COURT OF COMMON PLEAS OF

ORPHANS' COURT DIVISION

To _____:

IMPORTANT NOTICE
CITATION WITH NOTICE

A Petition has been filed with this Court to have you declared an Incapacitated Person. If the Court finds you to be an Incapacitated Person, your rights will be affected, including your right to manage money and property and to make decisions. A copy of the Petition which has been filed by _____is attached.

You are hereby ordered to appear at a hearing to be held in Courtroom No. _____, _____, Pennsylvania on _____, 2_____ at _____ __.m. to tell the Court why it should not find you to be an Incapacitated Person and appoint a Guardian to act on your behalf.

To be an Incapacitated Person means that you are not able to receive and effectively evaluate information and communicate decisions and that you are unable to manage your money and/or other property, or to make necessary decisions about where you will live, what medical care you will get, or how your money will be spent.

At the hearing, you have the right to appear, to be represented by an attorney, and to request a jury trial. If you do not have an attorney, you have the right to request the Court to appoint an attorney to represent you and to have the attorney's fees paid for you if you cannot afford to pay them yourself. You also have the right to request that the Court order that an independent evaluation be conducted as to your alleged incapacity.

If the Court decides that you are an Incapacitated Person, the Court may appoint a Guardian for you, based on the nature of any condition or disability and your capacity to make and communicate decisions. The Guardian will be of your person and/or your money and other property and will have either limited or full powers to act for you.

To: _____:

If the Court finds you are totally incapacitated, your legal rights will be affected and you will not be able to make a contract or gift of your money or other property. If the Court finds that you are partially incapacitated, your legal rights will also be limited as directed by the Court.

If you do not appear at the hearing (either in person or by an attorney representing you), the Court will still hold the hearing in your absence and may appoint the Guardian requested.

By: _____
Orphans' Court Clerk

COURT OF COMMON PLEAS
_____ COUNTY, PENNSYLVANIA
ORPHANS' COURT DIVISION

REPORT OF GUARDIAN OF THE ESTATE

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: _____

PART II. INCOME

1. List all sources of income received during the **Report Period:**

Did the Incapacitated Person receive any of the following?		Amount During **Report Period**
Alimony or Support	☐ Yes ☐ No	
Annuity Payments	☐ Yes ☐ No	
Dividends	☐ Yes ☐ No	
Interest Income	☐ Yes ☐ No	
IRA Distributions	☐ Yes ☐ No	
Long Term Care Insurance Benefits	☐ Yes ☐ No	
Pension/Retirement Benefits (for example: 401(k), 403(b), etc.)	☐ Yes ☐ No	
Public Assistance	☐ Yes ☐ No	
Rental Property Income	☐ Yes ☐ No	
Royalties (including from mineral and land rights)	☐ Yes ☐ No	
Social Security Benefits (Retirement, Disability, SSI)	☐ Yes ☐ No	
Tax Refund	☐ Yes ☐ No	
Trust Income	☐ Yes ☐ No	
Veterans Benefits (disability/pension/aid and attendance)	☐ Yes ☐ No	
Wages	☐ Yes ☐ No	
Worker's Compensation Benefits	☐ Yes ☐ No	
Other	☐ Yes ☐ No	
	TOTAL	0

PART III. ANNUAL EXPENSES

1. List all payments made for the care and maintenance of the Incapacitated Person during the **Report Period**.

Expense	To Whom Was It Paid?	Total for **Report Period**
Auto Insurance		
Cable/Satellite/Internet		
Child/Spousal Support/Alimony		
Clothing		
Condo/Co-op Assessments		
Debt (incurred prior to your appointment)		
Entertainment		
Fees/Costs Paid to Guardian		
Food		
Gifts - Personal or Charitable		
Home Health Care/Personal Aide		
Homeowners Insurance		
Home/Property Maintenance & Repair		
Income Taxes		
Life Insurance Premiums		
Medical Insurance Premiums		
Medical Expenses		
Medicine		
Mortgage		
Nursing Home/Assisted Living/Institutionalized Care		
Personal Expenses (including allowance)		
Phone/Cell Phone		
Real Estate Taxes		
Rent		
Utilities		
Other		
	TOTAL	0

2. Does the Incapacitated Person have a credit card(s)? ☐ Yes ☐ No

   If **yes**, has it been used during this report period? ☐ Yes ☐ No

   What is the current balance on the credit card(s)? _____

PART IV. COMPARING INCOME AND EXPENSES

1. Total Income (Part II, Question 1 TOTAL): 0
2. Unspent Income from Previous Year (Part IV, Question 5 from Last Year's Report): _____
3. Add lines 1 and 2 together to calculate this year's TOTAL INCOME: 0
4. Total Expense (Part III, Question 1 TOTAL): 0
5. Subtract line 4 from line 3.
   If amount is positive, enter it here to show UNSPENT INCOME, otherwise enter $0: 0
6. Subtract line 4 from line 3.
   If amount is negative, enter it here to show PRINCIPAL SPENT, otherwise enter $0: 0
7. Is line 6, PRINCIPAL SPENT, greater than $0?

   ☐ Yes

   ☐ No

   If **yes,** was a court order obtained?

   ☐ Yes - Date of Court Order: _____

   ☐ No - Explain why court approval was not obtained:

   _____

   _____

   _____

PART V. ASSETS

1. What was the value of the assets reported on the Inventory? _____
2. List any additional assets received during the **Report Period** (for example: gifts, inheritance, burial account, lawsuit recovery, etc.)

Description/Source	Value at the end of **Report Period**
TOTAL	0

3. Where are **all** the assets deposited or held at the end of the **Report Period**?

List of Assets: Type and Location	Co-Owners	Value at the end of **Report Period**
	TOTAL	0

4. Does the incapacitated person own a house/condo/co-op?

☐ Yes - Answer Questions a - e ☐ No

a. Address of property: _____

b. Does the Incapacitated Person live in the house/condo/co-op? ☐ Yes ☐ No

c. If purchased during the **Report Period**, what was the purchase price? _____

d. If real property was sold during the **Report Period**, what was the sale price? _____

e. Was a court order obtained if property was purchased or sold?

☐ Yes - Date of Court Order: _____

☐ No - Explain why court approval was not obtained:

_____

_____

_____

5. List any assets transferred to a third party such as a spouse or child.

Asset	**Transferred To**	**Relationship to IP**	**Amount**	**Order Date or Reason Not Approved**

PART VI. GUARDIAN'S COMPENSATION

1. Did the Guardian receive compensation during the **Report Period**?

☐ Yes - Complete the table below ☐ No - Skip to Question 3

Amount	Guardian Name	Is Amount Based on Hourly, Monthly or Annual Fee?

2. Was the compensation approved by the court?

☐ Yes - Date of Court Order: _____

☐ No - Explain why court approval was not obtained:

_____

_____

_____

3. Have you maintained a log of your activities as guardian?

☐ Yes - Attach a copy ☐ No

PART VII. ATTORNEY'S FEES

1. Were attorney's fees paid during the **Report Period?**

☐ Yes - Complete the table below ☐ No - Skip to Part VIII

Amount	Name of Counsel	Hourly Rate	# of Hours	Order Date or Reason Not Approved

PART VIII. REPRESENTATIVE PAYEE

1a. Social Security Administration (SSA) Benefits

☐ The Incapacitated Person does not receive SSA benefits.

☐ The Guardian acts as the representative payee - attach a copy of the report provided to the SSA during this **Report Period.**

☐ The Guardian is not the representative payee for SSA benefits. The payee is_____.

1b. Veterans Administration (VA) Benefits

☐ The Incapacitated Person does not receive VA benefits.

☐ The Guardian acts as the representative payee - attach a copy of the report provided to the VA during this **Report Period**.

☐ The Guardian is not the representative payee for VA benefits. The payee is _____.

PART IX. SURETY INFORMATION

1. Was a surety bond required?

☐ Yes - In what amount _____ - and then answer Questions a - b.

☐ No - The court waived a surety bond, skip to Question 2.

a. Is the surety bond still in effect?

☐ Yes

☐ No - Provide an explanation as to why not.

