

CAUSE NO. _____

IN THE GUARDIANSHIP OF

IN THE COUNTY

_____ ,

COURT AT LAW NO. _____

AN INCAPACITATED PERSON

JOHNSON COUNTY, TEXAS

GUARDIAN OF THE PERSON'S ANNUAL REPORT ON THE
CONDITION OF AN ADULT INCAPACITATED PERSON
FOR THE REPORTING PERIOD OF _____ TO _____

**DO NOT LEAVE ANY BLANKS – COMPLETE REPORT ENTIRELY OR YOUR REPORT
WILL NOT BE APPROVED**

A. Incapacitated Person ("IP") Name: _____

Age: _____ Date of Birth: _____

IP's residence is: Guardian's home IP's own home Group home Foster home

Nursing home Assisted Living **How long in this placement:** _____

Name of Facility (if applicable): _____

Address: _____

City, State, Zip: _____ Phone: _____

Has IP moved since the last Annual Report was filed? Yes No

B. Incapacity: Intellectual Disability Autism Asperger's
 Alzheimer's Dementia Brain Injury Stroke Other: _____

Chronic Mental Illness: _____

Level of incapacity: Severe Moderate Mild

Other medical conditions: _____

C. Guardian – Name: _____

Relationship to Ward: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____

Has your contact information changed since the last Annual Report was filed? Yes No

During the past reporting year, have you been convicted of a felony or a misdemeanor other than a minor traffic offense? Yes No If YES, explain: _____

D. Visitation/Phone Contact

IP Does Does Not live with the Guardian.

(If the IP "Does" live with the Guardian, skip to section "E")

Are you visiting the IP once a month? Yes No

If yes, list the date of your last personal visit: _____

If no, explain why you are not visiting monthly and list date of your last visit: _____

E. IP's Medical Condition:

During the past year, IP's **physical health** has:

Remained the same Improved Deteriorated

Describe: _____

During the past year, IP's **mental health** has:

Remained the same Improved Deteriorated

Describe: _____

During the past year, have you transported the Ward to an inpatient mental health facility for an examination? No Yes # of times: _____ Name of facility: _____

Injuries or hospitalizations within the last 12 months: Yes No

If yes, briefly describe what happened: _____

Medical/agency providers	Name	Phone #
Physician/PCP		
Psychiatrist		
Psychologist		
Dentist		
Social Worker or Case Mgr <i>with name of agency</i>		
Other Providers:		

I believe IP has **unmet medical needs:** Yes No

If yes, what is being done? _____

F. IP's Social Conditions, Education, Services and/or Employment

What does your ward do all day? Note that for each type of activity, you must describe the Activity ****Don't leave blank****

Is IP able to participate in activities? Yes No

If yes, list IP's activities (social, recreational, family, educational, job): _____

If no, explain why IP cannot participate: _____

I believe IP has **unmet social needs:** Yes No

If yes, what is being done? _____

1. Educational Conditions for IP with Intellectual/Development Disabilities:

Does IP attend school or Transition Program? Yes No

If YES, name of school: _____

Location of school: _____

2. Services or Benefits Received for IP with Intellectual/Development Disabilities:

Does IP currently receive services from one or more of the following agencies?

MHMR Johnson County: _____ (Service Coordinator)

CLASS/Easter Seals: _____ (Contact Person)

Day Habilitation: _____ (Name of Program)

If IP is not attending Day Habilitation, why not? _____

HCS: _____ (Agency Name)

Texas Workforce Commission: _____ (Case Worker)

If IP is not receiving any services, why not? _____

3. Employment:

Employed: _____ (Company Name)

Days/Hours worked: _____

Length of time employed here: _____

As a **Guardian**, I am taking the following actions to encourage the development of the ward's maximum self-reliance and independence: _____

G. IP's Living Conditions

I rate my IP's **living arrangements** as: Excellent Average Below Average

If below average, explain: _____

I believe IP is Content Unhappy with these living arrangements

I believe IP has **unmet basic needs**: Yes No

If yes, what is being done? _____

H. IP's Assets and Income

Does the IP have a Trust account in a nursing home or other residential facility?

Yes No

Current balance: \$ _____

Does IP receive Supplemental Security Income (SSI)? Yes No

If "Yes," how much per month? \$ _____ Payee: _____

Does IP receive Social Security (SS) benefits? Yes No

If "Yes," how much per month? \$ _____ Payee: _____

Are there any other benefits or income you receive on IP's behalf? Yes No

Child Support \$ _____ Pension/Retirement \$ _____

Oil/Gas Royalty \$ _____ Other _____ \$ _____

Has any of the IP's property been sold in the past year? Yes No

If yes, explain: _____

Has IP inherited anything in the past year? Yes No

If yes, explain: _____

Are there any lawsuits pending or filed that will affect or involve IP? Yes No

If yes, explain: _____

What plans have been made for IP's burial expenses? We know your Ward may be young, or this is something you prefer not to address, but it is very important and should be arranged.

Preneed: _____ Life Ins: _____

Special Needs Trust ABLE account

If not, why: _____

I. Additional Information

Has the IP **regained capacity** to make decisions? Yes No *If Yes, please describe how and in what areas the IP has regained decision making capacity:*

J. WARD'S BILL OF RIGHTS: I provided a copy of the "Ward's Bill of Rights" to the Ward and explained the rights in the Ward's native language or preferred method of communication. Yes No, if not why: _____

My **powers** as Guardian should:

Remain the same

Be decreased Be increased as follows: _____

I wish to resign as Guardian - *Explain why and who you would recommend:* _____

K. In case of an emergency

Name, Address & Phone # of two friends or family members who know how to reach you:

1. Name: _____

Physical Address: _____

Mailing Address (if different): _____

Tel. No.: _____ - _____ - _____

2. Name: _____

Physical Address: _____

Mailing Address (if different): _____

Tel. No.: _____ - _____ - _____

