

IN THE COURT OF CHANCERY FOR THE STATE OF DELAWARE

_____, C.M.# _____

A person with a disability

Date of birth: _____

Annual Update and Medical Statement

Note: Guardians are required to answer every question, every year. If a question does not apply, write "N/A". If you need additional space to respond, please do so on a separate page and submit it as an exhibit to the form. The failure to submit a full and complete update may result in the issuance of a rule to show cause, which triggers a hearing and the assessment of fees or other penalties.

<u>Qtr.</u>	<u>Order Date</u> If the date of the final order appointing you as guardian(s) falls between...	<u>Due Date</u> ...your Annual Update and Medical Statement is due every year by...
1st	January 1st to March 31st	January 1st
2nd	April 1st to June 30th	April 1st
3rd	July 1st to September 30th	July 1st
4th	October 1st to December 31st	October 1st

1. Name of guardian(s): _____

2. Date guardian(s) was/were appointed: _____

3. List the mailing address(es) for **all** guardians: _____

4. List the telephone number(s) for **all** guardians: _____

5. List the email address(es) for **all** guardians: _____

6. List the current residence and phone number for the person with a disability: _____

a. Is this a new residence or phone number? Yes No.

b. If yes, why did the person with a disability's residence or number change?

7. In what type of facility does the person with a disability reside?

Foster home

Group home

State facility

Guardian's home

Nursing home

Their own home

Other (specify): _____

8. If the person with a disability resides in a group home, nursing home, or other facility, list the name and phone number of the staff or personnel most knowledgeable about the person with a disability's day-to-day activities:
- a. Name: _____
 - b. Phone number: _____
9. If the person with a disability does not live in the same home as the guardian, please indicate approximately how often you see the person with a disability each month: _____
10. Are you having any difficulty visiting with or contacting the person with a disability? Yes No. Explain your difficulty: _____
11. Identify any changes in the physical or mental condition of the person with a disability since the last review: _____
12. Identify any governmental agencies or non-profit agencies that provide services, care, treatment, or otherwise are involved with the person with a disability (e.g. DDDS, Chimes, Easter Seals): _____
13. Are you having any difficulty accessing the services, care, treatment, or other benefits of or for the person with a disability? Yes No If yes, why? _____
14. Who manages the financial affairs of the person with a disability? _____
- Are you having, or are you aware of, any problems or changes in how the financial affairs of the person with a disability are being managed? Yes No. If yes, why? _____
15. Have you explored whether the person with a disability qualifies for assistance programs such as Social Security, Medicare, Medicaid, Food Stamps, or Veteran's benefits? Yes No. What benefits does the person with a disability receive? _____

16. Can you continue to serve as guardian of the person with a disability? Yes No. If no, why? _____

17. Who would be best suited to serve as an additional or successor guardian for the person with a disability, if needed?

a. Name: _____

b. Phone number: _____

c. Current mailing address: _____

18. Is the person with a disability under a permanent disability? Yes No. If no, explain why there is a continuing need for guardianship: _____

19. Are you or the person with a disability having problems that you would like the Court to help with? Yes No. If yes, please explain the difficulties and how you think the Court can help: _____

20. Is there anything else you think the Court should know about the guardianship? Yes No
If yes, explain: _____

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.

Signature section for guardian	Signature section for any co-guardian
Date: _____	Date: _____
Signature: _____	Signature: _____

Please mail or fax the completed form (with the medical statement) to the Register in Chancery's Office where your case is managed

500 N. King St., 7th Floor, Wilmington, DE 19801 (Fax: 302-622-4482)

38 The Green, Ste. 208, Dover, DE 19901 (Fax: 302-735-2155)

34 The Circle, Georgetown, DE 19947 (Fax: 302-856-5778)

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, _____ [Provider's name and title], last examined
_____ [Name of person with a disability] on the following date
_____. **Examination must have occurred within the last calendar year**

1. Describe health of the person with a disability/diagnosis: _____

2. Significant changes in the last year: _____

3. Hospitalizations/Surgical procedures in the last year: _____

4. Is there a continued need for guardianship of the person with a disability? Yes No
If No, why not? _____

Provider's signature and title: _____

Date form completed: _____