_____

_____

_____

b. Is the value of the estate at the end of the **Report Period** greater than the amount reported at the end of the prior report period?

☐ Yes

☐ No

If **yes**, has the amount of the surety bond been increased?

☐ Yes. To what amount: _____

☐ No

2. If you are a professional guardian, agency or an attorney serving as guardian, do you have professional/guardian liability insurance that covers theft?

☐ Yes - Answer Question a and b.

☐ No - Skip to Part X.

☐ N/A

a. Are the coverage limits greater than the assets (Part V, Question 3)?

☐ Yes

☐ No

b. Describe the deductible and any exclusions.

_____

_____

_____

PART X. GUARDIAN INFORMATION

1. During this **Report Period**, did any guardian participate in guardianship training?

☐ Yes
☐ No

If yes, provide the following information:

Guardian Name	Dates of Training Starting	Ending	Provider	Training Description

2. During this **Report Period**, have any judgments been filed against any guardian, or has any guardian filed for bankruptcy protection?

☐ Yes - Please describe ☐ No

Guardian Name *Description*

3. During this **Report Period**, was any guardian charged with or convicted of a crime?

☐ Yes - Please describe ☐ No

Guardian Name *Description*

4. Is there any reason any guardian cannot continue to serve as guardian?

☐ Yes - Please describe ☐ No

Guardian Name *Description*

PART XI. SUMMARY

1.	If this is the first annual report, state the value of the assets reported on the Inventory. (Use amount from Part V, Question 1 of *this* Report.) (principal)	
2.	If this is not the first annual report, state the Total Assets (principal) from the prior Report. (Use TOTAL amount from Part V, Question 3 of *prior* Report.)	
3.	What was the total income received during the **Report Period**? (Use the amount from Part IV, Question 3 of *this* Report.)	0
4.	What is the total amount of Expenses paid during the **Report Period**? (Use the amount from Part III, Question 1 of *this* Report.)	0
5.	What are the Total Assets remaining at the end of the **Report Period**? (Use the amount from Part V, Question 3 of *this* Annual Report.)	0
6.	What is the Unspent Income at the end of the **Report Period**? (Use the amount from Part IV, Question 5 of *this* Report.)	0

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

Date

Signature of Guardian of the Estate

Name of Guardian of the Estate (type or print)

Address

City, State, Zip

Home Phone Number

Office Phone Number

Cell Phone Number

Email

Date

Signature of Co-Guardian of the Estate

Name of Co-Guardian of the Estate (type or print)

Address

City, State, Zip

Home Phone Number

Office Phone Number

Email

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: _____/_____/_____

2. Incapacitated Person's Current Residence:

   _____
   _____
   _____

3. Residence of the Incapacitated Person

   ☐ Incapacitated Person's home (☐ 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 Facility? ☐ Yes ☐ No

   ☐ Assisted Living Facility
   Facility Name: _____
   Is this a Memory Support Facility? ☐ Yes ☐ No

   ☐ Nursing Home Facility
   Facility Name: _____
   Is this a Memory Support Facility? ☐ Yes ☐ No

   ☐ Other: _____

4. The Incapacitated Person has been in the residence noted in question 3 since: _____

5. Has the Incapacitated Person moved 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.

   _____

   _____
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**, did any guardian participate in guardianship training?

☐ Yes

☐ No

If **yes**, provide the following information:

Guardian Name	Dates of Training		Provider	Training Description
	Starting	Ending		

5. During this **Report Period**, was any guardian charged with or convicted of a crime?

☐ Yes - Please describe ☐ No

Guardian Name *Description*

_____ _____

_____ _____

6. 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 ☐ No

Guardian Name *Description*

_____ _____

_____ _____

7. Is there any reason any guardian cannot continue to serve as guardian?

☐ Yes - Please describe ☐ No

Guardian Name *Description*

_____ _____

_____ _____

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

Date

Signature of Guardian of the Person

Name of Guardian of the Person (type or print)

Address

City, State, Zip

Home Phone Number

Office Phone Number

Cell Phone Number

Email

Date

Signature of Co-Guardian of the Person

Name of Co-Guardian of the Person (type or print)

Address

City, State, Zip

Home Phone Number

Office Phone Number

Cell Phone Number

Email

COURT OF COMMON PLEAS OF _____ COUNTY, PENNSYLVANIA

ORPHANS' COURT DIVISION

GUARDIAN'S INVENTORY FOR A MINOR

Estate of _____, } a Minor

No._____

1. **Real Estate: (Location, by whom occupied and rental terms, if applicable)**	**Estimated Value:**
Sub-Total for Real Estate:	

2. **Personal Property:**	**Estimated Value:**

3. **Jointly Held Property:** *(Set forth real and personal property owned by the Minor JOINTLY with any other person(s). State whether held as tenants by the entireties; if not, whether the right of survivorship exists.)* ***Jointly Held Property***	**Estimated Value:**

Estate of _____,} a Minor

4. Anticipated Assets: **Estimated Value:**

(Set forth property of any kind expected to be acquired hereafter, together with anticipated date of acquisition.)

Property	***Anticipated Date of Acquisition***	
_____		_____
_____		_____
_____		_____
	Sub-Total for Personal Estate:	_____

Attach Additional Sheets if necessary

TOTAL OF ITEMS 1, 2, 3, and 4: . . . . . _____

Commonwealth of Pennsylvania :
: ss.
County of _____ :

_____, says that the foregoing is a full, true and complete
Guardian
Inventory of the Estate of _____ , a Minor; and that all of the information set forth herein is true and correct to the best of the Guardian's knowledge and belief.

I verify that the statements made in this Inventory are true and correct. I understand that false statements herein are made subject to the penalties of 18 Pa.C.S. § 4904 relating to unsworn falsification to authorities.

_____
Guardian Signature

Attorney for Guardian: _____

Supreme Court I.D. No.: _____

Address: _____

_____

Telephone: _____

COURT OF COMMON PLEAS
_____ COUNTY, PENNSYLVANIA
ORPHANS' COURT DIVISION

GUARDIAN'S INVENTORY FOR AN INCAPACITATED PERSON

Estate of: _____, an Incapacitated Person
Name of Incapacitated Person

Case File No: _____

DATE COURT APPOINTED YOU AS GUARDIAN: _____

PART I: INTRODUCTION

Inventory type:

☐ Initial
☐ Amended

PART II: ASSETS (PRINCIPAL)

1. List all bank accounts, real estate, burial accounts, and other personal property below. If the property is owned by both the incapacitated person and others, indicate in the last column the name of the co-owner.

Asset	Value	Name of Co-Owner(s)
TOTAL	$ 0.00	

2. Is any property (specifically bank accounts or real estate) co-owned by the Incapacitated Person and the guardian?

☐ Yes

☐ No

If **yes:**

a. On what date was the property acquired? _____

b. On what date was the guardian's name added? _____

c. The guardian is:

☐ an individual having access or control over the account

☐ an owner of the account

3. Does the Incapacitated Person have a homeowners insurance policy for real property?

☐ Yes (Copy of policy to be provided upon request)

☐ No

If **yes:**

a. Carrier: _____

b. Coverage period: _____

4. Does the Incapacitated Person have an automobile insurance policy?

☐ Yes (Copy of policy to be provided upon request)

☐ No

If **yes:**

a. Carrier: _____

b. Coverage period: _____

5. Does the Incapacitated Person have a safe deposit box?

☐ No

☐ Yes, in sole name

☐ Yes, in joint name(s). List the name(s) of joint owner(s): _____

If **yes:**

a. Location of safe deposit box: _____

b. Are there plans to inventory the contents?

