**PIKE COUNTY PROBATE COURT**
**230 WAVERLY PLAZA, SUITE 600**
**WAVERLY, OHIO 45690**
**(740) 947-2560**
**(740) 941-3086 (FAX)**

**INFORMATION AND INSTRUCTIONS FOR FILING A GUARDIAN'S REPORT:**

By law, the Probate Court is the superior guardian. At the time of their appointment, all guardians sign an oath with regards to their duties and must obey all court orders with regards to the guardianship. The Court uses several means to assist in this supervisory role.

A guardian of a person must file a Guardian's Report every two (2) years with the Court. This report will inform the Court of the ward's mental and physical status and the continuing need for the guardianship. The report must include an updated Statement of Expert Evaluation.

The Statement of Expert Evaluation that is submitted with the Guardian's Report may be completed by a licensed physician, licensed clinical psychologist, licensed independent social worker, licensed professional clinical counselor or a mental retardation team.

The Pike County Probate Court has established a practice of reminding guardians when their report is due. However, this is only offered as a courtesy for case efficiency and should not be relied upon by the guardian. The guardian is required to submit their report on a timely basis when due.

You will need the following forms to file your report. It is suggested that you call the Court prior to filing them to see if there will be any court costs due.

Form 17.7 – Guardian's Report

Form 17.1 – Statement of Expert Evaluation

# PROBATE COURT OF ______________ COUNTY, OHIO

# ____________, JUDGE

**GUARDIANSHIP OF** ______________________________________________

**CASE NO.** __________

## GUARDIAN'S REPORT

**[R.C. 2111.49 and Sup.R. 66.05(B)(2)]**

NOTE: If allotted space is inadequate to respond, write "See Exhibit" in the space and add appropriate exhibit letter sequence, then attach exhibit containing information requested for that space.

1. This is the **(circle one)** 1st, 2nd, 3rd, 4th, 5th, 6th, or _________, Guardian's Report.
2. Ward's present address:______________________________________________
   City ______________________________ State ____________________
   Zip Code____________________Telephone Number (____)______________
3. Ward's living arrangements at the above address are best described as:
   - ☐ a. His or her own apartment or home (includes assisted living facilities.)
   - ☐ b. Private home or apartment of:
     - ☐ (1) the ward's guardian
     - ☐ (2) a relative of the ward, whose name is ______________________________
       and relationship is ______________________________________
     - ☐ (3) a non-relative whose name is ______________________________
   - ☐ c. A foster, group, or boarding home.
   - ☐ d. A nursing home.
   - ☐ e. A medical facility or state institution.
   - ☐ f. Other (describe) ______________________________________________
     ______________________________________________________________
   - g. If **c**, **d**, **e,** or **f** is checked, complete the following:
     - ☐ (1) The name of the home, facility, or institution ______________________________
     - ☐ (2) The name of an individual at the home, facility, or institution who has knowledge and is authorized to give information to the court about the ward.
       Name ______________________________________________
       Telephone Number (_____)______________________________
4. The ward will be at the address given in Item 2:
   - ☐ a. Indefinitely.
   - ☐ b. Temporarily. The new address and telephone number is:
   - ☐ (1) Unknown. I will provide this information when known.
   - ☐ (2) ______________________________________________
     City ______________________________________ State __________________
     Zip Code ________________ Telephone Number (____)__________________________



**Amended: March 1, 2017**
Discard all previous versions of this form

**CASE NO.__________**

5. Guardian's contact with the ward.
   a. Approximate number of times the guardian had contact with the ward during the period covered by this report: _________________
   b. The nature of those contacts (phone, personal, or other): ______________________________
   ________________________________________________
   c. Date the ward was last seen by the guardian: ______________________________________

6. Have you observed any **major** change in the ward's physical or mental condition during the period covered by this report? ☐ Yes ☐ No
   If "yes" is checked, briefly describe the changes.____________________________________
   ________________________________________________
   ________________________________________________

7. The care given to the ward is ☐ Adequate ☐ Not Adequate
   If "Not Adequate" is checked, explain. ____________________________________
   ________________________________________________
   ________________________________________________

8. The guardianship should be ☐ Continued ☐ Not Continued
   If "Not Continued" is checked, explain. ____________________________________
   ________________________________________________
   ________________________________________________

9. During the period covered by this report, the ward ☐ has ☐ has not been seen by a physician. If the ward has been seen, the last date was ______________________________ and for the purpose of ________________________________________

10. ☐ I currently serve as the guardian to ten or more wards and certify to the Court that I am unaware of any circumstances that may disqualify me from serving as guardian for this ward.

11. With regard to the continuing education requirement pursuant to Sup.R. 66.07:
    ☐ I have completed the continuing education requirement. (Attach Certificate of Completion if applicable)
    ☐ The continuing education requirement was waived.

