Variable #	0	1	2	3	4	5	6
FORMS - FREE TEXT	Docket #	Division*	Resp First Name	Resp Middle Name	Resp Last Name	Age of Respondent	Resp current street address
MOTION TO EXTEND AND/OR AMEND TREATMENT ORDER	1	1	1	1	1		
GUARDIAN'S CARE PLAN/REPORT	1	1	1	1	1	1	
REPORT OF MONITOR	1	1	1	1	1		1
TREATMENT PLAN	1	1	1	1	1		
TOTAL (status quo)	4	4	4	4	4	1	1
TOTAL (Rogers Review Assistant)	1	1	1	1	1	1	1

*division list
**must be able to add multiple w/in reporting period
***only answer if facility
ALL concern reporting period

7	8	9	10	11	12	13	14
Resp Apt, Unit, No, etc.	Resp City/Town	Resp Zip	Resp State	Resp current residency is Comm Res, DDS, DMH, Nursing, Private home, Other (check)	**LIVING ARRANGEMENTS: Date of Stay or Residency	**LIVING ARRANGEMENTS: Address	**LIVING ARRANGEMENTS: if facility--name and type of facility
					1	1	1
	1	1	1	1	1		
	1	1	1	1	1	1	1
	1	1	1	1	1	1	1

15	16	17	18	19	20	21	22	23
***LIVING ARRANGEMENTS: Best int of Respondent. Why?	Moving Party's First Name	Moving Party's Middle Name	Moving Party's Last Name	Moving Party's Street Address	Moving Party's Apt, Unit, No, etc.	Moving Party's City/Town	Moving Party's State	Moving Party's Zip
		1	1	1	1	1	1	1	1
1		1	1	1	1	1	1	1	1
1		2	2	2	2	2	2	2	2
1		1	1	1	1	1	1	1	1

24	25	26	27	28	29	30	31
Moving Party's Primary Phone No.	Movant (Guardian) e-mail	Moving Party's Relationship to Respondent	Co-Guard Party's First Name	Co-Guard Middle Name	Co-Guard Last Name	Co-Guard Street Address	Co-Guard Apt, Unit, No, etc.
	1						
	1	1	1	1	1	1	1
	2	1	1	1	1	1	1
	1	1	1	1	1	1	1

32	33	34	35	36	37	38
Co-Guard City/Town	Co-Guard State	Co-Guard Zip	Co-Guard Primary Phone No.	co-guard email	Monitor gaurdian (y /n)	Monitor conservator (y /n)
	1	1	1	1	1	
						1
	1	1	1	1	1	1
	1	1	1	1	1	1

39	40	41	42	43	44	45	46	47	48
Monitor Party's First Name	Monitor Middle Name	Monitor Last Name	Monitor Street Address	Monitor Apt, Unit, No, etc.	Monitor City/Town	Monitor State	Monitor Party's Zip	Monitor Primary Phone No.	Monitor Relationship to Resp
1	1	1	1	1	1	1	1	1	1
1	1	1	1	1	1	1	1	1	1
1	1	1	1	1	1	1	1	1	1

49	50	51	52	53	54	55	56	57	58
Monitor Appointed date	Date Court Approved Previous Treatment Plan on	Previous Treatment Plan Expires on	Date of Decree of Guardianship	Current Reportng Period: Last Review Date	Current Reportng Period: This Review Date	Extend or Amend Treatment	60 day care plan or Annual Report	Date Monitor last met w/ Resp	Specific discussing w/ Resp by Monitor
		1	1				1		
				1	1	1		1	
	1	1							1	1
	1	2	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1	1	1

59	60	61	62	63	64	65	66	67	68
Date of Monitor's last review Resp med rec, Treatment Plan	Antipsych Meds (Y/N)	**Antipsych meds	**Antipsych med dosage	**Antipsych med dose range	**Alternative Antipsych meds	**Alternative antipsych med dose range	Resp antipsych med in compliance w/ order (y / n - CC)	Non-compliance, explain	Describe Respondent's current mental, physical, and social condition
		1							1
1			1	1			1	1	
			1	1	1	1	1		
1	1	2	2	1	1	1	1	1	1
1	1	1	1	1	1	1	1	1	1

69	70	71	72	73
Services Provided to Respondent (med, edu, vocation, other)	Monitor has discussed Resp present status and treatment w/ treating clinician (Y - CJ / N - CL)	What was discussed; in person or phone; when	Date effor made to contact clinician; clinicians progress notes reviewed	Monitor has discussed Resp present status and treatment w/ residential or day program staff (specifics of convo, who, inperson or phone, dates)
1				
	1	1	1	1
1	1	1	1	1
1	1	1	1	1

74	75	76	77
Crim charges/reports of abuse/neglect invovling Respondent filled in ct/admin (y - explain/n)	**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.**	**Describe the extent to which the Incapacitated Person did/did not participate in decision-making about personal and health care decisions.**	**Describe the needs of the Incapacitated Person for a continued guardianship. Include any recommended changes and/or limitations to the guardianship.**
1	1	1	1
1	1	1	1
1	1	1	1

78	79	80	81	82	83
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.	Are you a Representative Payee (y/n)	Hold/receive funds belonging to Resp in Guardian role (not as payee) (y-AM / n - AO)	Conservator appointed? (y - AN / n - AO)	FIN ACTIVITY: Beginning Balance	FIN ACTIVITY: Money received
1	1	1	1	1	1
1	1	1	1	1	1
1	1	1	1	1	1

84	85	86	87	88	89	
FIN ACTIVITY: Care provider fees	FIN ACTIVITY: Money to Resp	FIN ACTIVITY: Guardian Fees	FIN ACTIVITY: Other Expenses	FIN ACTIVITY: End Balance (AN + AO - AP - AQ - AR -AS)	Comments/concerns about Resp or Guardianship	TOTAL
						17
1	1	1	1	1	1	54
						36
						10
1	1	1	1	1	1	117
1	1	1	1	1	1	90