IN THE CIRCUIT COURT OF THE EIGHTEENTH JUDICIAL CIRCUIT
IN AND FOR SEMINOLE COUNTY, FLORIDA, PROBATE DIVISION

IN RE: GUARDIANSHIP OF: **Case Number: YYYYGANNNN**

_____ _____

Guardianship Type: **Amended Form?** **Amended Form Version:**

_____ _____ _____

INITIAL GUARDIANSHIP PLAN

Plan Period From: _____ **Plan Period To:** _____

_____

Guardianship Inception Date: **Date of Order of Incapacity:** **Guardian Name:** **Guardian of the person of:**

_____ _____ _____ _____

submits the following Initial Guardianship Plan for the Ward:

1. The Ward's present location is:

Facility Name / Name of Caregiver with whom the Ward resides: **Facility Type:** **Phone Number:**

_____ _____ _____

Street Address: **City:** **State:** **Zip:**

_____ _____ _____ _____

_____

2. The Guardian for the plan period proposes the following as to the provision of medical and rehabilitative services for the Ward:

- ☐ **Physical Therapy**
- ☐ **Routine examination by Dentist**
- ☐ **Routine examination by Primary Care Physician**
- ☐ **Routine examination by Ophthalmologist**
- ☐ **Routine examination by Specialist** Name of Specialist**: _____**
- ☐ **Speech Therapy**
- ☐ **Occupational Therapy**
- ☐ **The Ward retains the right to make their own decision**
- ☐ **Other**

Explanation required only if "other" checked: _____

_____

_____.

3. The Guardian for the plan period proposes the following as to the provision of mental health services for the Ward:

- ☐ **Routine Examination by Psychiatrist/Psychologist**
- ☐ **Ongoing Treatment Outpatient**
- ☐ **Ongoing Treatment Inpatient**
- ☐ **None**
- ☐ **Other**

Explanation required only if "other" checked: _____

_____

_____

_____

_____.

4. The Ward presently is prescribed or takes the following types of medications:

- ☐ **Anti-Anxiety**
- ☐ **Anti-Depressant**
- ☐ **Cardiac**
- ☐ **Diabetic**
- ☐ **Memory Enhancement**
- ☐ **Over the Counter**
- ☐ **Psychotropic**
- ☐ **Other Prescription**

Explanation required if "other" checked: _____

Explanation required if "Over the Counter" checked: _____

5. The guardian for the plan period proposes the following as to the provision of personal care services for the Ward:

- ☐ **Care Facility Nurses**
- ☐ **Aides Family**
- ☐ **Friends**
- ☐ **Other**

Explanation required only if "other" checked: _____

6. The guardian for the plan period proposes the following as to the provision of social/recreational services for the Ward:

- ☐ **Care Facility Nurses**
- ☐ **Aides Family**
- ☐ **Friends**
- ☐ **Ward retains the right to make their own decision**
- ☐ **Other**

Explanation required only if "other" checked: _____

7. The Guardian for the plan period proposes the following as to the provision of social services for the Ward:

- ☐ Adult Day Care
- ☐ Counseling
- ☐ Homemaker/Personal Care
- ☐ Home Delivered Meals
- ☐ Private Services
- ☐ Public Services Senior
- ☐ Center Sheltered
- ☐ Training Program
- ☐ Transportation
- ☐ Volunteer Services
- ☐ Other

Explanation required only if "other" checked: _____

8. The Guardian states the place and kind of residential setting best suited for the needs of the Ward is:

_____ (Required)

If "other was selected from the previous list, please provide an explanation.

Explanation:

_____

The guardian will ensure that the above is in the best residential setting for the Ward by:

- ☐ Periodically Assessing Needs
- ☐ The Ward retains the right to decide
- ☐ No change, unless required by medical condition
- ☐ Other

Explanation required only if "other" checked: _____

9. The Ward has the following health insurance, accident insurance, private benefits, or governmental benefits available to meet the costs of medical, mental health, or related services:

- ☐ **Health Maintenance Organization (HMO)**
- ☐ **Institutional Care Program**
- ☐ **Optional State Supplement**
- ☐ **Medicare**
- ☐ **Medicaid**
- ☐ **Pending Benefits, not yet received**
- ☐ **Pension**
- ☐ **Social Security**
- ☐ **Social Security Disability Income (SSDI)**
- ☐ **Supplemental Insurance**
- ☐ **Supplemental Security Income (SSI)**
- ☐ **VA**
- ☐ **Other**

Explanation required only if "other" checked: _____

10. The Guardian will secure the following physical/mental examinations to determine the Ward's medical and mental health treatment needs:

Physical/Mental Examinations:

#	Provider's Name, Address, and Phone Number	Type of Provider	Approximate Date of Exam

11. To assist the Court with review of the initial plan to determine if it is in the best interest of the Ward, please provide the following information:

A. Please rate the ability of the Ward to engage in activities of daily living or instrumental activities of daily living:

