

IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT, IN AND FOR MIAMI-DADE COUNTY, FLORIDA, PROBATE DIVISION

IN RE: GUARDIANSHIP OF:

Section:

Case Number: YYYYNNNNNN@@02 (@@ = GD, MH or CP)

Guardianship Type:

Amended Form?:

If Yes, version of the Amended Form?:

ANNUAL GUARDIANSHIP PLAN

Plan Period From:

Plan Period To:

Guardianship Inception Date:

Date of Order of Incapacity:

Guardian Name:

Guardian of the person of:

Guardian Type:

Report Type:

submits the following Annual Guardianship Plan for the Ward:

1. The Ward's present location is:

Facility Name / Name of Caregiver with whom the Ward resides:

Facility Type:

Phone Number:

Street Address:

City:

State:

FL

Zip:

2. Prior to the current residence, the Ward lived at the following location(s) during the past year:

#	Facility Name, Address, and Phone Number	Type of Facility	Start Date of Residence	Approximate Ending Date of Residence
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3. A. The guardian states the place and kind of residential setting best suited for the needs of the Ward is:

If "other" was selected from the previous list, please provide an explanation.

Explanation:

B. The guardian will ensure that the above is the best residential setting for the Ward by:

C. The guardian states that every facility where the Ward resided was licensed, if licensing is required by law:

If no, please provide an explanation as to why the Ward resided in a non licensed facility:

Explanation:

4. Care plans were required to be prepared by any facility where the Ward resided during the preceding 12 months:

If yes, the number of care plan meetings the guardian attended or discussed with the facility on the Ward's behalf during the preceding 12 months:

If "0" was answered above, please provide an explanation:

Explanation:

5. The guardian visited the Ward during the preceding 12 months as follows:

Note: Please select all that applies and enter the number of visits.

First three months:

Third three months:

Second three months

Fourth three months:

This applies to each quarter of the plan period for the last 12 months.

6. The following is a description of the medical and/or mental health treatment provided to the Ward during the preceding 12 months:

#	Provider's Name Address, and Phone Number	Type of Provider	Number of Visits
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7. The guardian for the plan period proposes the following as to the provision of medical and rehabilitative services for the Ward:

- Physical Therapy
- Routine examination by Dentist
- Routine examination by Primary Care Physician
- Routine examination by Ophthalmologist
- Routine examination by Specialist Name of Specialist: _____

- Speech Therapy
- Occupational Therapy
- The Ward retains the right to make their own decision
- Other

Explanation required only if "other" checked: _____

8. The guardian for the plan period proposes the following as to the provision of mental health services for the Ward:

- Routine Psych Exam
- On Going Treatment Outpatient
- On Going Treatment Inpatient
- None
- Other

Explanation required only if "other" checked: _____

9. The Ward during the preceding 12 months was prescribed or took the following types of medications:

- Anti-Anxiety
- Anti-Depressant
- Cardiac
- Diabetic
- Memory Enhancement
- Over the counter
- Psychotropic
- Other Prescription

10. The guardian for the plan period proposes the following as to the provision of personal care services for the Ward:

- Care Facility
- Nurses And Aides
- Family And Friends
- Other

Explanation required only if "other" checked: _____

11. The guardian for the plan period proposes the following as to the provision of social recreation for the Ward:

- Care Facility
- Nurses And Aides
- Family And Friends
- Ward Retains Right to Decide
- Other

Explanation required only if "other" checked:

12. A. Baker Act - Was the Ward involuntarily placed or examined during the preceding 12 months under Chapter 394, F.S.?

If yes, the number of times the Ward was involuntarily placed or examined during the preceding 12 months:

B. How the Ward was involuntarily placed in a treatment facility?

13. The guardian provides the following statement as to the social condition of the Ward:

A. The guardian provides the following statement of the social skills of the Ward, including how well the Ward maintains interpersonal relationship with others:

B. The guardian provides the following description of the Ward's activities at communication and visitation:

Explanation required only if "other" checked:

C. The guardian provides the following description of the unmet social needs of the Ward:

Explanation required only if "Unmet Needs" checked:

D. The guardian for the plan period proposes the following as to the provision of social services for the Ward:

- Adult Day Care
- Counseling
- Homemaker/Personal Care
- Home Delivered Meals
- Private Services
- Public Services
- Senior Center
- Sheltered Workshop
- Transportation
- Volunteer Services
- Other

Explanation required only if "other" checked: _____

14. The following activities were undertaken during the preceding 12 months in an effort to increase the capacity of the Ward:

- Encouragement to participate in social/recreational activities
- Occupational Therapy
- Physical Therapy
- Psychiatric Care
- Rehabilitation Services
- Speech Therapy
- Other

Explanation required only if "other" checked:

15. The guardian during the preceding 12 months utilized the following health insurance, accident insurance, private benefits, or governmental benefits available to meet the costs of medical, mental health, or related services:

- Health Maintenance Organization (HMO)
- Institutional Care Program
- Optional State Supplement
- Medicare
- Medicaid
- Pension Social
- Security
- Social Security Disability Income (SSDI)
- Supplemental Insurance
- Supplemental Security Income (SSI)
- Veteran s Administration
- Other

Explanation required only if "other" checked:

16. Can any of the following rights be restored?

**Right To:
Answer**

a. Consent to Medical Treatment

b. Contract

c. Determine Residence

d. Have a Driver's License

e. Make decision about social environment or other aspects of social life

f. Manage Property or make Gift of Disposition

g. Marry

h. Personally apply for Government Benefits

i. Seek or Retain Employment

j. Sue and be Sued

k. Travel

l. Vote

17. If you answered yes to any rights listed in question 16, or if the doctor has indicated on the attached physician's report that a right may be restored - will restoration be sought?