☐ Yes

☐ No

PART III: ANNUAL INCOME

1. List all sources of income for the Incapacitated Person:

Does the Incapacitated Person receive any of the following as income?		Specify Amount
Alimony or Support	☐ Yes ☐ No	
Annuity Payments	☐ Yes ☐ No	
Dividends	☐ Yes ☐ No	
Interest Income	☐ Yes ☐ No	
IRA Distributions	☐ Yes ☐ No	
Long Term Care Insurance Benefits	☐ Yes ☐ No	
Pension/Retirement Benefits (for example: 401(k), 403(b), etc.)	☐ Yes ☐ No	
Public Assistance	☐ Yes ☐ No	
Rental Property Income	☐ Yes ☐ No	
Royalties (including from mineral and land rights)	☐ Yes ☐ No	
Social Security Benefits (Retirement, Disability, SSI)	☐ Yes ☐ No	
Tax Refund	☐ Yes ☐ No	
Trust Income	☐ Yes ☐ No	
Veterans Benefits (disability/pension/aid and attendance)	☐ Yes ☐ No	
Wages	☐ Yes ☐ No	
Workers' Compensation Benefits	☐ Yes ☐ No	
Other	☐ Yes ☐ No	
	TOTAL	$0.00

PART IV: LIABILITIES/DEBTS

1. List all debts the Incapacitated Person owes, including mortgages, loans, credit card debt, etc.

Liabilities/Debts	Lender	Value
	TOTAL DEBTS:	$ 0.00

PART V: GUARDIAN COVERAGE

1. Was a surety bond required by the decree appointing you as guardian?

   ☐ Yes (Please attach a copy of the bond)

   ☐ No

2. Are you a professional guardianship agency or an attorney serving as a guardian?

   ☐ Yes

   ☐ No

   If **yes**, do you have professional liability coverage?

   ☐ Yes (Please attach a copy of the insurance policy)

   ☐ No

   If **no**, explain: _____

PART VI: PERSONAL CARE PLAN

1. Can the Incapacitated Person remain in his or her current residence with assistance, or in the home of a relative?

☐ Yes
☐ No
☐ N/A - The Incapacitated Person is already in a supervised residential setting.

If **yes**:

a. List the name of the responsible family member:

_____

b. What services does the Incapacitated Person require?

☐ Services from local Area Agency on Aging

☐ Private Companion/Assistance Service

Number of days per week: _____

Number of hours per week: _____

☐ Assistance from family members

Will compensation be provided?

☐ Yes
☐ No

If **yes**, indicate compensation amount: _____

2. Will the Incapacitated Person be moved into a supervised residential setting?

☐ Yes
☐ No
☐ N/A - The Incapacitated Person is already in a supervised residential setting.

If **yes**:

a. Indicate the type of supervised residential setting:

☐ Domiciliary Care
☐ Personal Care
☐ Boarding Home / Group Home
☐ Assisted Living Facility
☐ Nursing Home
☐ Other: _____

b. Describe the steps that are being taken to move the Incapacitated Person into a supervised residential setting.

_____
_____
_____
_____

PART VII: FINANCIAL PLAN

1. Complete the following table using initial inventory or most recent amended inventory.

a. Total Annual Income (Part III, Question 1) $ 0.00

b. Annual estimated expenses _____

c. Net Income (a minus b) $ 0.00

d. Total assets (principal) (Part II, Question 1) $ 0.00

2. Is the net income listed above sufficient to care for the needs of the Incapacitated Person?

- ☐ Yes
- ☐ No, but assets (principal) are available if a court order approves expenditures
- ☐ No, and assets (principal) are not available

3. Indicate any applications for government benefits that have been submitted:

Application Type	Date of Submission
Social Security Disability Insurance (SSDI)	
Supplemental Security Income (SSI)	
Social Security Retirement Benefits	
Veterans Benefits	
Medical assistance, long term care	
Medical assistance, Home Waiver	
Other (Explain: _____)	

4. Describe all real estate included in the estate and how it will be maintained or sold:

5. Prior to the appointment of a guardian, has an agent under a Power of Attorney been serving?

☐ Yes
☐ No

If **yes**, has an accounting ever been requested or filed with the Orphans' Court?

☐ Yes
☐ No

If **yes**, was the agent the same person as the guardian?

☐ Yes
☐ No

PART VIII: MEDICAL INFORMATION

1. Is a "no-code" (Do Not Resuscitate) provision in place for the incapacitated person?

☐ Yes
☐ No

2. When still capacitated, did the Incapacitated Person execute a durable power of attorney for health care or some other health care directive (including, but not limited to, a POLST, a living will, or a mental health care power of attorney)?

