

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 Guardian was discharged by a court order dated: \_\_\_\_\_

Order for Adjudication of Capacity dated: \_\_\_\_\_

Limited Duration Order Expired, 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. Where is the Incapacitated Person physically living?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Nature of Residence of the Incapacitated Person (Select One)

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: \_\_\_\_\_

Is this a Memory Support Facility?       Yes  No

Personal Care Boarding Home

Facility Name: \_\_\_\_\_

Is this a Memory Support Facility?       Yes  No

Group 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: \_\_\_\_\_

6. What is the Gender of the Incapacitated Person?

Female

Male

Unreported / Unknown

7. What is the Race of the Incapacitated Person?

Asian

Asian / Pacific Islander

Black

Multi-Racial

Native American / Alaskan Native

Native Hawaiian / Pacific Islander

Unreported / Unknown

White

8. What is the Ethnicity of the Incapacitated Person?

Hispanic

Non Hispanic

Unknown

**PART III. MEDICAL INFORMATION**

1. List the medical professionals who have seen the Incapacitated Person during the **Report Period**:

	Name
<b>Medical Doctor</b>	
<b>Dentist</b>	
<b>Eye Doctor</b>	
<b>Ear Doctor</b>	
<b>Psychologist or Psychiatrist</b>	
<b>Physical Therapist</b>	
<b>Occupational Therapist</b>	
<b>Social Worker</b>	
<b>Geriatric Caseworker</b>	
<b>Other</b>	

2. The major medical or psychiatric problems of the Incapacitated Person are as follows:

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3. Describe any social, medical, psychological and support services the Incapacitated Person is receiving:

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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. Does the Incapacitated Person still require a guardian? Should the guardianship be:

Continued

Continued with modifications

Discharged

2. Provide the reasons for your opinion. List specific recommended modifications.

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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*

\_\_\_\_\_

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

Yes - Complete the table below

No

Amount	Guardian Name	Is Amount Based on Hourly, Monthly or Annual Fee?	If Hourly, # of Hours

9. Was the compensation approved by the court?

Yes - Date of Court Order: \_\_\_\_\_

No - Explain why court approval was not obtained:

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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.

I further acknowledge the Notice of Filing must be served within 10 days of the filing of this report pursuant to Pa.R.O.C.P. 14.8(b). Service shall be in accordance with Pa.R.O.C.P. 4.3.

\_\_\_\_\_  
*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 (if applicable)*

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

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*City, State, Zip*

\_\_\_\_\_  
*Home Phone Number*

\_\_\_\_\_  
*Office Phone Number*

\_\_\_\_\_  
*Cell Phone Number*

\_\_\_\_\_  
*Email*