**Right To:
Answer**

a. Consent to Medical Treatment

b. Contract

c. Determine Residence

d. Have a Driver's License

e. Make decision about social environment or other aspects of social life

f. Manage Property or make Gift of Disposition

g. Marry

h. Personally apply for Government Benefits

i. Seek or Retain Employment

j. Sue and be Sued

k. Travel

l. Vote

18. To assist the Court with review of the annual plan to determine if it is in the best interest of the Ward, please provide the following information: a. Please indicate the Ward's ability to engage in activities of daily living or instrumental activities of daily living:

**Right To:
Answer**

i. Administration of Medication

ii. Bathing

iii. Climbing Stairs

iv. Doing Laundry

v. Dressing

vi. Eating

vii. Grooming

viii. Heavy Chores

ix. Light Housekeeping

x. Managing Money

xi. Preparing Meals

xii. Shopping

xiii. Toileting

xiv. Transferring (from wheelchair to chair/bed)

xv. Walking/Mobility

B. The diagnosed mental disabilities of the Ward are:

- Alzheimer's type of dementia
- Autism Spectrum Disorders
- Closed Head Injury
- Dementia
- Depression
- Developmental Disabilities
- Induced by substance abuse
- Schizophrenia or related disorders
- Other

Explanation required only if "other" checked: _____

C. The diagnosed physical disabilities of the ward are:

- Mobility
- Blindness
-

Deafness

- Diabetic
- Parkinson's disease
- Severe arthritis
- Other

Explanation required only if "other" checked: _____

D. The assistive devices used by the Ward are:

- Crutches
- Dentures
- Glasses
- Hearing Aid
- Prosthetics
- Walker/Cane
- Wheelchair
- None
- Other

Explanation required only if "other" checked: _____

E. The plan for the next twelve (12) months for disaster preparedness for the Ward is:

19. The following is a list of all preexisting orders not to resuscitate executed under §401.45(3), Fla. Stat or preexisting advance directives as defined in §765.101, Fla. Stat., concerning the adult ward, discovered during the preceding 12 months.

Orders Not to Resuscitate or Advance Directives

#	Title of Order/Directive	Date of Order/Directive	Suspended by Court (Yes/No)	Steps Taken to Identify and Locate Order/Directive
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20. The following is a listing of the types, sources and total amounts of all remuneration (i.e., payments or other benefits made directly or indirectly, overtly or covertly, or in cash or in kind) received by the guardian for services rendered to or on behalf of the ward.

Remuneration

#	Date of Court Order if any	Type of Remuneration	Source	Amount
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CERTIFICATION AND SIGNATURE OF GUARDIAN(S)

(Check all that apply)

- The recommendations of the examining committee are incorporated into this plan.
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The Ward was declared totally incapacitated.

- The Ward is a minor.
- The guardian has consulted with the Ward, to the extent reasonable, has honored the Ward's wishes, and to the maximum extent possible the plan is in accordance with the Ward's wishes or consistent with the rights retained by the Ward.
- The plan does not restrict the physical liberty of the Ward except as necessary to protect the Ward and others from serious physical injury, illness, or disease.
- The plan provides for the Ward's medical care and mental health treatment.

UNDER PENALTIES OF PERJURY, I declare that I have read and examined the foregoing plan, and the facts alleged are true, to the best of my knowledge and belief.

Guardian

Guardian Signature:

Guardian Name:

Date signed by Guardian:

Guardian Taxpayer Identification #:

Guardian Telephone #:

Guardian's Email Address:

Guardian Mailing Address:

City:

State:

FL

Zip:

Co-Guardian

Co-Guardian Signature:

Co-Guardian Name:

Date signed by Co-Guardian:

Co-Guardian Taxpayer Identification #:

Co-Guardian Telephone #:

Co-Guardian's Email Address:

Co-Guardian Mailing Address:

City:

State:

FL

Zip:

CERTIFICATION AND SIGNATURE OF PREPARER

The preparation of this form is based upon the information provided by the guardian(s) and/or attorney with no independent verification of the information contained herein. I have not audited or reviewed the guardianship plan or documents supporting the preparation of the guardianship plan and, accordingly, do not express an opinion or any other form of assurance as to the accuracy of the information contained in the plan.

Preparer Signature:

Preparer Name:

Date signed by Preparer:

Preparer Taxpayer Identification #:

Preparer Telephone #:

Preparer's Email Address:

Preparer Mailing Address:

City:

State:

FL

Zip:

CERTIFICATION AND SIGNATURE OF GUARDIAN'S ATTORNEY

The undersigned hereby notifies the Court of the filing of the initial guardianship plan of the guardian of the person. This initial plan is the representation of the guardian. I have not audited the accompanying initial guardianship plan. The undersigned attorney represents that he/she has examined the contents of this plan and that it conforms to the requirements of the Florida Guardianship Law.

Attorney Signature:

Attorney Name:

Date signed by Attorney:

Attorney Bar Number:

Attorney Telephone #:

Attorney Fax #:

Attorney's Email Address:

Attorney Mailing Address:

City:

State:

FL

Zip: