Washington State Office of Public Guardianship
Guardianship Status Report

Guardianship Information

Name | dba The Public Guardian for | CPG #

Case # | Initials of Incapacitated Person | Date of Visit

Type of Guardianship:

- ○ Guardianship of the Person
- ○ Guardianship of the Estate
- ○ Guardianship of Both

IP's Address

City | State | Zip Code

Phone #

Physical Appearance and Living Conditions

Yes	No	
○	○	Is this the first home visit to the client?
○	○	Does the client appear clean and well-groomed?
○	○	Is the client dressed appropriately for season and planned activities?
○	○	Does the client look well-nourished?
○	○	If the client's meals are charted, does the chart indicate stable and appropriate meal patterns?
○	○	Do you notice any new rashes, scratches, sores or bruises on the client?
○	○	Did you notice any physical changes from your previous visit?

Comments:

Is there a significant decline in the client's overall physical appearance since your last visit? Yes ◯ No ◯

If yes, to whom did you address your concern? Name

How did they agree to resolve the issue?

Has your concern from your last visit been adequately addressed and resolved? Yes ◯ No ◯

Comments:

Date of previous visit

Current Health Status

Describe incapacitated person's current health status, including diagnoses; describe any significant health changes since the last review:

Height ' " Weight Lbs Weight Loss Weight Gain 5% or More? Yes ◯ No ◯

Number of times admitted to the hospital in the past 30 days

Number of times visited the emergency room in the past 30 days

Previous Month's Appointments

Date of Last Appointment: Type:

Date of Last Appointment: Type:

Outcome/Recommendations

Current Level of Functioning

Describe incapacitated person's ability to care for self and any significant changes in ability to care for self or communicate/understand since the last review:

Current General Well Being (Information provided verbally by caregiver)

Social

Yes	No	N/A	
○	○	○	Does facility or care log indicate client has received social visitors since your last visit?
○	○	○	Has client traveled away from facility or home since last visit?
○	○	○	Is client participating regularly in activities or outings?
○	○	○	Have there been any escalations of tension with client's family or friends since last visit?

Environmental

Yes	No	N/A	
○	○	○	Overall condition of facility or home is pleasant?
○	○	○	Does the client express a perception that he/she is home?
○	○	○	Are there any visible safety hazards or concerns now present?
○	○	○	Does the daily living space appear to be comfortable and reflective of the client's preferences?
○	○	○	Does the client express positive feelings about his/her residency?
○	○	○	Did you feel your visit was welcomed/supported with an appropriate space for meeting made available?

Comments:

Describe the current living situation (own home, board & care, skilled nursing, etc.):

Have living arrangements changed since the last report? Yes ○ No ○

If yes, please explain the reason for the change:

If the incapacitated person lives at home, does he/she receive In Home Care Services benefits? Yes ○ No ○

If yes, name of provider: Phone number:

Name of social worker at HomeCare Services:

Describe any plans to change the living situation:

This Information is Absolutely Essential - Complete Information is Required

Date of last visit by Guardian:

List names and contact information of other persons who have visited the incapacitated person over the last month:

Client needs and requests:

Current Estate Status

Present Market Value $

Is it adequate to meet the needs of the incapacitated person? Yes ◯ No ◯

Please explain:

Do you plan to make significant changes in the manner in which the estate is being handled? Yes ◯ No ◯

If yes, please describe the changes (e.g., a reverse annuity mortgage in order to keep the incapacitated person in their own home?):

Guardian's Comments

Please indicate any unusual problems/successes you wish OPG to be aware of that occurred since the last review.

Determination: I have reviewed the status of the incapacitated person referenced herein and determined that the Public Guardianship services should:

- ○ Continue as provided.
- ○ Be limited in the following manner and the Superior Court has been asked to take appropriate action:
- ○ Be terminated and the Superior Court has been asked to take appropriate action.

CPG Contact Information

Date CPG# Case #

Address

City State Zip Code

I declare under penalty of perjury that the information contained in this form is true and correct. I certify that I have consulted with the incapacitated person regarding the foregoing care/service plan and have honored the incapacitated person's wishes to the extent possible.

Print Name Signature _____

Additional Comments: