NOTICE: THIS DOCUMENT CONTAINS SENSITIVE DATA.

CAUSE NO. _____

GUARDIANSHIP OF	**§**	**IN PROBATE COURT**
_____,	**§**	**NUMBER _____ OF**
AN INCAPACITATED PERSON	**§**	**DALLAS COUNTY, TEXAS**

ANNUAL REPORT OF GUARDIAN OF THE PERSON ON THE LOCATION, CONDITION AND WELL-BEING OF INCAPACITATED PERSON

Now comes _____ and _____, Co-guardians of the Person of _____, and presents the following information as of _____ [date]:

1. Incapacitated Person's current address (street, city, state, zip code, county):

   _____

   Phone number: _____ How long at this address? _____

   Incapacitated Person's age: _____Date of Birth: _____ Military Veteran: ☐Yes ☐No

   If the incapacitated person does not reside in Texas, how often does he/she return to Texas and when? _____

2. *Co-guardian 1*

   Guardian's current name and address: (street, city, state, zip code, county):

   _____

   _____ Home phone number: _____

   Work phone number: _____ Cell phone number: _____

   E-mail address: _____ Date of Birth: _____

   During the past reporting period, have you (the guardian) been convicted of a felony or misdemeanor?

   ☐Yes ☐No If YES, explain: _____

   During the past reporting period, have you (the guardian) been contacted by Adult or Child Protective Services? ☐Yes ☐No If YES, explain: _____

*****A Guardian of the person or estate or both of a ward who is 60 years of age or older, or under 60 and diagnosed with Alzheimer's Disease, dementia, or a related disorder must complete a 1-hour training course on these issues within 6 months after appointment and every year thereafter. (Tex. Gov't Code 155.204(a)(2)).*****

Co-guardian 2

Guardian's current name and address: (street, city, state, zip code, county):

_____

_____ Home phone number: _____

Work phone number: _____ Cell phone number: _____

E-mail address: _____ Date of Birth: _____

During the past reporting period, have you (the guardian) been convicted of a felony or misdemeanor?

☐Yes ☐No If YES, explain: _____

During the past reporting period, have you (the guardian) been contacted by Adult or Child Protective Services? ☐Yes ☐No If YES, explain: _____

3. The incapacitated person lives in: (select one) ☐ Own home ☐ Guardian's home

☐ Foster home (Foster Care Provider's name): _____

☐ Relative's home (Describe relationship) _____

☐ Boarding home (Owner's name): _____

☐ Group home (Agency name): _____

☐ Nursing home (Facility name): _____

☐ Hospital or Medical facility (Facility name): _____

☐ Other (specify) _____

4. Regardless of ownership, please list all weapons (including firearms, machetes, nunchuks, etc.) contained in the incapacitated person's residence and describe how each weapon is secured. If extra room is need, please attach additional sheets or use the back of this form.

_____

_____

_____

_____

_____

5. If the incapacitated person resides in a nursing home, ICF facility, State Supported Living Center, or any residential care facility, is there a necessity for continued care in the residential care facility?

☐ Yes ☐ No

If you answered YES to the above question, explain why there is a continuing necessity for the incapacitated person to reside in the residential care facility?

_____

_____

6. If the incapacitated person lives in a private residence, list the names of all other persons living in the residence:

Relationship to Incapacitated Person	Full Name (first, middle last)	Date of Birth mm/dd/yyyy

7. Has the incapacitated person's residence changed within the past 12 months? ☐ Yes ☐ No

If YES, state the date and reason:

_____

If YES, was the incapacitated person moved from a home and placed in a more restrictive care facility, such as a nursing home, ICF/IDD facility, or State Supported Living Center? ☐Yes ☐No

If YES, was NOTICE sent to the court regarding this move? ☐Yes ☐No
On what date was the notice sent to the court? _____

8. If the incapacitated person does not live with you, the guardian, please state the number of times you have visited the incapacitated person in the past year:____ times. Date of last visit: _____

9. Were you also appointed Guardian of the Estate OR as Guardian of the Person did you post a corporate bond? ☐ Yes ☐ No

If YES, have you paid the bond premium for the next reporting period?

☐ Yes, on (date) _____, 20_____ ☐ No

9a. Has a Supplemental or Special Needs Trust (SNT) been created for the incapacitated person? ☐Yes ☐No

If YES, has the SNT been funded? ☐Yes ☐No

10. If during the past year the guardian has received and spent funds for the care and maintenance of the incapacitated person, provide the amounts below:

a. Total funds received monthly: $_____

b. Source of funds and total amount received annually:

- ☐ SSI or SSDI $_____
- ☐ Child Support $_____
- ☐ Private Retirement $_____
- ☐ VA $_____
- ☐ Social Security Survivor Benefits (RSDI) $_____
- ☐ Trust Account Allowance $_____

c. Total funds spent for the incapacitated person's care: $_____

Who has possession or control of the Incapacitated Person's estate (name, address, phone number):

_____

***IF IN THE PAST YEAR THE GUARDIAN OF THE PERSON HAS RECEIVED FOR THE INCAPACITATED PERSON ANY OTHER FUNDS FROM ANY OTHER SOURCES, INCLUDING BUT NOT LIMITED TO STATE OR FEDERAL BENEFIT LUMP SUM PAYMENTS, AWARDS, INHERITANCE, SETTLEMENTS, CLAIMS, JUDGMENTS, LOTTERY, TRUSTS, MONETARY GIFTS IN EXCESS OF $500 OR FROM ANY OTHER SOURCE, REPORT THE SOURCE(S) AND TOTAL AMOUNTS RECEIVED:

***If this information is included in the ANNUAL ACCOUNTING, skip this and go to #11, below.

SOURCE:	TOTAL INCOME:

Please attach a page to this report if additional space is needed.

