IN THE CIRCUIT COURT FOR _____ COUNTY, FLORIDA
PROBATE DIVISION

IN RE: GUARDIAN ADVOCACY
OF

FILE NO: _____
DIVISION PROBATE

_____

Respondent,
Person with Developmental Disability

_____

ANNUAL GUARDIAN ADVOCACY PLAN (GUARDIANSHIP REPORT) OF GUARDIAN/CO-GUARDIAN ADVOCATE(S) OF PERSON

_____, the Guardian/Co-Guardian Advocate(s) of the Person of _____ (the Respondent), and submits the following plan as the Annual Guardianship Report.

The Annual Guardian Advocacy Plan for the period beginning _____, and ending _____, shall be as follows:

1. The Respondent's address at the time of filing the plan is _____.

The Respondent's residence is (group home, assisted living, live with parents, Respondent's private residence, other: please specify): _____

2. During the preceding year (prior 12 months), the Respondent was maintained at (include dates, names, addresses and length of stay at each place):

LOCATION	DATES	LENGTH OF STAY
_____	_____	_____
_____	_____	_____

3. The current residential setting (is or is not) _____ best suited for the current needs of the Ward.

4. Plans for ensuring that the Respondent is in the best residential setting to meet the Respondent's needs during the coming year (next twelve months) are as follows: _____

_____.

5. The following is a description of the Respondent's medical, mental health and rehabilitation needs: _____.

_____.

6. The following preexisting orders not to resuscitate executed under Fla. Stat. § 401.45(3) and preexisting advance directives, as defined in Fla. Stat. § 765.101, have been identified and located:

Date of Order/Directive	**Description of Order/Directive**	**Suspended by Court?**
_____	_____	_____
_____	_____	_____

If none, the following steps have been taken to identify and locate preexisting orders not to resuscitate and preexisting advance directives:

_____

7. The following is a description of professional medical treatment given to the Respondent during the preceding year:

Name of Physician	**Treatment**	**Date**
_____	_____	_____
_____	_____	_____

8. Attached is a report of a physician who examined the Respondent no more than ninety (90) days before the beginning of the report period, containing an evaluation of the Respondent's condition and a statement of the current level of capacity of the Respondent.

9. The plan for providing medical, mental health and rehabilitative services in the coming year (next twelve months) is as follows: _____

_____.

10. The following information is submitted concerning the social condition of the Ward:

a. The social and personal services currently used by the Respondent are as

_____

follows:

Name and address	**Services rendered**

b. The following is a statement of the social skills of the Respondent, including how well the Respondent communicates and maintains interpersonal relationships:

_____.

c. The following is a description of the social needs of the Respondent:

_____.

11. The following is a summary of activities during the preceding year that were designed to enhance the capacity of the Respondent: _____

_____.

12. The Respondent (is or is not) _____ now capable of having some or all of the Respondent's rights restored. If so, the rights *(to marry, to vote, to travel, to have a driver's license, to seek or retain employment, to personally apply for government benefits, to contract, to sue and defend lawsuits, to manage property or to make any gift or disposition of property, to determine the Ward's residence, to consent to medical and mental health treatment, to make decisions about the Ward's social environment or other social aspects of the Ward's life OR liste "NONE")* that should be restored are identified as follows:

_____

13. I/We (do or do not) _____ plan to seek the restoration of any rights to the Respondent.

14. This plan (has or has not) _____ been reviewed with the Respondent to the extent possible.

15. The Guardian/Co-Guardian Advocate(s) has/have received the following remuneration for services rendered to or on behalf of the Ward (if none, list "NONE.":

Description	**Amount**

Under penalties of perjury, I/we declare that I/we have read the foregoing, and the facts alleged are true, to the best of my/our knowledge and belief.

Signed on this _____ day of _____, 20_____.

Signature:_____
Guardian/Co-Guardian Advocate
Name:_____
Address:_____
_____
Phone Number:_____
Email Address: _____

Signature:_____
Guardian/Co-Guardian Advocate
Name:
Address:

Phone Number:_____
Email Address: _____
_____

Certificate of Service

(A certificate of service as required by Florida Rule of Judicial Administration 2.516 must be included if Respondent is over the age of 14 and is not totally incapacitated.)

I hereby certify that on _____, 20____, the foregoing document has been furnished by:
_____ email delivery, or
_____ U.S. mail delivery, or
_____ fax delivery,
to: Name, address, email, fax number of recipients:

_____

Signature: _____
Guardian Advocate
Name: _____
Address: _____
_____
Phone Number: _____
Email Address: _____

IN THE CIRCUIT COURT OF _____COUNTY, FLORIDA

DIVISION PROBATE
Case No.:

Respondent,
Person with Developmental Disability

PHYSICIAN'S REPORT

(Required by Florida Statutes, Section 744.3675 for filing with Annual Guardian Advocacy Plan)

1. Name of Physician:
   Address:

2. Name of the Protected Person/Ward:
3. Date of examination:
4. Purpose of examination:
   A. Regular checkup
   B. Treatment for

5. Evaluation of Protected Person/Ward's condition: (Specify mental and physical condition at time of examination)

6. Description of Protected Person/Ward's capacity to live independently:

7. The Protected Person/Ward (*does or does not*) _____ continue to need the assistance of a Guardian.

8. Is the Protected Person/Ward capable of being restored to capacity at this time? (*Yes or No*)_____
9. Date of this report:_____

Signature of physician completing this report

_____