IN THE COURT OF CHANCERY FOR THE STATE OF DELAWARE

_____, C.M.# _____
A person with a disability
Date of birth: _____

ANNUAL UPDATE & MEDICAL STATEMENT

Qtr	**Order Date** If the date of the final order appointing you as guardian(s) falls between…	**Due Date** …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 mailing address(es) for **all** guardian(s): _____
   _____
   _____
   _____
4. List telephone number(s) for **all** guardian(s): _____
   _____
   _____
5. Print clearly the current e-mail address(es) for guardian(s): _____
   _____
   _____
6. Current residence and phone number of person with a disability: _____
   _____
   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): _____

7. List name and phone number of group home coordinator or facility director, if applicable:
   _____
   _____
8. If there has been a change in residence since the last review, please identify the reason for the change: _____
   _____
9. If the person with a disability does not reside in your home, please indicate approximately how often you see the person with a disability each month: _____
   _____

10. Identify any changes in the physical or mental condition of the person with a disability since the last review: _____
_____
_____

11. 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): _____
_____
_____

12. Describe the management of the financial affairs of the person with a disability and identify any changes since the last review: _____
_____
_____

13. If the guardian(s) do(es) not manage the financial affairs of the person with a disability, who does? _____

14. Have you explored whether the person with a disability qualifies for assistance programs such as Social Security, Medicare, Medicaid, SSI, Food Stamps, or Veteran's benefits and identify the benefits the person with a disability receives: _____
_____
_____

15. Identify any information regarding the relationship the person with a disability has with family or interested parties that may be important in the event that additional or successor guardians seek to be appointed: _____
_____
_____

16. 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: _____
_____
_____

17. Identify any other matters relating to this guardianship of which the Court should be aware: _____
_____
_____

18. Is the person with a disability under a permanent disability? ☐ Yes ☐ No

19. If the answer to Question 18 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 _____.
Name of person with a disability

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

Significant changes since last review: _____
_____
_____
_____
_____

Hospitalizations/Surgical procedures since last review: _____
_____
_____
_____
_____

Consequently, there is a continued need for guardianship of the person with a disability:
☐ Yes ☐ No

If No, why not? _____
_____
_____
_____
_____

_____ _____
Date Provider's signature and title