Attached is a statement by a licensed physician, a licensed clinical psychologist, a licensed social worker, or a developmental disability team, that has evaluated or examined the ward within three months prior to the date of this report regarding the need for continuing the guardianship. [R.C. 2111.49(A)(1)(I)](Form 17.1)

If an attorney has been consulted on this report:

Date ______________________________

| | |
|---|---|
| ______________________________ | ______________________________ |
| Attorney for Guardian | Guardian's Printed Name |
| ______________________________ | ______________________________ |
| Street | Guardian's Signature |
| ______________________________ | ______________________________ |
| City State Zip Code | Street |
| ______________________________ | ______________________________ |
| Telephone Number (include area code) | City State Zip Code |
| ______________________________ | ______________________________ |
| Attorney Registration No. | Telephone Number (include area code) |

**(Knowingly giving false information on a Probate document is a criminal offense)**
**[R.C. 2921.13(A)(11)]**



**Amended: March 1, 2017**
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## PROBATE COURT OF ________________ COUNTY, OHIO

**IN THE MATTER OF THE GUARDIANSHIP OF** ________________________________________

**CASE NO.** ______________________

# STATEMENT OF EXPERT EVALUATION

**[Sup. R. 66 & R.C. 2111.49]**

Definition of Incompetent (R.C. 2111.01(D)): “"Incompetent" means any person who is so mentally impaired as a result of a mental or physical illness or disability, or mental retardation, or as a result of chronic substance abuse, that the person is incapable of taking proper care of the person’s self or property or fails to provide for the person’s family or other persons for whom the person is charged by law to provide, or any person confined to a correctional institution within this State.”

The Statement of Evaluation does not declare the individual competent or incompetent, but is evidence to be considered by the Court. The fee for completing this evaluation **WILL NOT** be paid by the Probate Court. Each evaluator should secure payment from the Applicant/Guardian.

1. This Statement of Expert Evaluation is to be filed with or attached to:

☐ A. Guardianship Application: Completed by ☐ Licensed Physician or ☐ Licensed Clinical Psychologist prior to the filing and attached to the application.

☐ B. Guardian’s Report: Completed by ☐ Licensed Physician ☐ Licensed Clinical Psychologist ☐ Licensed Independent Social Worker ☐ Licensed Professional Clinical Counselor or ☐ Mental Retardation Team.
The evaluation or examination shall be completed within three months prior to the date of the Report. R.C. 2111.49

☐ C. Application for Emergency Guardian: ☐ of the person: a Licensed Physician shall complete the Supplement for Emergency Guardian, form 17.1A with <u>specificity</u> indicating the emergency, and why immediate action is required to prevent significant injury to the person. The Supplement shall be signed, dated, and attached as part of this completed Statement.

2. Statement completed by: ____________________________________________

Name & Title/Profession: ____________________________________________

Business Address: ____________________________________________

Business Telephone Number: ____________________________________________

3. Date(s) of evaluation: ____________________________________________

Place(s) of evaluation: ____________________________________________

Amount of time spent on evaluation: ____________________________________________

Length of time the individual has been your patient: ______________________________

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4. Is the individual presently under medication? ☐ Yes ☐ No If yes, what is the medication, dosage, and purpose? ____________________________________________

____________________________________________

Are there any signs of physical and/or mental impairments caused by the medications themselves? ___

____________________________________________

5. Is the individual mentally impaired? ☐ Yes ☐ No If yes, indicate the diagnosis below:

☐ Mental Retardation/Developmental Disabilities:

☐ Profound ☐ Severe ☐ Moderate ☐ Mild

☐ Mental Illness: Type and Severity ____________________________________________

____________________________________________

☐ Substance Abuse: Description ____________________________________________

____________________________________________

☐ Dementia: Description ____________________________________________

____________________________________________

☐ Other: Description ____________________________________________

____________________________________________

Please provide additional comments and test scores if available. (Continue comments on page 4): ___

____________________________________________

6. During the examination did you notice an impairment of the individual's:

| | | | |
|---|---|---|---|
| a) Orientation | ☐ Yes | ☐ No | ☐ Unknown |
| b) Speech | ☐ Yes | ☐ No | ☐ Unknown |
| c) Motor Behavior | ☐ Yes | ☐ No | ☐ Unknown |
| d) Thought Process | ☐ Yes | ☐ No | ☐ Unknown |
| e) Affect | ☐ Yes | ☐ No | ☐ Unknown |
| f) Memory | ☐ Yes | ☐ No | ☐ Unknown |
| g) Concentration and comprehension | ☐ Yes | ☐ No | ☐ Unknown |
| h) Judgment | ☐ Yes | ☐ No | ☐ Unknown |

7. Please describe any impairments identified in question six. (Continue comments on page 4).

____________________________________________

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8. Is the individual physically impaired? ☐ Yes ☐ No If yes: Description

______________________________________________________________________

9. Are there any special characteristics of the individual which should be considered in evaluating the individual for guardianship: ☐ Yes ☐ No If yes: Explain

______________________________________________________________________

______________________________________________________________________

10. Are there any indication of abuse, neglect or exploitation of the individual? ☐ Yes ☐ No
If yes: Explain ____________________________________________________________

______________________________________________________________________

11. Do you believe the individual is capable of caring for the individual's activities of daily living or making decisions concerning medical treatments, living arrangements and diet? ☐ Yes ☐ No
If no: Explain ____________________________________________________________

12 Do you believe this individual is capable of managing the individual's finances and property?
☐ Yes ☐ No If no: Explain

______________________________________________________________________

13. Prognosis:
A. Is the condition stabilized? ☐ Yes ☐ No
B. Is the condition reversible: ☐ Yes ☐ No

14. In my opinion a guardianship should be:
☐ Established/Continued
☐ Denied/Terminated

I certify that I have evaluated the individual on ______________________________, 20 ______.

Date: ______________________ ______________________
Signature of Evaluator

## GUARDIAN'S REPORT ADDENDUM

(Not to be used with initial Application)

It is my opinion, based upon a reasonable degree of medical or psychological certainty that the mental capacity of this ward will not improve.

Date ______________________ ______________________
Signature – Licensed Physician/Clinical Psychologist

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## ADDITIONAL COMMENTS

Date ______________________________

______________________________________
Signature – Licensed Physician/Clinical Psychologist