

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

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, or 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 Statement of Evaluation does not declare the individual competent or incompetent but is evidence to be considered by the Court. The fee for completing this evaluation WILL NOT be paid by the Probate Court. Each evaluator should secure payment from the Applicant/Guardian.

- 1. This Statement of Expert Evaluation is to be filed with or attached to:
A. Guardianship Application: Completed by [ ] Licensed Physician or [ ] Licensed Clinical Psychologist prior to the filing and attached to the application.
B. Guardian's Report: Completed by [ ] Licensed Physician [ ] Licensed Clinical Psychologist [ ] Licensed Independent Social Worker [ ] Licensed Professional Clinical Counselor or [ ] Intellectual Disability Team.
The evaluation or examination shall be completed within three months prior to the date of the Report. R.C. 2111.49
C. Application for Emergency Guardian: [ ] of the person: a Licensed Physician shall complete the Supplement for Emergency Guardian, form 17.1A with specificity indicating the emergency, and why immediate action is required to prevent significant injury to the person. The Supplement shall be signed, dated, and attached as part of this completed Statement.

2. Statement completed by:
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: \_\_\_\_\_

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

4. Is the individual presently under medication?  Yes  No If yes, what is the medication, dosage, and purpose? \_\_\_\_\_

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 Disability/Developmental Disabilities:  
 Profound  Severe  Moderate  Mild  
 Mental Illness: Type and Severity \_\_\_\_\_

Substance Abuse: Description \_\_\_\_\_

Dementia: Description \_\_\_\_\_

Other: Description \_\_\_\_\_

Please provide additional comments and test scores if available. (Continue comments on page 4): \_\_\_\_\_

6. During the examination did you notice an impairment of the individual's:

- a) Orientation  Yes  No  Unknown
- b) Speech  Yes  No  Unknown
- c) Motor Behavior  Yes  No  Unknown
- d) Thought Process  Yes  No  Unknown
- e) Affect  Yes  No  Unknown
- f) Memory  Yes  No  Unknown
- g) Concentration and comprehension  Yes  No  Unknown
- h) Judgment  Yes  No  Unknown

7. Please describe any impairments identified in question six. (Continue comments on page 4). \_\_\_\_\_

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

8. Is the individual physically impaired?  Yes  No If yes: Description  
\_\_\_\_\_

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

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

11. Do you believe the individual is capable of caring for the individual's activities of daily living or making decisions concerning medical treatments, living arrangements and diet?  Yes  No  
If no: Explain \_\_\_\_\_

12. Do you believe this individual is capable of managing the individual's finances and property?  
 Yes  No If no: Explain  
\_\_\_\_\_

13. Prognosis:  
A. Is the condition stabilized?  Yes  No  
B. Is the condition reversible:  Yes  No

14. In my opinion a guardianship should be:  
 Established/Continued  
 Denied/Terminated

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

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

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

**ADDITIONAL COMMENTS**

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Date \_\_\_\_\_

\_\_\_\_\_  
Signature – 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.lucas-co-probate-ct.org

**JACK R. PUFFENBERGER**  
JUDGE

**SUSAN A. BRAITHWAITE**  
COURT ADMINISTRATOR

**NANCY A. MILLER**  
CHIEF MAGISTRATE



## MAGISTRATES

TREVOR N. FERNANDES  
STEVE CASIERE  
NEDAL N. ADYA  
MARGARET M. WEISENBURGER

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.lucas-co-probate-ct.org](http://www.lucas-co-probate-ct.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,

  
\_\_\_\_\_  
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
- \_\_\_\_\_  
\_\_\_\_\_

\*\*\* Signature required if box 2 or 3 is checked.

\_\_\_\_\_  
Guardian