



5. List name and phone number of group home coordinator or facility director, if applicable): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. If there has been a change in residence since the last review, please identify the reason for the change: \_\_\_\_\_  
\_\_\_\_\_
7. If the disabled person does not reside in your home, please indicate approximately how often you see the disabled person each month:  
\_\_\_\_\_  
\_\_\_\_\_
8. Identify any changes in the disabled person's physical or mental condition since the last review: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Identify any governmental agencies or non-profit agencies that provide services, care, treatment, or otherwise are involved with the disabled person: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Describe the management of the disabled person's financial affairs and identify any changes in the disabled person's financial affairs since the last review:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. If the Guardian(s) do(es) not manage the disabled person's financial affairs, who does?  
\_\_\_\_\_  
\_\_\_\_\_
12. State whether the disabled person's eligibility for assistance programs such as Social Security, Medicare, Medicaid, SSI, Food Stamps, or Veteran's benefits has been explored, and identify the benefits the disabled person receives: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
13. Identify any information regarding the disabled person's relationship with family or interested parties that may be important in the event that additional or successor guardians seek to be appointed: \_\_\_\_\_  
\_\_\_\_\_

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14. Identify any problems or concerns that have arisen since the last review that you believe may limit your ability to continue to serve as guardian: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Identify any other matters relating to this guardianship of which the Court should be aware: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Is the disabled person under a permanent disability?  Yes  No

17. If the answer to Question 16 is No, explain why there is a continuing need for guardianship : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-Guardian's signature

*NOTE: If more than one guardian has been appointed, only one guardian is required to sign this form. If preferred, all guardians may sign the form.*

MEDICAL STATEMENT

*(This portion of the form must be completed by a Doctor of Medicine, a Doctor of Osteopathic Medicine, a Physician Assistant, or an Advanced Practice Registered Nurse, actively licensed in the practice of medicine or surgery or the advanced practice of nursing in any jurisdiction in the United States of America.)*

I, \_\_\_\_\_, last examined

Provider's name and title

\_\_\_\_\_ on the following date \_\_\_\_\_.

Disabled person's name

Describe health of the disabled person/diagnosis: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Significant changes since last review: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations/Surgical procedures since last review: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Consequently, there is a continued need for guardianship of the disabled person:

Yes       No

If No, why not? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's signature and title