

PROBATE COURT OF LUCAS COUNTY, OHIO

JACK R. PUFFENBERGER, JUDGE

GUARDIANSHIP OF \_\_\_\_\_

CASE NO. \_\_\_\_\_

GUARDIAN'S REPORT
[R.C. 2111.49 and Sup.R. 66.05(B)(2)]

NOTE: If allotted space is inadequate to respond, write "See Exhibit" in the space and add appropriate exhibit letter sequence, then attach exhibit containing information requested for that space.

1. This is the (check one) 1st, 2nd, 3rd, 4th, 5th, 6th, or \_\_\_\_\_, Guardian's Report.

2. Ward's present address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

3. Ward's living arrangements at the above address are best described as:

[ ] a. His or her own apartment or home (includes assisted living facilities.)

[ ] b. Private home or apartment of:

[ ] (1) the ward's guardian

[ ] (2) a relative of the ward, whose name is \_\_\_\_\_ and relationship is \_\_\_\_\_

[ ] (3) a non-relative whose name is \_\_\_\_\_

[ ] c. A foster, group, or boarding home.

[ ] d. A nursing home.

[ ] e. A medical facility or state institution.

[ ] f. Other (describe) \_\_\_\_\_

g. If c, d, e, or f is checked, complete the following:

[ ] (1) The name of the home, facility, or institution \_\_\_\_\_

[ ] (2) The name of an individual at the home, facility, or institution who has knowledge and is authorized to give information to the court about the ward.

Name \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_

4. The ward will be at the address given in Item 2:

[ ] a. Indefinitely.

[ ] b. Temporarily. The new address and telephone number is:

[ ] (1) Unknown. I will provide this information when known.

[ ] (2) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

CASE NO. \_\_\_\_\_

- 5. Guardian's contact with the ward.
  - a. Approximate number of times the guardian had contact with the ward during the period covered by this report: \_\_\_\_\_
  - b. The nature of those contacts (phone, personal, or other): \_\_\_\_\_  
\_\_\_\_\_
  - c. Date the ward was last seen by the guardian: \_\_\_\_\_
  
- 6. Have you observed any **major** change in the ward's physical or mental condition during the period covered by this report?  Yes  No  
If "yes" is checked, briefly describe the changes. \_\_\_\_\_  
\_\_\_\_\_
  
- 7. The care given to the ward is  Adequate  Not Adequate  
If "Not Adequate" is checked, explain. \_\_\_\_\_  
\_\_\_\_\_
  
- 8. The guardianship should be  Continued  Not Continued  
If "Not Continued" is checked, explain. \_\_\_\_\_  
\_\_\_\_\_
  
- 9. During the period covered by this report, the ward  has  has not been seen by a physician. If the ward has been seen, the last date was \_\_\_\_\_ and for the purpose of \_\_\_\_\_
  
- 10.  I currently serve as the guardian to ten or more wards and certify to the Court that I am unaware of any circumstances that may disqualify me from serving as guardian for this ward.
  
- 11. With regard to the continuing education requirement pursuant to Sup.R. 66.07:
  - I have completed the continuing education requirement. (Attach Certificate of Completion if applicable)
  - The continuing education requirement was waived.

Attached is a statement by a licensed physician, a licensed clinical psychologist, a licensed social worker, or a developmental disability team, that has evaluated or examined the ward within three months prior to the date of this report regarding the need for continuing the guardianship. [R.C. 2111.49(A)(1)(I)](Form 17.1)

If an attorney has been consulted on this report:

Date \_\_\_\_\_

\_\_\_\_\_  
Attorney for Guardian

\_\_\_\_\_  
Guardian's Printed Name

\_\_\_\_\_  
Street

\_\_\_\_\_  
Guardian's Signature

\_\_\_\_\_  
City ~~State~~ State Zip Code

\_\_\_\_\_  
Street

\_\_\_\_\_  
Telephone Number (include area code)

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Attorney Registration No.

