

**PROBATE COURT OF LUCAS COUNTY, OHIO**  
**JACK R. PUFFENBERGER, JUDGE**

IN THE MATTER OF THE GUARDIANSHIP OF \_\_\_\_\_

CASE NO.: \_\_\_\_\_

**GUARDIAN'S REPORT**  
**(R.C. 2111.49)**

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 **(check one)**:  1<sup>st</sup>,  2<sup>nd</sup>,  3<sup>rd</sup>,  4<sup>th</sup>,  5<sup>th</sup>,  6<sup>th</sup>, or \_\_\_\_, Guardian's Report.

2. Ward's present address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Telephone ( \_\_\_\_ ) \_\_\_\_\_

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 \_\_\_\_\_ Telephone ( \_\_\_\_ ) \_\_\_\_\_



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 \_\_\_\_\_.

Attached is a statement by a licensed physician, a licensed clinical psychologist, a licensed social worker, or a mental retardation 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's Name

\_\_\_\_\_  
Guardian's Signature

\_\_\_\_\_  
(Type or print Attorney's Name)

\_\_\_\_\_  
(Type or print Guardian's Name)

\_\_\_\_\_  
(Street)

\_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City, State, Zip Code)

\_\_\_\_\_  
(City, State, Zip Code)

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Sup. Ct. Regis. No.

**PROBATE COURT OF LUCAS COUNTY, OHIO**  
**JACK R. PUFFENBERGER, JUDGE**

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 or  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 specificity 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: \_\_\_\_\_

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                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| a) Speech                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| a) Motor Behavior                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| a) Thought Process                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| a) Affect                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| a) Memory                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| a) Concentration and Comprehension | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| a) Judgment                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

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

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

CASE NO.: \_\_\_\_\_

**ADDITIONAL COMMENTS**

Date \_\_\_\_\_

\_\_\_\_\_  
Signature – Licensed Physician/Clinical Psychologist