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 with a copy in hand, or by certified mail, return receipt requested. Complete the Certificate of Service at the end of this Report.

Age of Incapacitated Person _____ Your relationship to Incapacitated Person _____

Date of Decree of Guardianship: _____

(Check one box)

☐ **INITIAL 60 DAY CARE PLAN**

☐ **ANNUAL REPORT**

CURRENT Reporting Period: from _____ (date) to _____ (date)

CURRENT CONDITION OF THE INCAPACITATED PERSON

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

_____

_____

_____

LIVING ARRANGEMENTS

1a. List the name, address, and type of facility where the Incapacitated Person currently resides or stayed or resided during this reporting period. Include dates indicating when 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. Do you consider the current living arrangements or habilitation plan and level of care and treatment to be in the best interests of the Incapacitated Person? Explain why or why not. Include your opinion about the adequacy of care and services.

LEVEL OF CARE ☐ very good ☐ good ☐ adequate ☐ poor

_____

_____

_____

CONDITIONS AND SERVICES

2. SERVICES PROVIDED TO THE INCAPACITATED PERSON

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

3. ANTIPSYCHOTIC MEDICATION

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

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 this 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.

FUTURE CARE

7. RECOMMENDED CHANGES

Describe the needs of the Incapacitated Person for a continued guardianship. Include any recommended changes and/or limitations to the guardianship.

8. FUTURE ARRANGEMENTS

Describe what residence, services and levels of personal/health care you expect might change for the Incapacitated Person during the next 18 months, if any.

FINANCES

9a. Are you a Representative Payee? ☐ Yes ☐ No

9b. Do you hold or receive funds belonging to the Incapacitated Person in your role as Guardian **other than** as a Representative Payee?

☐ Yes If Yes, answer Question 9c. ☐ No If No, skip to Question 10.

9c. Is there a Conservator appointed?

☐ Yes If Yes, skip to Question 10. ☐ No If No, answer Question 9d.

9d. 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 of this documentation at any time.

10. ADD 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 #: _____

E-mail: _____ | E-mail: _____

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 on page 1 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.: _____

E-mail: _____

(Do Not Write Below This Line-For Court Use Only)

Reviewed by: _____ Date: _____
Justice, Assistant-Register, Assistant-Judicial Case Manager, Judicial Designee

The filed Guardian's Care Plan/Report has been reviewed and

☐ accepted. No further review needed.

☐ needs the following further judicial review:

_____

_____

_____

Further judicial review completed by: _____ Date: _____
Probate and Family Court Judge

☐ Additional orders:

_____

_____

_____

_____

_____

Reset Form