Name of Person Filing this Document

Mailing Address (Street or P.O. Box)

City, State, ZIP Code

Telephone Number

Email Address (if any)

IN THE DISTRICT COURT

COUNTY OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, STATE OF MONTANA

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| IN THE MATTER OF THE GUARDIANSHIP OF:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ,  ⬜ an Adult.  ⬜ a Minor. | Case No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GUARDIAN’S ANNUAL REPORT TO  THE COURT |

**Guidance.**

This form provides the court with information about an adult for whom a guardian has been appointed. This form should NOT be completed for a minor person who has been appointed a guardian.

A guardian must file this report each year within 30 days of the anniversary date of the guardian’s appointment or at other times, if ordered by the court. Please provide all the requested information about the person for whom you serve as guardian (referred to as “Person” below).

This report must be signed by the guardian under penalty of perjury and filed with the court. Copies must be provided to the person under guardianship, his/her attorney and any other individuals specified by the court. Keep a copy for your records.

**SECTION 1 - Person’s Residence.**

Physical Address:

Phone Numbers / Contact Information:

Residence:

Mobile: Work:

Email:

Name of Facility or Caregiver:

If the Person resides in a facility, please provide the name of the contact:

Facility or Caregiver’s Physical Address:

Facility or Caregiver’s Telephone Numbers / Contact Information:

Cell: Work:

Fax: Email:

Has the Person’s residence changed in the last 12 months?

⬜ Yes ⬜ No

If yes, please explain the reason for the change:

Will the Person’s residence change during the next 12 months?

⬜ Yes ⬜ No ⬜ Unknown

If yes, please explain the reason for the anticipated change in residence:

**COMPLETE PART A OR B**

PART A: If the Person lives in a facility, such as a residential assisted living home, an intermediate care facility, a nursing home, or other home with more than three non-related residents, answer the following:

Type of facility:

⬜ Residential Assisted Living Home

⬜ Intermediate Care Facility

⬜ Nursing Home

⬜ Other (please explain)

How is the facility paid?

Do you have any concerns about the quality of care received by the Person in these respects?

Cleanliness ⬜ Yes ⬜ No

Nutrition/Meals ⬜ Yes ⬜ No

Personal Care ⬜ Yes ⬜ No

Privacy ⬜ Yes ⬜ No

Individualized Care Plans ⬜ Yes ⬜ No

Safety ⬜ Yes ⬜ No

If you marked yes to any of the above, please explain:

Describe any restrictions placed on the Person in the facility, such as limitations on the Person’s visitors or phone calls:

When were the restrictions imposed?

Why were the restrictions imposed?

How was this facility chosen for the Person?

Is the Person satisfied with the placement?

Do you believe the Person could live and function more independently in a different setting? ⬜ Yes ⬜ No

If yes, why?

If yes, have you tried to change the Person’s residence? ⬜ Yes ⬜ No

If yes, what was the outcome?

**(IF YOU COMPLETED PART A, PLEASE SKIP TO SECTION 2)**

PART B: If the Person does not live in a facility, please answer the following:

Identify any other people living in the Person’s home and their relationship to the Person:

List anyone who moved into the Person’s home during the last 12 months:

Identify any resident in the Person’s home who is paid to provide any service to the Person. Please list the service provided, the amount paid for the service on a monthly basis, and the source of payment:

Name: Relationship to Person:

Type of Service:

Monthly Payment: Source of Payment:

Name: Relationship to Person:

Type of Service:

Monthly Payment: Source of Payment:

Name: Relationship to Person:

Type of Service:

Monthly Payment: Source of Payment:

Does the Person live with a convicted felon?

⬜ Yes ⬜ No ⬜ Unknown

If yes, please explain:

**SECTION 2 – Person’s Health.**

Please describe the Person’s physical health:

⬜ Poor ⬜ Fair ⬜ Good ⬜ Excellent

Please explain:

Please describe the Person’s mental health:

⬜ Poor ⬜ Fair ⬜ Good ⬜ Excellent

Please explain:

Please describe any changes in the Person’s physical or mental health during the last 12 months:

Please describe any medical or mental health treatment the Person received during the last 12 months:

**SECTION 3 - Person’s Services and Activities.**

Is the Person involved in selecting the care and services he/she receives?

⬜ Yes ⬜ No

If no, please explain:

Is the Person involved in developing his/her own care plan?

⬜ Yes ⬜ No

If not, why not?

Comment on the Person’s ability and desire to participate in social activities, such as local events, worship services, community groups, etc.:

**SECTION 4 - Person’s Financial Status.**

Is the Person employed?

⬜ Yes ⬜ No

If yes, explain whether the Person has control of his/her earnings and, if not, why not:

Describe the Person’s financial resources under the guardian’s control: (Please also attach the most recent representative payee accounting provided to the Social Security Administration or other accounting)

List the name and address of the conservator, if any:

Describe any efforts made to allow the Person to make decisions regarding his/her finances and any significant changes in the Person’s ability to manage financial resources:

**SECTION 5 - Guardianship Status.**

Describe significant actions taken by you concerning the Person during the last 12 months:

How often are you in contact with the Person?

How often are you in contact with service providers?

Describe any significant problems or unmet needs of the Person:

Would you or the Person like an opportunity to discuss changing or terminating the guardianship?

⬜ Yes ⬜ No

If yes, please explain:

VERIFICATION

I declare under penalty of perjury and under the laws of the State of Montana that all statements and information, above, are true and correct.

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

Signature Date

Typed/Printed Name

CERTIFICATE OF SERVICE

I certify that on (date) I served a copy to: (name all parties in the case other than yourself)

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| --- | --- |
| ⬜ Person  By Mail  (Name)  By fax to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Street or Post Office Address) (number)  By personal delivery  (City, State, and Zip Code)    ⬜ Attorney or Guardian ad Litem  By Mail  (Name)  By fax to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Street or Post Office Address) (number)  By personal delivery  (City, State, and Zip Code)  By Mail  (Name)  By fax to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Street or Post Office Address) (number)  By personal delivery  (City, State, and Zip Code)  By Mail  (Name)  By fax to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Street or Post Office Address) (number)  By personal delivery  (City, State, and Zip Code)  By Mail  (Name)  By fax to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Street or Post Office Address) (number)  By personal delivery  (City, State, and Zip Code) | * By mail * By fax (number) * By personal delivery * By mail * By fax (number) * By personal delivery * By mail * By fax (number) * By personal delivery * By mail * By fax (number) * By personal delivery * By mail * By fax (number) * By personal delivery |
| Typed/Printed Name | Guardian’s Signature |