

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

O.C. No. _____ of _____

Estate of _____, an Incapacitated Person

**ANNUAL REPORT OF
GUARDIAN OF THE PERSON**

I. INTRODUCTION

I, _____, was appointed

Plenary Limited Guardian of the Person by Decree of _____,
J.,

dated _____.

A. This is my **Annual Report** for the period from _____, _____
to _____, _____ (the "Report Period"); *or*

B. This is my **Final Report** for the period from _____, _____
to _____, _____ (the "Report Period"), and is filed

for the following reason:

1. The death of the Incapacitated Person. Date of death: _____

2. The Guardianship was terminated by the Court by Decree of

_____ J., dated _____.

For a Final Report, omit Sections II through VII.

II. PERSONAL DATA

Age of the Incapacitated Person: _____ Date of Birth: _____

III. LIVING ARRANGEMENTS

A. Current address of the Incapacitated Person:

B. The Incapacitated Person's residence is:

- own home / apartment
- nursing home
- boarding home / personal care home
- Guardian's home / apartment
- hospital or medical facility
- relative's home (name, relationship and address)

other:

C. The Incapacitated Person has been in the present residence since _____

_____. If the Incapacitated Person has moved within

the past year, state change and reason(s) for change: _____

D. Name and address of the Incapacitated Person's primary caregiver:

IV. MEDICAL INFORMATION

A. The major medical or mental problems of the Incapacitated Person are as follows:

B. Specify what, if any, social, medical, psychological and support services the Incapacitated Person is receiving:

V. GUARDIAN'S OPINION

A. It is my opinion as Guardian of the Person that the guardianship should:

- continue
- be modified
- be terminated

My reasons are: _____

B. During the past year, I have visited the Incapacitated Person _____ times with the average visit lasting _____ hours, _____ minutes.

The report of a social service organization employed by the Guardian to oversee and coordinate the care of the Incapacitated Person for the period covered by this Report may be attached to supplement this Report.

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.A. 4904
relative to unsworn falsification to authorities.

Date

Signature of Guardian of the Person

Name of Guardian of the Person (type or print)

Address

City, State, Zip

Telephone Number