Instructions - Report of Well Being

If you are a guardian of the person, you will file the Report of Well-Being. This is a two-page document with ten (10) questions or requests for information. For any question that cannot be answered fully in the space provided, you should attach additional sheets, writing or typing on only one side of the page. Item 1 requests a description of the incapacitated person's overall situation. This item should be answered either by describing any significant changes in the incapacitated person's physical health, intellectual functioning, emotional health and/or living conditions, or by stating affirmatively that there has been no substantial change in these areas since the prior reporting period. This item should not be left blank even if there has been no change to the incapacitated person's overall situation since the establishment of the guardianship or the filing of the prior report.

Item 2 addresses the incapacitated person's residential setting. If you respond that the current setting is not suitable to the needs of the incapacitated person, then you must explain that response and should specifically state whether the unsuitability is temporary and being addressed (i.e., the incapacitated person's apartment flooded due to a storm, and from _____ to _____ he was placed in alternate housing while the damage was repaired) or an ongoing issue (i.e., the incapacitated person is no longer ambulatory but remains in _____ facility which lacks operational elevators, however, alternate housing has not yet been secured).

Item 3 asks whether suitable social activities are available to the incapacitated person and whether he or she partakes in such activities. Both aspects of this question should be answered taking into consideration the abilities and needs of the incapacitated person.

Item 4 requests information regarding a recent medical evaluation of the incapacitated person. A written statement of an examining professional (i.e., medical doctor (M.D.), doctor of osteopathic medicine (D. O.), etc.) must be attached to the Report of Well-Being. Although the statement need not be in any particular form, it must be legible.

Item 5 requires a list of other professional medical treatment provided to the incapacitated person. If the reporting period is other than a year, then this question should be answered to address the period covered by this report.

Item 6 addresses substantial changes to the incapacitated person's medication. If the incapacitated person is not prescribed any medication, then this should be stated. If there has been no substantial change to the incapacitated person's prescriptions, then you should state “no change to prescriptions.” If the incapacitated person is subject to a regimen of over-the-counter medications, then any substantial change in this regard should also be noted.

Item 7 provides for a description of the incapacitated person's treatment plan going forward. For any area that does not apply, you should note “N/A” (not applicable). Examples of additional related services include speech therapy, occupational therapy, therapeutic massage, etc.

Item 8 directs the guardian to assess various areas of the incapacitated person's functioning. Please provide further explanation if you select “Don't Know” for any area.

Item 9 asks if you have investigated eligibility for public benefits to which the incapacitated person may be entitled. If you have investigated all listed programs, then you should answer “Yes” even if the incapacitated person has been determined ineligible for some/all benefits.

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Item 10 allows you as guardian to identify any assistance required from the court or a community agency. Please be as specific as possible in describing any help that you need on behalf of the incapacitated person.

After the 10 items listed above is a section for service. As noted at the beginning of the Report of Guardian Cover Page, you must file the original report with the Surrogate and serve copies of the report on the interested parties. Remember that there is a fee of $5/page for all documents filed with the Surrogate, including the Cover Page and the evaluation statement required by Item 4. In terms of service, you should consult the Judgment to see if any particular method of service is required (i.e., by certified mail). If nothing is stated in the Judgment, then use your discretion as to the method of service.

The term “Interested Parties” (or parties-in-interest) includes the nearest of kin of the incapacitated person, meaning those relatives served with notice of the underlying guardianship action, including any relatives identified or located after the filing of the complaint and prior to entry of the judgment. Note that a child of an incapacitated person need not be served during minority but must be served upon reaching the age of eighteen (18) years, even if such child was a minor at the time of the guardianship proceeding and therefore not listed as an interested party in the verified complaint. Interested parties may also include any agent(s) appointed pursuant to a power of attorney or advance directive, as well as the director of a residential care facility having custody of the incapacitated person, and/or the attorney appointed for the incapacitated person in the guardianship action. If an interested party is under a guardianship or has died, then this should be noted in the certification of service section.

Report of Well Being

If You Are **Guardian of the Person**, **Complete the Following Questions**

Guardian's Name: _____ Docket Number: _____

1. Describe the incapacitated person's overall situation, including any significant changes in physical health, intellectual functioning, emotional health and living conditions over the past year.

   _____

2. Residential Setting: Is the current setting suitable to the needs of the incapacitated person? If no, please explain. ☐ Yes ☐ No

   _____

3. Socialization: Does the incapacitated person have access and partake in appropriate social activities, given his/her abilities and needs? Please describe. ☐ Yes ☐ No

   _____

4. Medical Examination: State the date and medical professional that last examined the incapacitated person and the purpose of such visit.

   Date: _____ Physician: _____ Purpose: _____

   Please attach a statement of the incapacitated person's condition and functional level from a professional who has evaluated or examined him/her *within this reporting period* (e.g. physician, psychologist, clinician).

5. Treatment. What professional medical treatment, if not mentioned above, has been given to the incapacitated person during the preceding year?

Date	**Treatment**
_____	_____
_____	_____

6. Has there been any substantial change in the incapacitated person's medication? If yes, please explain. ☐ Yes ☐ No

   _____

7. Treatment Plan: Describe the treatment plan for the coming year for the incapacitated person regarding:
   (a) Medical Treatment: _____
   (b) Dental Treatment: _____
   (c) Mental Health Treatment: _____
   (d) Additional Related Services: _____

8. Guardian's current assessment of Incapacitated Person's: (check a rating box for each category)

	1 - Excellent	2-Satisfactory	3-Fair	4-Poor	5-Don't Know
Physical Health	☐	☐	☐	☐	☐
Intellectual Functioning	☐	☐	☐	☐	☐
Emotional Health	☐	☐	☐	☐	☐
Living Situation	☐	☐	☐	☐	☐

9. Has eligibility for such programs as Social Security, Medicare, Medicaid, SSI or Food Stamps been investigated? If no, state reason. ☐ Yes ☐ No

   _____

10. Is assistance, whether from the court or a community agency, required? Please describe. ☐ Yes ☐ No

    _____

Guardian's Name: _____ Docket Number: _____

Service

I certify that on_____ (date), a copy of this report was served on each of the following interested parties (*e.g.,* incapacitated person's spouse, parents, siblings, children *et cetera*):

Name of Interested Party	Relationship to Incapacitated Person	Address	Manner of Service

(attach additional information as necessary)

Certification

_____ *(insert your name),* certifies that I am the Guardian of the within named incapacitated person and that the attached annual report of well-being is to the best of my personal knowledge, complete and true statement of my activities as Guardian. I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements are willfully false, I am subject to punishment.

_____ _____

Date Signature of Guardian

_____

Print Name