

**PROBATE COURT OF HAMILTON COUNTY, OHIO  
RALPH WINKLER, JUDGE**

**GUARDIANSHIP OF** \_\_\_\_\_  
**CASE NO.** \_\_\_\_\_

**GUARDIAN'S REPORT  
[R.C. 2111.49 and Sup.R. 66.05(B)(2)]**

NOTE: If allotted space is inadequate to respond, write "See Exhibit" in the space and add appropriate exhibit letter sequence, then attach exhibit containing information requested for that space.

1. This is the **(circle one)**: 1st, 2nd, 3rd, 4th, 5th, 6th, or \_\_\_\_\_, Guardian's Report.
2. Ward's Date of Birth: \_\_\_\_\_
3. Ward's present address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

4. Ward's living arrangements at the above address are best described as:
  - a. His or her own apartment or home (includes assisted living facilities).
  - b. Private home or apartment of:
    - (1) the ward's guardian
    - (2) a relative of the ward, whose name is \_\_\_\_\_  
and relationship is \_\_\_\_\_
    - (3) a non-relative whose name is \_\_\_\_\_

- c. A foster, group or boarding home.
- d. A nursing home.
- e. A medical facility or state institution.
- f. Other (describe) \_\_\_\_\_  
\_\_\_\_\_

- g. If c, d, e or f is checked, complete the following:
  - (1) The name of the home, facility or institution \_\_\_\_\_  
\_\_\_\_\_
  - (2) The name of an individual at the home, facility or institution who has knowledge  
and is authorized to give information to the Court about the ward.  
Name \_\_\_\_\_  
Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_

5. The ward will be at the address given in Item 3:
  - a. Indefinitely.
  - b. Temporarily. The new address and telephone number is:
    - (1) Unknown. I will provide this information when known.
    - (2) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

- 6. Guardian's contact with the ward:
  - a. Approximate number of times the guardian had contact with the ward during the period covered by this report: \_\_\_\_\_.
  - b. The nature of those contacts (phone, personal, or other): \_\_\_\_\_
  - c. Date the ward was last seen by the guardian: \_\_\_\_\_
  
- 7. Have you observed any major change in the ward's physical or mental condition during the period covered by this report?     Yes    No  
 If "yes" is checked, briefly describe the changes. \_\_\_\_\_
  
- 8. The care given to the ward is                     Adequate     Not Adequate  
 If "Not Adequate" is checked, explain. \_\_\_\_\_
  
- 9. The guardianship should be                     Continued     Not Continued  
 If "Not Continued" is checked, explain. \_\_\_\_\_
  
- 10. During the period covered by this report, the ward  has  has not been seen by a physician. If the ward has been seen, the last date was \_\_\_\_\_ and for the purpose of \_\_\_\_\_
  
- 11.  I currently serve as the Guardian to ten or more wards and certify to the court that I am unaware of any circumstances that may disqualify me from serving as Guardian of this Ward.
  
- 12. With regard to the continuing education requirement pursuant to Sup. R. 66.07:
  - I have completed the continuing education requirement. (Attach Certificate of Completion if applicable)
  - The continuing education requirement was waived.

Attached is a statement by a licensed physician, a licensed clinical psychologist, a licensed independent clinical social worker, a licensed professional clinical counselor or a developmental disability team, that has evaluated or examined the ward within three months prior to the date of this report regarding the need for continuing the guardianship. [R.C.2111.49(A)(1)(i)](Form 17.1)

Date \_\_\_\_\_

If an attorney has been consulted on this report:

\_\_\_\_\_  
 Attorney for Guardian

\_\_\_\_\_  
 Street

\_\_\_\_\_  
 City,                    State,                    Zip Code

\_\_\_\_\_  
 Telephone Number (include area code)

\_\_\_\_\_  
 Attorney Registration No.

\_\_\_\_\_  
 Guardian's Printed Name

\_\_\_\_\_  
 Guardian's Signature

\_\_\_\_\_  
 Street

\_\_\_\_\_  
 City,                    State,                    Zip Code

\_\_\_\_\_  
 Telephone Number (include area code)

\_\_\_\_\_  
 E-mail Address

(Knowingly giving false information on a Probate document is a criminal offense.)  
[R.C. 2921.13(A)(11)]

**PROBATE COURT OF HAMILTON COUNTY, OHIO  
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GUARDIANSHIP OF \_\_\_\_\_

CASE NO. \_\_\_\_\_

**STATEMENT OF EXPERT EVALUATION**

[ This form may only be used for purpose of the Guardian's Report ]

Definition of incompetent [ O.R.C. 2111. 01 (D) ]- "An Incompetent means any person who is so mentally impaired as a result of a mental or physical illness or disability, or intellectual disability, or as a result of chronic substance abuse, that the person is incapable of taking proper care of the person's self or property or fails to provide for the person's family or other persons for whom the person is charged by law to provide, or any person confined to a correctional institution within this state."