☐ Yes
☐ No

If **yes**, identify the authorized agent for making health care decisions:

_____

3. Are you aware of any will or trust executed by the Incapacitated Person, or any funeral or burial wishes of the Incapacitated Person?

☐ Yes
☐ No

If **yes**, please explain:

_____
_____
_____
_____

Has a burial account been established for the Incapacitated Person?

☐ Yes
☐ No

If **yes**, what is the value of the burial account? _____

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

Date

Signature of Guardian of the Estate

Name of Guardian of the Estate (type or print)

Address

City, State, Zip

Home Phone Number

Office Phone Number

Cell Phone Number

Email

Date

Signature of Co-Guardian of the Estate (if applicable)

Name of Co-Guardian of the Estate (type or print)

Address

City, State, Zip

Home Phone Number

Office Phone Number

Cell Phone Number

Email

INSTRUCTIONS FOR SUBMITTING AN EXPERT REPORT

To establish incapacity, the petitioner must present testimony from an individual qualified by training and experience in evaluating persons with incapacities of the type alleged by the petitioner. As an accommodation to such expert witnesses, the court may accept a complete and legible expert report in accordance with the attached form in lieu of expert testimony, whether in person or by deposition, unless otherwise required by rule or order of court.

COURT OF COMMON PLEAS OF
_____ COUNTY PENNSYLVANIA
ORPHANS' COURT DIVISION

EXPERT REPORT

RE: _____
An Alleged Incapacitated Person (AIP)

No. _____

PART I: PROFESSIONAL BACKGROUND (You may attach your curriculum vitae, if it provides answers to Questions 1 through 5. Please answer those questions not covered by curriculum vitae.)

1. Name: _____ Title: _____

2. Professional Address: _____

3. Complete education information:

	Name of Institution	Type of Degree Received	Date Completed
Undergraduate			
Graduate			
Post-Graduate			

4. Do you have any active professional licenses? ☐ Yes ☐ No
If **yes**, indicate in what state or states you are licensed as well as the date(s) issued.

_____

_____

List any board certifications: _____

5. An Incapacitated Person is legally defined as: An adult whose ability to receive and evaluate information effectively and communicate decisions in any way is impaired to such a significant extent that he/she is partially or totally unable to manage his/her financial resources or to meet essential requirements for his/her physical health and safety.

Do you have experience evaluating whether or not an individual is incapacitated? ☐ Yes ☐ No

If **yes**, indicate the basis of your experience:

_____

_____

_____

_____

_____

PART II: ALLEGED INCAPACITATED PERSON (AIP)

6. a. Have you treated, assessed, or evaluated the AIP?

☐ Yes ☐ No

b. Indicate the date(s) and location of any treatment, assessment, or evaluation you have provided or made over the last two (2) years:

_____

_____

_____

c. If 6a. is yes, what tests have you or others administered, e.g., mini mental status exam (MMSE), Montreal Cognitive Assessment (MOCA), St. Louis University Mental Status Exam (SLUMS), etc.? List dates administered and the score. (Attach test results, not just the score.)

_____

_____

_____

7. What is the present condition of the AIP? List all known medical and psychiatric diagnoses and current symptoms. (You may attach a list from your records.)

Diagnosis	Symptoms/Manifestations

8. List all known medications, including over-the-counter, that the AIP is taking. For each known medication, indicate, if known, the prescribing physician and the diagnosis for which the medication was prescribed or the reason for taking. (You may attach a list from your records.)

Medication	Diagnosis/Reason Taken	Prescribing Physician

9. Indicate the AIP's ability to perform the following functions:

	Unimpaired	Needs Some Help (Explain in #10)	Totally Impaired	Not Assessed or Not Enough Information
Receiving and evaluating information effectively	☐	☐	☐	☐
Communicating decisions	☐	☐	☐	☐
Ability to give informed consent	☐	☐	☐	☐
Short-term memory	☐	☐	☐	☐
Long-term memory	☐	☐	☐	☐
Activities of daily living	☐	☐	☐	☐
Managing finances (including paying bills, making deposits, withdrawals and working with financial institutions)	☐	☐	☐	☐
Managing health care (including following doctor's orders and managing/taking medications)	☐	☐	☐	☐
Providing for physical safety	☐	☐	☐	☐
Responding to emergency situations	☐	☐	☐	☐
Ability to resist scams	☐	☐	☐	☐

10. For any response in Question 9 where the AIP "needs some help," please describe the type and extent of assistance needed.

