COURT OF COMMON PLEAS COUNTY, PENNSYLVANIA ORPHANS' COURT DIVISION

REPORT OF GUARDIAN OF THE PERSON

Estate of:	_, an Incapacitated Person
Name of Incapacitated Person	
Case File No:	_
DATE COURT APPOINTED YOU AS GUARDIAN:	
PART I. INTRODUCTION	
1. Name(s) of Guardian(s):	
2. Is this a limited Guardianship? Yes No	
3. Report Period	
This is the Report for the period from	to
(the "Report Period"); or	
This is the Final Report for the period from	to
(the "Report Period") and is filed	for the following reason:
The death of the Incapacitated Person.	
Date of Death:	
Name of Executor/Administrator:	
The Guardianship was terminated by a court order dated:	
Transfer of Guardianship to:	
Date of court order approving transfer:	

IF THIS IS A FINAL REPORT, ONLY COMPLETE PARTS I AND V.

PART II. PERSONAL INFORMATION ABOUT THE INCAPACITATED PERSON

1.	Incapacitated Person's date of birth:	<u></u>
2.	Incapacitated Person's Current Resi	dence:
3.	Residence of the Incapacitated Pers	on
	_	with part-time home health care aide or 24/7 assistance)
	Your home	
	Relative's home	
	Relative's Name:	Relationship:
	Domiciliary Care Facility Name:	
	Personal Care Boarding Home Facility Name:	
	Is this a Memory Support Facil	lity? Yes No
	Assisted Living Facility	
	Facility Name:	
	Is this a Memory Support Facil	lity? Yes No
	Nursing Home Facility Facility Name:	
	Is this a Memory Support Facil	lity? Yes No
	Other:	
4.	The Incapacitated Person has been in	in the residence noted in question 3 since:
5.	Has the Incapacitated Person moved	d during the Report Period?
	Yes	
	No	
	If yes , date of move:	
	If yes , please provide:	
	Reason for move:	
	Previous residence/address:	

PART III. MEDICAL INFORMATION

1. List the medical professionals who have seen the Incapacitated Person during the **Report Period**: Name **Medical Doctor Dentist Eye Doctor Ear Doctor Psychologist or Psychiatrist Physical Therapist Occupational Therapist Social Worker** Geriatric Caseworker Other 2. The major medical or psychiatric problems of the Incapacitated Person are as follows: 3. Describe any social, medical, psychological and support services the Incapacitated Person is receiving: 4. Has the Incapacitated Person been hospitalized during the **Report Period**? Yes No If **yes**, date(s) of hospitalization: 5. Has the Incapacitated Person received a mental health assessment during the **Report Period**? Yes No If **yes**, date(s) of evaluation:

PART IV. GUARDIAN'S OPINION
1. Should the guardianship be:
Continued
Continued with modifications
Terminated
2. Provide the reasons for your opinion. List specific recommended modifications.
2. Trovide the reasons for your opinion. Dist specific recommended modifications.
3. Have you filed a petition for modification or termination?
Yes
No
PART V. INFORMATION ABOUT THE GUARDIAN
1. On average, how often did you visit the Incapacitated Person during the Report Period ?
I live with the Incapacitated Person
None
Quarterly
Monthly
Weekly
Daily
2. What is the average length of a visit?
Less than 15 minutes
Between 15 minutes and 1 hour
Between 1 and 2 hours
More than 2 hours
Not applicable
3. Have you maintained a log of your activities as guardian?
Yes - Attach a copy
No

4. During this Report Period Yes	, did any guar	dian particip	ate in guardianship training	g?				
No								
If yes , provide the following	g information	:						
Guardian Name	Dates of Training		Provider	Training Description				
	Starting	Ending						
S. During this Report Period , was any guardian charged with or convicted of a crime? Yes - Please describe Guardian Name Description Description								
During this Report Period , was a Protection from Abuse Order or Protection from Sexual Violence or Intimidation Order entered against any guardian?								
Yes - Please describe	Yes - Please describe No							
Guardian Name L	Description							
7. Is there any reason any guardian cannot continue to serve as guardian?								
Yes - Please describe	No							
Guardian Name L	Description							

this verification is subject to the penalties of 18 Pa.C.S. §4904 relative to unsworn falsification to authorities. Effective June 1, 2019, I further acknowledge the Notice of Filing must be served within 10 days of the filing of this report pursuant to Pa. O.C. Rule 14.8(b). Signature of Guardian of the Person Date Name of Guardian of the Person (type or print) Address City, State, Zip Home Phone Number Office Phone Number Cell Phone Number **Email** Signature of Co-Guardian of the Person Date Name of Co-Guardian of the Person (type or print) Address City, State, Zip Home Phone Number Office Phone Number Cell Phone Number **Email**

I verify that the foregoing information is correct to the best of my knowledge, information and belief; and that