Each guardian must complete their own Cover Page.
(Spouses at the same address can complete one together.)

Clear

Report of Guardian Cover Page

In the Matter of the Report of

_____, Guardian(s) for

_____, an Incapacitated Person.

Superior Court of New Jersey
Chancery Division - Probate Part
County of _____
Docket No. _____

Civil Action

Guardian's Report for the Period

_____ to _____

This report must be filed by every Guardian within fourteen (14) days of the anniversary date of your appointment, which is _____, unless the Judge otherwise specifies. File the original with the Surrogate.

1. Guardian's Current Information*

   Street address: _____

   City: _____ State: _____ Zip: _____

   Include mailing address, if different

   Mailing address: _____

   City: _____ State: _____ Zip: _____

   Phone: _____ ext. _____ Email Address: _____

   Select one: ☐ Guardian of Person ☐ Guardian of Estate ☐ Guardian of Both Person and Estate

   Guardian's relationship to the Incapacitated Person? _____

   State any changes to the guardian's criminal or civil judgment history, including bankruptcies:

   _____

   *If needed: attach a separate page with additional information, including for any co-guardian(s).

2. Incapacitated Person's Current Information: does he/she reside with the guardian? ☐ Yes ☐ No
   If No, complete the incapacitated person's residency information below. **If Yes,** continue to #3.

   A. Incapacitated Person's address: If the incapacitated person lives in a residential facility, include the name of the Director or person responsible for the incapacitated person's care.

   Address: _____

   City: _____ State: _____ Zip: _____

   Telephone Number: _____ ext. _____

   Contact Name: _____ Telephone Number: _____ ext. _____

   B. State the average number of visits you or your designee made to the Incapacitated Person during the period: _____.

3. Identify all Guardianship responsibilities (check all that apply):

   ☐ Manage financial affairs ☐ Provide necessities ☐ Feed ☐ Take on outings
   ☐ Provide transportation ☐ Housekeeping ☐ Bathe ☐ Provide continuous care
   ☐ Social Security Representative Payee

   List all other responsibilities assumed:

   _____

4. State if you believe the guardianship should continue? State reason: ☐ Yes ☐ No

   _____

5. Is there any change to the guardianship estate? **If Yes,** describe: ☐ Yes ☐ No

   _____

6. Are any modifications or adjustments needed in the guardianship? **If Yes,** describe: ☐ Yes ☐ No

   _____

   _____

Answer every single question. If you do not know the answer, you need to find out the answer.
Do not refer to attachments or direct us to someone else for the answers.

Report of Well-Being

Notice to Interested Parties: Interested parties should act to protect the welfare and/or finances of an adult incapacitated person under legal guardianship. Within the time and in the manner provided by law, interested parties may file a motion to object to actions taken by the guardian or to seek review of the guardianship. Although some guardianship reports are subject to review by authorized Judiciary and/or Surrogate personnel, interested parties remain responsible for requesting court review as to any misstatements or misconduct by a guardian.

If you are Guardian of the Person, Complete the Following Questions

Guardian's Name: _____ Docket Number: _____

Incapacitated Person's Name: _____

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? ☐ Yes ☐ No
If No, please explain.

_____

_____

_____

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 (*e.g.* physician, psychologist, clinician) who has evaluated or examined him/her *within this reporting period*. Either use the attached form or make sure that the statement addresses the same information.

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? ☐ Yes ☐ No
   If Yes, please explain.

_____

_____

_____

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	☐	☐	☐	☐	☐
Emotional Health	☐	☐	☐	☐	☐
Intellectual Functioning	☐	☐	☐	☐	☐
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 information or assistance, whether from the court or a community agency, required? ☐ Yes ☐ No
    If Yes, please describe.

_____

_____

_____

***Optional*:**

In addition to the information provided above, the court should be aware of the following issues related to the incapacitated person and/or the guardianship:

_____

_____

_____

_____

_____

_____

Note: The Judiciary's Guardian Support/Guardianship Monitoring Program webpage, found at http://www.njcourts.gov/courts/civil/guardianship.html, features general court information, forms, frequently asked questions, and helpful links.

Guardian's Name: _____ Docket Number: _____

Certification

_____, certifies that I/we am/are the Guardian(s) of the within named
(insert your name)
incapacitated person and that the attached report of well-being is to the best of my/our personal knowledge, complete and true statement of my/our activities as Guardian(s). I/we will supplement this form as may be necessary should additional information become available.

I/We am/are aware that if any of the foregoing statements are willfully false, I/we am/are subject to punishment.

_____ _____
Date Signature of Guardian

_____
Print Name

_____ _____
If applicable: Date Signature of Co-Guardian

_____
Print Name

_____ _____
If applicable: Date Signature of Co-Guardian

_____
Print Name

All guardians must sign (or complete their own well-being reports).

Guardian's Name: _____ Docket Number: _____

Certification of Examining Professional

Name: _____

Address: _____

_____

Telephone: _____ ext. _____

In the Matter of: (Insert the incapacitated person's name)

_____,

an Incapacitated Person.

THIS FORM IS TO BE COMPLETED BY A DOCTOR WHO EXAMINED THE PATIENT WITHIN YOUR REPORTING PERIOD.
It should not warrant a new exam (it can be completed retroactively).
Going forward, you may use a blank of this form at any appointment each year and attach it to that year's reports.

I, _____, of full age, hereby certify as follows:

1. This certification is made by me for purposes of the periodic report of the well-being of _____, an incapacitated person.
   [insert the incapacitated person's name]

2. I examined _____, on _____. The examination took place at
   [insert the incapacitated person's name] [insert date]
   _____.

   My examination revealed that (select one)

   ☐ the condition of the incapacitated person is essentially unchanged;

   ☐ during the reporting period, the condition of the incapacitated person has changed as follows:

   _____

   _____

   _____

3. In my opinion, _____,
   [insert the incapacitated person's name]

   ☐ continues to lack capacity to govern him/herself and to manage his/her affairs to the same extent and therefore the guardianship should continue unchanged;

   ☐ exhibits a change in capacity such that the guardianship should be modified as follows:

   _____

   _____

   _____

I hereby certify and say that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____
Date Signature of Professional

_____
Print Name