_____

_____

_____

11. What recommendations have you made or would you make concerning services necessary to meet the essential requirements for the AIP's physical health and safety?

_____

_____

_____

12. What recommendations have you made or would you make concerning management of the AIP's finances?

_____

_____

_____

13. As indicated in Question 5, an Incapacitated Person is legally defined as: An adult whose ability to receive and evaluate information effectively and communicate decisions in any way is impaired to such a significant extent that he/she is partially or totally unable to manage his/her financial resources or to meet essential requirements for his/her physical health and safety.

In your expert opinion, within a reasonable degree of professional certainty and based on your knowledge, skills, experience, and education, is the AIP incapacitated?

☐ Yes, totally impaired ☐ Yes, partially impaired ☐ No

14. In your opinion, the most appropriate, least restrictive living situation for the AIP is (check one):

☐ The AIP can be left alone without supervision
☐ Home (☐ with part-time home health aide or ☐ 24/7 assistance)
☐ Independent living facility (room and board provided, emergency services readily available)
☐ Assisted living facility (room and board provided, assistance with some activities of daily living)
☐ Secure facility (Alzheimer's/Mental Health for safety and basic needs)
☐ Skilled nursing facility

15. If your responses in Question 9 indicated that the AIP is totally impaired or "needs some help", do you expect the AIP's abilities in the next 6 months to (Check best estimate):

☐ Stay the same ☐ Improve ☐ Decline

Please explain:

_____

_____

_____

PART III: GUARDIANSHIP AND SERVICES

16. Are you aware of any circumstances, medical or otherwise, that create a need for the appointment of an emergency guardian for the AIP?

☐ Yes ☐ No

If yes, indicate reasons:

_____

_____

_____

17. The AIP is required to be at the hearing, absent circumstances that could cause harm to the AIP. Putting aside whether the court proceeding may be moderately upsetting to, confusing to or not understood by the AIP, do you believe that the AIP's presence at the hearing would cause harm to the AIP's physical or mental condition?

☐ Yes ☐ No

Indicate reason for response:

_____

_____

_____

_____

18. Please provide any additional information that could assist the court in determining incapacity.

_____

_____

_____

_____

I verify that the foregoing information is correct to the best of my knowledge, information and belief; and that this verification is subject to the penalties of 18 Pa.C.S. § 4904 relative to unsworn falsification to authorities.

_____
Date

_____
Signature

_____
Name (type or print)

_____
Address

_____
City, State, Zip

_____
Telephone

_____
Email

COURT OF COMMON PLEAS OF

COUNTY, PENNSYLVANIA

ORPHANS' COURT DIVISION

NOTICE OF FILING

ESTATE/GUARDIANSHIP OF _____,

AN INCAPACITATED PERSON

_____, GUARDIAN

No. _____

I certify that on _____ I filed the following documents:

- ☐ Inventory
- ☐ Amended Inventory
- ☐ Annual Report - Guardian of the Person
- ☐ Annual Report - Guardian of the Estate
- ☐ Final Report

A copy of this Notice of Filing is being served on the following person(s) designated by court order and in the following manner:

1. _____

☐ By mail ☐ By fax ☐ By personal delivery ☐ By e-mail if requested

2. _____

☐ By mail ☐ By fax ☐ By personal delivery ☐ By email if requested

3. _____

☐ By mail ☐ By fax ☐ By personal delivery ☐ By email if requested

4. _____

☐ By mail ☐ By fax ☐ By personal delivery ☐ By email if requested

Submitted by:

Date

Signature

Name (print or type)

Address

City, State, Zip

Telephone

Email

Instructions for Document Access

If you are one of the individuals noted above to whom this notice of filing was sent, you may access and view the documents filed by presenting this notice of filing along with proper identification to the Clerk of the Orphans' Court in the county listed on the previous page.