The statement of evaluation does not declare the ward incompetent, but is evidence to be considered by the Court.

The fee for completing this evaluation WILL NOT be paid by the Court. Each evaluator should secure payment from the Guardian.

1. This statement of expert evaluation is for the Guardian's Report. **Evaluation and statement by a Licensed Physician, Licensed Clinical Nurse Specialist, Licensed Certified Nurse Practitioner, Licensed Clinical Psychologist, Licensed Independent Social Worker, Licensed Professional Clinical Counselor or Developmental Disability Team to be completed within three months of the date of this report. O.R.C. 2111.49(A)(1).**

2. Statement completed by:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

who is a:

Licensed Physician \_\_\_\_\_

Licensed Clinical Psychologist \_\_\_\_\_

Developmental Disability Team \_\_\_\_\_

Licensed Certified Nurse Practitioner \_\_\_\_\_

Licensed Independent Social Worker \_\_\_\_\_

Licensed Clinical Nurse Specialist \_\_\_\_\_

Licensed Professional Clinical Counselor \_\_\_\_\_

3. Date(s) of evaluation: \_\_\_\_\_

Place(s) of evaluation: \_\_\_\_\_

Time spent with ward: \_\_\_\_\_

Length of time ward has been your patient: \_\_\_\_\_

4. Is the ward presently under medication? Yes \_\_\_\_ No \_\_\_\_ If yes, what is the medication, dosage, and purpose. \_\_\_\_\_

Are there any signs of physical and/or mental impairments caused by the medications themselves? \_\_\_\_\_

5. During the examination did you note a disturbance of the ward's:

	Yes	No
a) Orientation?.....	_____	_____
b) Speech?.....	_____	_____
c) Motor Behavior?.....	_____	_____
d) Thought Process?.....	_____	_____
e) Affect?.....	_____	_____
f) Memory?.....	_____	_____
g) Concentration and Comprehension?.....	_____	_____
h) Judgment?.....	_____	_____
i) Perception of Time and Place?.....	_____	_____

6. Please describe any abnormalities identified in question five. (Attach addenda if space is not adequate.) \_\_\_\_\_

7. Is the ward mentally impaired? Yes \_\_\_\_ No \_\_\_\_ If yes, what is the cause? \_\_\_\_\_

8. Is the ward physically impaired? Yes \_\_\_\_ No \_\_\_\_ If yes, what is the cause? \_\_\_\_\_

9. Did you consult any collateral information in conjunction with your evaluation? Yes \_\_\_No\_\_\_  
If yes, explain: \_\_\_\_\_

\_\_\_\_\_

10. Please give a summary of background / historical information obtained from the ward and/or collateral source. \_\_\_\_\_

\_\_\_\_\_

11. Could you determine the general level of intelligence and fund of knowledge of the ward?  
Yes \_\_\_No\_\_\_ If yes, explain: \_\_\_\_\_

\_\_\_\_\_

12. Do you believe this ward in his/her present condition, is substantially capable of managing his/her finances and property? Yes \_\_\_No\_\_\_ If yes, explain: \_\_\_\_\_

\_\_\_\_\_

13. Do you believe this ward in his/her present condition, is substantially capable of caring for his/her activities of daily living or making decisions concerning medical treatments, living arrangements, and diet?

Yes \_\_\_No\_\_\_ If yes, explain: \_\_\_\_\_

\_\_\_\_\_

14. Prognosis: \_\_\_\_\_

\_\_\_\_\_

In my opinion a guardianship should be:

Continued

Terminated

CASE NO. \_\_\_\_\_

Additional Comments

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I certify that I have evaluated \_\_\_\_\_ for the purpose of guardianship.

\_\_\_\_\_  
Date of Evaluation

\_\_\_\_\_  
Evaluator



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**CASE NO.** \_\_\_\_\_

**GUARDIANSHIP INFORMATION**

The Applicant/Guardian hereby provides the Court with the following information:

**RESIDENTIAL PROVIDER INFORMATION**

Residential Provider: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Phone Number (including area code): \_\_\_\_\_

Email: \_\_\_\_\_

**HAMILTON COUNTY BOARD OF DEVELOPMENTAL DISABILITIES INFORMATION**

SSA Name: \_\_\_\_\_

SSA Phone Number (including area code): \_\_\_\_\_

SSA Email: \_\_\_\_\_

**DAY PROGRAM/WORKSHOP/COMMUNITY EMPLOYMENT INFORMATION**

Program Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Phone Number (including area code): \_\_\_\_\_

Address: \_\_\_\_\_

Days/Hours Attend: \_\_\_\_\_

\_\_\_\_\_  
Applicant/Guardian