



## GUARDIAN'S CARE PLAN REPORT

Docket No.

**Massachusetts Trial Court  
Probate and Family Court****In the Interests of:****Division**

First Name

MI

Last Name

**Adult (Incapacitated) with a Guardian**

**Instructions:** Answer all the questions below and then date and sign this Care Plan Report. Make a copy(ies) of this report and serve the Adult under guardianship, the attorney (if there is one), and the conservator (if there is one) with the copy by hand or by certified mail. You will then need to file the original Care Plan Report with the completed Certificate of Service with the Court. For more information visit: <https://www.mass.gov/office-of-adult-guardianship-and-conservatorship-oversight-oagco>

1. This is the  **60 Day Report**  **Annual Report** for the reporting period of \_\_\_\_\_ to \_\_\_\_\_ .  
(month/year) (month/year)

2. I am the Adult's:  parent  child  sibling  family member  professional:  
 other: \_\_\_\_\_

3. The Adult's current address: \_\_\_\_\_  
(Street Address, City, State, Zip)

The Adult's current residency type:  private home  foster home  group home  nursing home  hospital  
 assisted living  other: \_\_\_\_\_

4. Did the Adult reside at any other address during this reporting period?  Yes  No

If yes, list the address(es): \_\_\_\_\_  
(Street Address, City, State, Zip)

If yes, list the residency type(s): \_\_\_\_\_  
(residency type)

5. Is the Adult restricted from any of the following in their living arrangements? If yes, explain the reason(s) below.

- a. Having visitors?  Yes  No
- b. Making or receiving telephone calls?  Yes  No
- c. Sending or receiving personal mail or email?  Yes  No
- d. Participating in social activities?  Yes  No

**Reason(s) for restriction(s):** \_\_\_\_\_

6. Rate and explain the Adult's current overall condition.

- a. Mental condition:  excellent  good  fair  poor
- b. Physical condition:  excellent  good  fair  poor
- c. Social condition:  excellent  good  fair  poor

**Explanation Required:** \_\_\_\_\_

7. List and rate the adequacy of the services the Adult receives.

- a. Medical services: \_\_\_\_\_  
Rating of services:  excellent  good  fair  poor
- b. Educational services: \_\_\_\_\_

Rating of services:  excellent  good  fair  poor  not receiving this service

c. Vocational Services: \_\_\_\_\_

Rating of services:  excellent  good  fair  poor  not receiving this service

d. Other services: \_\_\_\_\_

Rating of services:  excellent  good  fair  poor

8. How often did you have contact with the Adult during this reporting period.  daily  weekly  monthly  quarterly

never  other: \_\_\_\_\_

9. Did the Adult participate in any decision making?  Yes (if yes, go to #10)  No (if no, skip to #11)

10. Which of the following decisions did the Adult participate in? (check all that apply)  medical  meals  extracurriculars

clothes  other: \_\_\_\_\_

11. Summarize and rate your interactions and contact with the Adult's health care providers.

\_\_\_\_\_

\_\_\_\_\_

12. Has the Adult been hospitalized, institutionalized, or admitted to a medical facility during this reporting period, or are they now?  Yes  No

If yes, list the location, length of stay, and reason(s) why: \_\_\_\_\_

If yes, is the current/previous treatment or habilitation plan in the Adult's best interest?  Yes  No

13. What are the plans for the future care of the Adult? **Explain.** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. In your opinion, is there a need for the guardianship to continue and/or any changes in the scope of the guardianship?

**Explain:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

15. Have any criminal charges, reports of abuse, or neglect involving the Adult been filed with a court or agency since the last reporting period?  Yes  No If yes, **explain:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

16. Do you hold or control financial funds belonging to the Adult?  Yes  No (skip #17)

17. Are these financial funds because of your role as:  representative payee  conservator  power of attorney

trustee of behalf of the Adult  ABLE Savings Account **OR**

none of the options listed, **explain:** \_\_\_\_\_

Sign your form and complete the Certificate of Service on the next page (page 3).

## **SIGNED UNDER THE PENALTIES OF PERJURY**

I swear or affirm under oath that I have read this Care Plan Report and that the statements contained in it are true and correct to the best of my knowledge and information.

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)

This is an updated/new addresses from my last filing.

This is an updated/new addresses from my last filing.

Primary Phone #: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_

E-mail: \_\_\_\_\_

E-mail: \_\_\_\_\_

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

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

**By providing my telephone number, I consent to receive text message communications and notifications from the above Probate and Family Court.**

**By providing my telephone number, I consent to receive text message communications and notifications from the above Probate and Family Court.**

## **CERTIFICATE OF SERVICE**

I certify that on \_\_\_\_\_ I provided a copy of this Guardian's Care Plan Report to:

**the Adult:**  by handing it to them    **OR**     by mailing it to their address listed in Question 3.

**the Attorney for the Adult, if any:**  by handing it to them    **OR**     by mailing it to their primary business address    **OR**  
 by e-mailing to their primary business e-mail address.

**the Conservator for the Adult, if any:**  by handing it to them    **OR**     by mailing it to the address they provided to the court

Signature of Guardian(s) or Attorney for Guardian(s)

Print Name

(Address)

(Apt, Unit, No. etc.)

(City/Town)

(State)

(Zip)

Primary Phone #: \_\_\_\_\_

BBO No: \_\_\_\_\_

E-mail: \_\_\_\_\_