Incapacitated Person been filed with a court or agency since the last report? ☐ Yes ☐ No

If **Yes,** please explain:

5. GUARDIAN'S VISITS AND CONTACT WITH CAREGIVERS

Describe the nature and frequency of your visits with the Incapacitated Person, your contact with caregivers and health care providers, and any other activities you undertook on the Incapacitated Person's behalf during the reporting period.

6. INCAPACITATED PERSON'S PARTICIPATION IN DECISION-MAKING

Describe the extent to which the Incapacitated Person did/did not participate in decision-making about personal and health care decisions.

7. LEVEL OF CARE

The Incapacitated Person's care is ☐ very good ☐ good ☐ adequate ☐ poor

FUTURE CARE

8. RECOMMENDED CHANGES

Describe the needs of the Incapacitated Person for a continued guardianship including any recommended changes to the guardianship or the Incapacitated Person's future care.

9. FUTURE ARRANGEMENTS

Describe what residence, services and levels of personal/health care you expect to arrange for the Incapacitated Person during the next 18 months.

FINANCES

10a. Are you a Representative Payee? ☐ Yes ☐ No

10b. Do you hold or receive funds belonging to the Incapacitated Person in your role as Guardian other than as a Representative Payee?

☐ Yes, if the answer is yes, answer question 10c. ☐ No, if the answer is no, skip to question 11.

10c. Is there a Conservator appointed?

☐ Yes, if the answer is yes, skip to question 11. ☐ No, if the answer is no, answer question 10d.

10d. SUMMARY OF FINANCIAL ACTIVITY DURING REPORTING PERIOD

Beginning balance of bank accounts (savings, checking, CDs, money market, etc.)	**$**	
Plus (+) money received from any source on behalf of the Incapacitated Person (Social Security, SSI, pension, disability, interest, etc.)	**+**	
Less (-) total fees to care providers	**-**	
Less (-) total monies paid to the Incapacitated Person (personal needs, etc.)	**-**	
Less (-) total fees paid to the Guardian	**-**	
Less (-) any other expenses (housing, insurance, maintenance, etc.)	**-**	
ENDING BALANCE OF BANK ACCOUNTS $		

It is unlawful for a Guardian to co-mingle personal funds with funds belonging to the Incapacitated Person. All funds of the Incapacitated Person MUST be maintained separately and accounted for in this Summary of Financial Activity.

You are required to maintain supporting documentation for all receipts and payments. The Court or any Interested Persons may request copies at any time.

11. PLEASE ADD ANY ADDITIONAL COMMENTS OR CONCERNS THAT YOU HAVE ABOUT THE INCAPACITATED PERSON OR ABOUT THE GUARDIANSHIP.

Note: If you wish to modify or terminate this Guardianship, you must file a separate Petition with the Court.

VERIFICATION AND ACKNOWLEDGEMENT

I swear or affirm that the statements contained in this Report are accurate and complete, to the best of my knowledge and belief.

Signed under the penalties of perjury _____ .
(date)

Guardian's Signature	Co-Guardian's Signature (if applicable)
Print Name	Print Name
(Address) (Apt, Unit, No. etc.)	(Address) (Apt, Unit, No. etc.)
(City/Town) (State) (Zip)	(City/Town) (State) (Zip)
Primary Phone #:	Primary Phone #:

CERTIFICATE OF SERVICE

I certify that on _____ I provided a copy of this Guardian's Care Plan/Report to the
(date)

Incapacitated Person ☐ in hand or ☐ by certified mail, return receipt requested, at the current address as listed in Section 2 of this Report.

Signature of Guardian or Attorney for Guardian

Print Name

(Address) (Apt, Unit, No. etc.)

(City/Town) (State) (Zip)

Primary Phone #: _____

BBO No.: _____

Reset Form