\_\_\_\_\_  
Telephone Number (include area code)

**(Knowingly giving false information on a Probate document is a criminal offense)**

**[R.C. 2921.13(A)(11)]**

**PROBATE COURT OF LUCAS COUNTY, OHIO**  
**JACK R. PUFFENBERGER, JUDGE**

**GUARDIANSHIP OF** \_\_\_\_\_

**CASE NO.** \_\_\_\_\_

**ANNUAL GUARDIANSHIP PLAN - PERSON**

[Sup.R. 66.08 (G)]

[Attach as addendum to Form 17.7-Guardian's Report.]

I am the guardian of the for the above-named Ward. I have identified the following goal(s) for the next year and how I intend the goal(s) to be met.

**For the Person**

**Goal** - (for example: address medication issues; obtain assistance devices; secure medical and rehab services; meet mental health service needs; secure personal care services; enhance nutrition; improve social skills, etc.)

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**Means to Meet the Goal** – (for example: educate on benefits of medications and compliance; obtain walker, wheelchair, hearing aid; schedule semi-annual checkups/exams; secure outpatient examinations and mental health counseling; arrange for shopping and/or meals on wheels; enroll in sheltered workshop/socialization programs, etc.)

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[Attach additional pages if necessary]

**CASE NO.**\_\_\_\_\_

\_\_\_\_\_  
Guardian's Printed Name

\_\_\_\_\_  
Guardian's Signature

\_\_\_\_\_  
Street

\_\_\_\_\_  
Telephone Number (include area code)

\_\_\_\_\_  
City                      State                      Zip Code

**PROBATE COURT OF LUCAS COUNTY, OHIO**  
**JACK R.PUFFENBERGER, JUDGE**

**IN THE MATTER OF THE GUARDIANSHIP OF** \_\_\_\_\_

**CASE NO.** \_\_\_\_\_

**STATEMENT OF EXPERT EVALUATION**

[Sup.R. 66 & R.C. 2111.49]

Definition of Incompetent (R.C. 2111.01(D)): "Incompetent" means any person who is so mentally impaired, as a result of a mental or physical illness or disability, as a result of intellectual disability, or as a result of chronic substance abuse, that the person is incapable of taking proper care of the person's self or property or fails to provide for the person's family or other persons for whom the person is charged by law to provide, or any person confined to a correctional institution within this State. The examiner shall complete this statement using personal observations and prior history obtained during the examiners course of treatment / interaction with the individual.

The Statement of Evaluation does not declare the individual competent or incompetent. It is evidence to be considered by the Court. The Probate Court **WILL NOT** pay the fee for completing this evaluation, unless otherwise ordered by the Court. The evaluator should secure payment from the Applicant or Guardian.

1. This Statement of Expert Evaluation is to be filed with or attached to:

A. Guardianship Application: [Evaluation must be completed before the filing of the attached application.]

Evaluation completed by:  Licensed Physician  Licensed Clinical Psychologist

B. Application for Emergency Guardianship:

Evaluation completed by:  Licensed Physician  Licensed Clinical Psychologist

[NOTE: If this Statement relates to an emergency guardianship of the person, a Licensed Physician or a Licensed Clinical Psychologist must complete the Supplement for Emergency Guardian, Form 17.1A, specifying the details of the emergency, and why immediate action is required to prevent significant injury or death to the person. The Supplement must be signed by a Licensed Physician or a Licensed Clinical Psychologist, dated, and attached to this completed Statement.]

C. Guardian's Report: [Evaluation must be conducted within three months before the date of this Report. R.C. 2111.49]

Evaluation completed by:  Licensed Physician  Licensed Clinical Psychologist

Licensed Independent Social Worker  Licensed Professional Clinical Counselor

Developmental Disability Team  Certified Nurse Practitioner  Licensed Clinical Nurse Specialist

2. Statement completed by: (Please print clearly)

Name & Title/Profession: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Telephone Number: \_\_\_\_\_

3. Date(s) of evaluation: \_\_\_\_\_

Place(s) of evaluation: \_\_\_\_\_

Amount of time spent on evaluation: \_\_\_\_\_

Length of time the individual has been your patient: \_\_\_\_\_

Individual's language preference: \_\_\_\_\_

4. Is the individual presently taking medication?  Yes  No If yes, what is the medication, dosage, and purpose? [Continue comments on page 4]

Are there any signs of physical and/or mental impairments caused by the medications themselves? \_\_\_\_\_