	Description	Rating (1-10)
i.	Administration of Medication	_____
ii.	Bathing	_____
iii.	Climbing Stairs	_____
iv.	Doing Laundry	_____
v.	Dressing	_____
vi.	Eating	_____
vii.	Grooming	_____
viii.	Heavy Chores	_____
ix.	Light Housekeeping	_____
x.	Managing Money	_____
xi.	Shopping	_____
xii.	Toileting	_____
xiii.	Transferring	_____
xiv.	Walking/Mobility	_____

B. The diagnosed mental disabilities of the Ward are:

- ☐ **Alzheimer's type of dementia**
- ☐ **Autism Spectrum Disorders**
- ☐ **Closed Head Injury Dementia**
- ☐ **Depression**
- ☐ **Developmental Disabilities**
- ☐ **Induced by substance abuse**
- ☐ **Schizophrenia or related disorders**
- ☐ **Other**

Explanation required only if "other" checked: _____

C. The diagnosed physical disabilities of the ward are:

- ☐ **Mobility**
- ☐ **Blindness**
- ☐ **Deafness**
- ☐ **Diabetic**
- ☐ **Parkinson's disease**
- ☐ **Severe arthritis**
- ☐ **Other**

Explanation required only if "other" checked: _____

D. The assistive devices used by the Ward are:

- ☐ **Crutches**
- ☐ **Dentures**
- ☐ **Glasses**
- ☐ **Hearing Aid**
- ☐ **Prosthetics**
- ☐ **Walker/Cane**
- ☐ **Wheelchair**
- ☐ **None**
- ☐ **Other**

Explanation required only if "other" checked: _____

E. The plan for the next twelve (12) months for disaster preparedness for the Ward is:

12. Please list, for adult wards only, any preexisting orders not to resuscitate executed under §401.45(3), Fla. Stat. or preexisting advance directives as defined in §765.101, Fla. Stat., including the date an order or directive was signed, whether such order or directive has been suspended by the court, and a description of the steps taken to identify and locate the preexisting order not to resuscitate or advance directives.

#	Title of Order/Directive	Date of Order/Directive	Suspended by Court (Yes/No)	Steps Taken to Identify and Locate Order/Directive

CERTIFICATION AND SIGNATURE OF GUARDIAN(S)

(Check all that apply)

- ☐ **The recommendations of the examining committee are incorporated into this plan.**
- ☐ **The Ward was declared totally incapacitated.**
- ☐ **The Ward is a minor.**
- ☐ **The guardian has consulted with the Ward, to the extent reasonable, has honored the Ward's wishes, and to the maximum extent possible the plan is in accordance with the Ward's wishes or consistent with the rights retained by the Ward.**
- ☐ **The plan does not restrict the physical liberty of the Ward except as necessary to protect the Ward and others from serious physical injury, illness, or disease.**
- ☐ **The plan provides for the Ward's medical care and mental health treatment.**

UNDER PENALTIES OF PERJURY, I declare that I have read and examined the foregoing plan, and the facts alleged are true, to the best of my knowledge and belief.

Guardian

Guardian Signature: _____

Guardian Name: _____

Date signed by Guardian: _____

Guardian's Email Address:
_____

Guardian Mailing Address: _____

City: _____

State: _____

Zip: _____

Co-Guardian

Co-Guardian Signature: _____

Co-Guardian Name: _____

Date signed by Co-Guardian: _____

Co-Guardian's Email Address:
_____

Co-Guardian Mailing Address: _____

City: _____

State: _____

Zip: _____

CERTIFICATION OF SERVICE

I hereby certify that a true copy of the foregoing has been furnished by mail to _____ (name of attorney for the person with a developmental disability/name of attorney for the person adjudged incapacitated) at _____(address of the attorney for the person with a developmental disability/name of attorney or the person adjudged incapacitated) this _____ day of _____, 20_____ and to _____(the person with a developmental disability/the person adjudged incapacitated).

Signature of Guardian/Guardian Advocate
_____

Signature of Co-Guardian/Co-Guardian Advocate
_____

Printed Name of Guardian/Guardian Advocate
_____

Printed Name of Co-Guardian/Co-Guardian Advocate
_____

Reset Button

IN THE CIRCUIT COURT OF THE EIGHTEENTH JUDICIAL CIRCUIT
IN AND FOR SEMINOLE COUNTY, FLORIDA.

IN RE: THE GUARDIANSHIP OF CASE NUMBER: _____

_____
Guardianship of Person

ORDER APPROVING INITIAL GUARDIAN PLAN OF THE PERSON

The Court has reviewed the Initial Guardian Plan of _____, the Guardian of the Person of _____ (the "Ward"), consisting of the Initial Guardian Plan filed on _____, and the Clerk's report thereon filed on _____. The Court finds that said Plan:

(a) Meets the needs of the Ward;

(b) Authorizes the Guardian to act only in areas in which the Ward has been declared incapacitated; and

(c) Conforms to all other requirements of the Florida Statutes.

It is therefore

ADJUDGED that the Initial Plan (Initial Guardianship Plan) of the Guardian of the Person is approved and constitutes the authority for the Guardian to act in the forthcoming year, and the Guardian powers are limited as set forth in said Report.

ADJUDGED FURTHER that any attorney appointed by the Court to represent the Ward and review that Initial Guardianship Report is discharged.

DONE AND ORDERED on _____.

_____
CIRCUIT JUDGE

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