GUARDIANSHIP OF PERSON CARE PLAN/REPORT INCAPACITATED PERSON	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. 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, indicating the date the Incapacitated Person was served. All personal identifying information in any report attached should be redacted.

(Check one box)

☐ **INITIAL 60 DAY CARE PLAN**

☐ **ANNUAL REPORT**

☐ **COURT ORDERED REPORT**

Dated: _____

1. CASE HISTORY

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

Date Guardianship Entered: _____ (date)

Date Last Report Filed: _____ (date)

2. INCAPACITATED PERSON'S INFORMATION ☐ **Updated Information from last filed Report**

Name: _____ First Name _____ M.I. _____ Last Name

_____ (Address Line 1) _____ (Apt, Unit, No. etc.) _____ (City/Town) _____ (State) _____ (Zip)

Primary Phone #: _____

Type of Residence: ☐ Private ☐ Nursing Home ☐ Assisted Living Home ☐ Other: _____

3. GUARDIAN'S INFORMATION ☐ **Updated Information from last filed Report**

Name: _____ First Name _____ M.I. _____ Last Name

_____ (Address Line 1) _____ (Apt, Unit, No. etc.) _____ (City/Town) _____ (State) _____ (Zip)

Primary Phone #: _____

Co-Guardian's Information (if applicable)

Name: _____ _____ _____
First Name M.I. Last Name

_____ _____ _____ _____ _____
(Address Line 1) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Primary Phone #: _____

click to add

Complete Section 4 only for 60 day Reports. If this is not a 60 day Report, skip Section 4 and proceed to Section 5.

4. INITIAL GUARDIANSHIP PLAN

A. **Does the Incapacitated Person have a Health Care Agent/Proxy?** ☐ Yes ☐ No ☐ Unknown

If **Yes**, who is it?

Name: _____ _____ _____
First Name M.I. Last Name

_____ _____ _____ _____ _____
(Address Line 1) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Primary Phone #: _____

B. **Does the Incapacitated Person have a Power of Attorney?** ☐ Yes ☐ No ☐ Unknown

If **Yes**, who is it?

Name: _____ _____ _____
First Name M.I. Last Name

_____ _____ _____ _____ _____
(Address Line 1) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Primary Phone #: _____

C. **Describe your plans for the Incapacitated Person's future care:**

_____

_____

_____

D. **Explain what steps, if any, you plan to take to improve the Incapacitated Person's ability to make his/her own decisions:**

_____

_____

_____

5. SUMMARY OF REPORT (This section MUST be completed in ALL cases)

A. **Do you recommend that the Guardianship continue?** ☐ Yes ☐ No

If **No**, explain:

_____

_____

_____

B. **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**, explain:

C. **Do you recommend any changes to the Guardianship?** ☐ Yes ☐ No

If **Yes**, explain:

D. **Does the Incapacitated Person have financial resources sufficient to meet their needs?** ☐ Yes ☐ No

Explain:

6. CURRENT CONDITION OF THE INCAPACITATED PERSON (This section MUST be completed in ALL cases)

Describe the Incapacitated Person's mental, physical, and social condition and identify any additional evaluations needed. If a facility or service provider has prepared report(s) of the Incapacitated Person's mental, physical, and social conditions within the past sixty days, a copy of the report(s) may be attached in lieu of filling out the following lines provided the report answers the above question and does not contain privileged information.

7. PLACEMENT AND CARE SUPERVISION (This section MUST be completed in ALL cases)

A. **Has the Incapacitated Person's residence changed since the last report was filed?** ☐ Yes ☐ No
If **Yes**, describe specifics:

B. **Has the Incapacitated Person been admitted to a hospital or facility during the current reporting period?** ☐ Yes ☐ No

If Yes, please identify the date, address and reason for each admission or change of residence in the chart below. In lieu of filling out the chart, you may prepare and attach to this Report a narrative summary of the dates, reasons and results of admission during the reporting period.

Date	Name of Facility and Address	Type of Residence	Reason for Change

click to add

C. **If the Incapacitated Person is currently residing in a hospital/facility, nursing home or assisted living home, please identify a social worker or other staff person with the responsibility for the Incapacitated Person's daily care and treatment.**

Name: _____ Telephone #: _____

Title/Position _____

8. VISITATION WITH THE INCAPACITATED PERSON (This section MUST be completed in ALL cases)

Massachusetts Law requires that a Guardian maintain sufficient contact with the person under guardianship. The following is a summary of the Guardian's visits with and activities on behalf of the Incapacitated Person and the extent to which the Incapacitated Person participated in decision-making.

