CIRCUIT COURT FOR _____ ☐ **, MARYLAND**
City/County

Located at _____ **Case No.** _____
Court Address

In the Matter of

_____ _____
Name of Disabled Person Docket Reference

ANNUAL REPORT OF GUARDIAN OF DISABLED PERSON
(Md. Rule 10-206(e))

NOTE: Guardians of the person of disabled persons must complete and file this form each year within 60 days of the anniversary of their appointment, or as the court otherwise directs. Attach additional sheets if needed.

If a section of this form does not apply, write "Not applicable" or "N/A."

Disabled person's Date of Birth: _____
Gender: ☐ Female ☐ Male

REPORTING PERIOD

I/We, _____ and (if applicable) _____ ,
Name of Guardian Name of Guardian 2
make this annual report for the period of _____ to _____ .
Date Date

<u>Part I.</u> Information about the disabled person

A. RESIDENCE AND HOUSING

Disabled person's address (where he or she lives or is physically present):

_____
Address

_____
City, state, zip

Select all that apply:

☐ This is the disabled person's permanent residence.

☐ This is not the disabled person's permanent residence. His/Her permanent residence is located at _____ , _____ .
Address City, state, zip

☐ This is a new address (check if the disabled person's address changed since the last annual report or since your appointment as guardian if this is your first report).

Explain why the address changed:

_____

Type of housing *(select one)*:

☐ Own home ☐ Guardian 1's home ☐ Guardian 2's home

☐ Relative's home: _____
Name of relative

_____
Relationship to disabled person

☐ Hospital or medical facility: _____
Name of hospital or facility

Type of facility *(select one)*: ☐ nursing home ☐ assisted living
☐ group home ☐ residential treatment facility
☐ other (describe):

☐ School: _____
Name of school

Do you plan to change the place where the disabled person lives? ☐ Yes* ☐ No
If yes, explain why:

***You may need permission from the court before you move the disabled person from one location to another (Estates & Trusts, Art., § 13-708).**

B. MEDICAL AND PERSONAL CARE

Conditions. List significant health or mental health issues the disabled person has (asthma, diabetes, anxiety, etc.):

Issue(s)	Treatment/treatment plan

Hospitalizations. Was the disabled person hospitalized during the reporting period? ☐ Yes ☐ No
If yes, explain:

Date	Hospital	Reason

Providers. Which medical professional(s) did the disabled person see during the reporting period?

	Name	City, state	Date(s) seen
☐ Primary care			
☐ Dentist			
☐ Eye doctor			
☐ Ear doctor			
☐ Psychiatrist			
☐ Psychologist			
☐ Therapist (mental health)			
☐ Physical or occupational therapist			
☐ Speech therapist			
☐ Other (describe):			

Medications. List medications the disabled person takes on a regular basis:

Name	Purpose	Dosage/Schedule

Personal care. Are there problems providing meals, clothing, housing, or transportation for the disabled person? ☐ Yes ☐ No

If yes, explain:

C. SCHOOL AND JOB TRAINING

School. Does the disabled person attend school? ☐ Yes ☐ No

If yes: _____ (Name of school) _____ (City, state, zip)

Is there a care plan or an Individualized Education Program (IEP)? ☐ Yes ☐ No

If yes, did you participate in developing the care plan or IEP? ☐ Yes ☐ No

Do you believe the care plan or IEP is good or appropriate for the disabled person (in his or her best interest)? ☐ Yes ☐ No (explain):

Job training. Is the disabled person in a job training program? ☐ Yes ☐ No

If yes: _____ (Name of program) _____ (City, state, zip)

Describe: _____

D. EMPLOYMENT

Does the disabled person have a job? ☐ Yes ☐ No

If yes: _____ (Name of employer) _____ (City, state, zip) _____ (Hours worked per week)

Type of job: _____

E. SOCIAL AND RECREATIONAL ACTIVITIES

Describe social or recreational activities the disabled person enjoyed during the reporting period (sports, hobbies, clubs, adult day care, etc.).

F. CONTACTS

Contact with you. If the disabled person **does not** live with you, how often did you visit him or her during the reporting period?

Describe your other types of contact with the disabled person:

Type	Frequency
☐ Telephone	
☐ Mail or e-mail	
☐ Other (describe):	

Contact with others. Describe the disabled person's contact with family members during the reporting period.

Visitation plan. Is there a formal visitation plan (guidelines for who visits or communicates with the disabled person)? ☐ Yes ☐ No
If yes, how is it working?

G. DECISION-MAKING

Describe any changes in the disabled person's ability to make decisions affecting his or her health.

Is the disabled person involved in decisions about his or her housing, medical care, education, employment, social or recreational activities, etc.? *(select one)*
☐ Yes. Describe how:

☐ No. Explain why:

H. COMMUNITY SUPPORT

List community organizations currently involved with the disabled person (case or care management, community services, government programs, religious programs, charitable organizations, etc.).

Organization/Provider	Services received	City, state

Part II. Information about the guardianship

A. FUNDS

Did the guardian of the property, if any, provide funds toward the disabled person's support, care, or education? ☐ Yes ☐ No ☐ Not applicable

If yes, describe *(Select all that apply):*

☐ clothing ☐ food ☐ housing ☐ health care (co-pays, insurance, etc.)

☐ transportation ☐ education ☐ extracurricular/recreational activities ☐ job training

☐ other (describe):

B. HEALTH OF GUARDIAN(S)

Guardian 1 *(select one):*

☐ I have no serious health problems that affect my ability to serve as guardian.

☐ I have the following serious health problems that may affect my ability to serve as guardian:

Guardian 2 (if any) *(select one):*

☐ I have no serious health problems that affect my ability to serve as guardian.

☐ I have the following serious health problems that may affect my ability to serve as guardian:

C. CONTINUATION OF GUARDIANSHIP

This guardianship *(select one):*

☐ should be continued.

☐ should not be continued for the following reason(s):

D. POWERS OF GUARDIAN(S)

My/Our powers as guardian should *(select one):*

☐ stay the same.

☐ change in the following ways for the following reasons:

E. OTHER

The court should be aware of the following other matters relating to this guardianship:

I/we solemnly affirm under the penalties of perjury that the contents of this document are true to the best of my/our knowledge, information, and belief.

Date

Signature of Guardian 1

Printed Name

Address

City, state, zip

Telephone

☐ This is a new address since the last report (or since appointment if this is your first report).

Date

Signature of Guardian 2 *(if applicable)*

Printed Name

Address

City, state, zip

Telephone

☐ This is a new address since the last report (or since appointment if this is your first report).

Reset