



GUARDIAN'S CARE PLAN REPORT

Docket No. _____

**Massachusetts Trial Court
Probate and Family Court**

In the Interests of:

First Name

MI

Last Name

Division

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 _____

Print Name

(Address)

(Apt, Unit, No. etc.)

(City/Town)

(State)

(Zip)

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

Primary Phone #: _____

E-mail: _____

Date: _____

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

Co-Guardian's Signature (if applicable) _____

Print Name

(Address)

(Apt, Unit, No. etc.)

(City/Town)

(State)

(Zip)

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

Primary Phone #: _____

E-mail: _____

Date: _____

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:
(date)

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: _____