A. **How often do you currently visit the Incapacitated Person?**

☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____

B. **How often do you plan to visit the Incapacitated Person in the future?**

☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____

C. **How often do you contact the Incapacitated Person or Incapacitated Person's care provider?**

☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____

D. **When was the last time you saw the Incapacitated Person in person?** _____ (date)

Where? _____

E. **How long are the visits and summarize your activities with and on behalf of the Incapacitated Person?**

_____

_____

_____

F. **Does or will the Incapacitated Person participate in decision-making?** ☐ Yes ☐ No

Briefly describe how this happens or how you plan for this to happen:

_____

_____

_____

G. **Describe any other ways in which you keep up-to-date on information and maintain contact with the Incapacitated Person and the Incapacitated Person's care-givers and service-providers:**

_____

_____

_____

9. FINANCIAL MATTERS (This section MUST be completed in ALL cases)

A. **Are there sufficient financial resources under your control or the control of others to take care of the Incapacitated Person?** ☐ Yes ☐ No

If **No**, what do you believe is the best way to handle this problem?

_____

_____

_____

B. **Has a Conservator been appointed?** ☐ Yes ☐ No ☐ Unknown

If **Yes**, who is it?

Name: _____ (First Name) _____ (M.I.) _____ (Last Name)

_____ (Address Line 1) _____ (Apt, Unit, No. etc.) _____ (City/Town) _____ (State) _____ (Zip)

Primary Phone #: _____

C. **Do you have possession or control of the Incapacitated Person's assets, example: property, financial accounts?** ☐ Yes ☐ No

If **Yes**, describe:

_____

_____

_____

D. **Does the Incapacitated Person receive any income?** ☐ Yes ☐ No

If **Yes**, list amount of income, source of income and when income is received:

Source of Income	Date Received	Amount Received
	Total	

click to add

E. **Do you have control over the Incapacitated Person's income?** ☐ Yes ☐ No

If **Yes**, explain:

_____

_____

_____

F. **If applicable, identify the Representative Payee for Social Security and/or other income benefits received by the Incapacitated Person. If you have filed a Representative Payee annual report during the past six months and if you possess or control no other funds of the Incapacitated Person, then you may omit Sections G and H below and instead attach a copy of the Report.**

Name: _____ (First Name) _____ (M.I.) _____ (Last Name)

Primary Phone #: _____

G. **Have any fees been paid to you for your work as Guardian?** ☐ Yes ☐ No

If **Yes**, amount: _____

H. **Have any fees been paid to others for the care of the Incapacitated Person or his/her property?** ☐ Yes ☐ No

If **Yes**, describe the fees and identify name of person(s) receiving fees:

Description of Fee	Name of Person	Amount
	Total	

click to add

I. **Complete this section ONLY if there is no Conservatorship**

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 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.

10. PERSONAL CARE AND OTHER ISSUES (This section MUST be completed in ALL cases)

A. **Describe the medical, educational, vocational and other services provided to the Incapacitated Person. (If the Incapacitated Person's care-providers have a current written care plan that describes these services, you may attach that plan instead of filling out this Question A).**

_____

_____

_____

B. **Describe any additional medical, educational, vocational and other services which you plan to provide to the Incapacitated Person and when you plan to provide them.**

_____

_____

_____

C. **Does the Incapacitated Person receive any services from any state agency (example: Department of Mental Health, Department of Developmental Services, MA Rehabilitation Commission, etc.)?** ☐ Yes ☐ No

If **Yes**, identify the agency. If **No**, describe any plans you have to seek services from a state agency:

D. **Does the Incapacitated Person have a written care plan of any kind?** ☐ Yes ☐ No

If **Yes**, describe and explain your participation and the Incapacitated Person's participation in the development of the plan:

E. **Do you believe the current plan for care, treatment and/or rehabilitation is in the Incapacitated Person's best interest?** ☐ Yes ☐ No

If **No**, describe what changes would be appropriate:

F. **If the Incapacitated Person is institutionalized indicate whether you consider the current treatment or rehabilitation plan to be in the Incapacitated Person's best interest.**

G. **The Incapacitated Person's care is:** ☐ Very Good ☐ Good ☐ Adequate ☐ Poor

H. **Describe your plans for the Incapacitated Person's future care including any recommended changes.**

Please add any 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 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)

CERTIFICATE OF SERVICE

I certify that on _____ I sent 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 address listed in Section 2 of this Report.

_____
Signature of Guardian or Attorney for Guardian

_____
Print Name

_____ _____
(Address Line 1) (Apt, Unit, No. etc.)

_____ _____ _____
(City/Town) (State) (Zip)

Primary Phone #: _____

BBO No.: _____