IN THE COURT OF CHANCERY FOR THE STATE OF DELAWARE

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

ANNUAL UPDATE & 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.

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 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: _____
_____
_____
_____

Is this a new residence or phone number? ☐ Yes ☐ No
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:
Name: _____
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? _____
_____

15. 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? _____
_____
_____
_____

16. 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?
☐ Yes ☐ No
What benefits does the person with a disability receive? _____
_____

17. Can you continue to serve as guardian of the person with a disability? ☐ Yes ☐ No
If not, why? _____
_____

18. Who would be best suited to serve as an additional or successor guardian for the person with a disability, if needed?
Name: _____ Phone number: _____
Current mailing address: _____
_____

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

20. 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: _____
_____
_____

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

_____ _____
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.

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., Ste. 11600, Wilmington, DE 19801 (Fax: 302-255-2213)
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, _____, last examined
Provider's name and title

_____ on the following date _____.**
Name of person with a disability

Examination must have occurred within the last calendar year

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

Significant changes in the last year: _____
_____
_____
_____
_____

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

Is there is a continued need for guardianship of the person with a disability?
☐ Yes ☐ No

If No, why not? _____
_____
_____
_____
_____

_____ _____
Date Form Completed Provider's signature and title