5. Is the individual mentally impaired?  Yes  No If yes, indicate the diagnosis below:
- Intellectual or Developmental Disabilities: *(Please check the severity)*
- Profound  Severe  Moderate  Mild
- Mental Illness: Type and Severity \_\_\_\_\_
- Substance Abuse: Description \_\_\_\_\_
- Dementia: Type and Severity \_\_\_\_\_
- Other: Description, Type, and Severity \_\_\_\_\_  
[Continue comments on page 4]

6. During the examination did you notice an impairment of the individual's:
- |                    |                              |                             |                                  |
|--------------------|------------------------------|-----------------------------|----------------------------------|
| a) Orientation     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| b) Speech          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| c) Motor Behavior  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| d) Thought Process | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| e) Affect          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| f) Memory          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| g) Concentration   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| h) Comprehension   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| i) Judgment        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

7. Please describe any impairments identified in question six. [Continue comments on page 4].

8. Is the individual physically impaired? I.e. visual, mobility, hearing, etc.  Yes  No If yes, please describe: \_\_\_\_\_

9. Are there any special characteristics of the individual which should be considered in evaluating the individual for guardianship:  Yes  No If yes, please explain: \_\_\_\_\_

10. Is there any indication of abuse, neglect, or exploitation of the individual?  Yes  No If yes, please explain: \_\_\_\_\_

11. Do you believe the individual is capable of caring for his or her activities of daily living or making decisions concerning his or her own medical treatments, living arrangements, and diet?

Yes  No If no, please explain: \_\_\_\_\_

CASE NO. \_\_\_\_\_

12 Do you believe this individual is capable of managing his or her finances and property?  Yes  No If no, please explain: \_\_\_\_\_

13. What is the recommended living situation for the individual?

- Independent living arrangement
- Assisted living facility or group home
- A nursing home
- A memory care facility or lockdown unit
- Other: \_\_\_\_\_

14. Prognosis of the individual:

- A. Is the condition stabilized?  Yes  No  Unknown
- B. Is the condition reversible:  Yes  No  Unknown

15. In my opinion a guardianship should be:

- If this is a new application for appointment of guardian:  Established  Denied
- If this is an existing guardianship:  Continued  Terminated

I certify that I have evaluated the individual on \_\_\_\_\_, 20\_\_\_\_\_.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Evaluator

\_\_\_\_\_  
Printed Name of Evaluator

### GUARDIAN'S REPORT ADDENDUM

(Not to be used with initial Application)

It is my opinion, based upon a reasonable degree of medical or psychological certainty that the mental capacity of this ward will not improve.

Date \_\_\_\_\_

\_\_\_\_\_  
Signature – Licensed Physician/Clinical Psychologist

\_\_\_\_\_  
Printed Name of Licensed Physician/Clinical Psychologist



# Lucas County Probate Court

700 ADAMS STREET, SUITE 200, TOLEDO, OHIO 43604-5660  
TELEPHONE (419) 213-4775 FACSIMILE (419) 213-4764  
e-mail address – info@lucasprobate.org  
Web Site – www.lucasprobate.org

**JACK R. PUFFENBERGER**  
JUDGE

**SUSAN A. BRAITHWAITE**  
COURT ADMINISTRATOR

**NANCY A. MILLER**  
CHIEF MAGISTRATE



## MAGISTRATES

TREVOR N. FERNANDES  
STEVE CASIERE  
NEDAL N. ADYA  
SUE FREDERICK

Date:

Case Number:

Ward's Name:

Dear:

There is a \$5.00 fee for filing your **Guardian's Report and annual report**. Please return this letter with the **REPORT and annual report**. To obtain these forms, you may either come to the Probate Court or visit our website at [www.lucasprobate.org](http://www.lucasprobate.org).

If the ward or guardian is unable to pay this fee, please indicate below and return this letter to request a filing fee waiver.

Thank You,

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Deputy Clerk

1.  \$5.00 filing fee enclosed
  2.  The ward is on Medicaid and cannot pay the filing fee. Please waive costs.
  3.  The ward or guardian cannot pay and request that the costs be waived because
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\*\*\* Signature required if box 2 or 3 is checked.

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Guardian