11. Who is the incapacitated person's Representative Payee for governmental funds?

Name: _____ Phone: _____

Address: _____

12. The incapacitated person's physical health has:

☐ Improved ☐ Deteriorated ☐ Remained Unchanged

The incapacitated person's mental health has:

☐ Improved ☐ Deteriorated ☐ Remained Unchanged

If the incapacitated person's condition has changed, please describe all changes: _____

_____

13. The incapacitated person's present primary physician is:

Name: _____

Address _____Phone: _____

Has the incapacitated person been treated or evaluated in the past year by a:

a) Specialist_____ Phone: _____

Treatment received: _____

b) Psychiatrist or other Mental Health professional:

Name: _____ Phone: _____

Treatment received: _____

c) Dentist_____ Phone: _____

Treatment received: _____

d) Case worker _____ Phone: _____

Agency: _____

Use space below for additional medical information:

_____

_____

14. Briefly describe all recreational, educational, occupational, and social activities in which the incapacitated person has participated during the past year (If the incapacitated person is unable or has refused to participate, please explain):

_____
_____
_____
_____

15. The incapacitated person's present living arrangements are:
☐ Excellent ☐ Average ☐ Below Average
If below average, please explain: _____
_____

16. Is the incapacitated person ☐ content or ☐ unhappy with the living arrangements? If unhappy, why? _____

17. As the guardian, what steps are you taking to address any and all unmet needs of the incapacitated person (if there are any)?_____

18. Has the guardian filed for Emergency Detention (mental illness warrant) of the incapacitated person?
☐ Yes ☐ No If you have filed, please list the number of times and the dates:
_____

19. Should your powers/duties as guardian of the person be:
☐ Increased ☐ Decreased ☐ Remain Unchanged
If change is recommended, please state the change and reasons: _____
_____

20. Please select your relationship to the incapacitated person (check all that applies):
☐ Uncompensated family member or friend
☐ Family member or friend compensated or paid as a Foster Care Provider;
Agency Name: _____
☐ Paid Foster Care Provider – No Familial or Friend Relationship
Agency Name: _____
☐ Attorney
☐ Private Professional Guardian
☐ Department of Aging and Disability Services
☐ Guardianship Program; Program Name: _____
☐ Other _____
☐ Paid Foster Care Provider – No Familial Relationship

21. If you are NOT compensated for providing guardianship services skip to #22.
a) If you <u>are</u> compensated, are you a Texas Certified Guardian?
☐ Yes, TxCG number: _____ ☐ No

b) If you <u>are</u> a Private Professional Guardian or required to be certified by the Guardianship Certification Board, during the last reporting period were you the subject of an investigation conducted by the Guardianship Certification Board? ☐Yes ☐No
If YES, explain: _____

c) If you <u>are not</u> a Texas Certified Guardian, are you exempt from qualification under the Guardianship Certification requirements pursuant to Government Code Chapter III? (Attorney, guardianship program volunteer, or corporate fiduciary) ☐Yes ☐No

22. Please list the names and phone numbers of two persons who will always know how to contact you.

Name: _____ Phone: _____
Name: _____ Phone: _____

23. Does the Incapacitated Person have any children under the age of 18? ☐Yes ☐No
If YES, do the Incapacitated Person's children live with the Incapacitated Person? ☐Yes ☐No

If the Incapacitated Person's children live with the Incapacitated Person, list the names and ages of the children below or attach the information to this report.

_____

24. If there is additional information you wish to provide the court, please state or attach the information to this report.

_____
_____
_____

IN COMPLIANCE WITH THE BRADY ACT of 1993, THE FOLLOWING INFORMATION IS REQUIRED:

Incapacitated Person's Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Refused ☐ UNKNOWN

Incapacitated Person's Race: ☐ Asian ☐ Black, African American ☐ American Indian or Alaskan Native

☐ White ☐ UNKNOWN ☐ Other Race: _____

SWORN DELARATION

STATE OF TEXAS §
COUNTY OF DALLAS §

Before me, the undersigned authority, on this day personally appeared (Co-guardians) _____ and _____, who being first duly sworn under penalty of perjury, states on oath that the foregoing report is a true, correct, and complete statement of the present condition, welfare, and well-being of (INCAPACITATED PERSON)_____, as of the date stated herein.

By signing below, I affirm that I delivered and communicated or will deliver and communicate to the Incapacitated Person, within one week of the date of my signature below, the Bill of Rights for Persons under Guardianship as described in Texas Estates Code §1151.351.

Printed Name	Printed Name
Signature: CO-GUARDIAN OF THE PERSON	Signature: CO-GUARDIAN OF THE PERSON

SWORN TO and subscribed before me on this _____day of_____, 20_____.

_____
Notary Public in and for the State of Texas

WHEN THE REPORT HAS BEEN COMPLETED BY THE GUARDIAN
AND IS READY FOR SUBMISSION TO THE JUDGE, PLEASE RETURN TO:

Dallas County Clerk, Probate Department
George Allen Courts Building
600 Commerce Street
7th Floor, Suite 400
Dallas, Texas 75202

CAUSE NO. _____

GUARDIANSHIP OF	**§**	**IN PROBATE COURT**
_____,	**§**	**NUMBER _____ OF**
AN INCAPACITATED PERSON	**§**	**DALLAS COUNTY, TEXAS**

ORDER APPROVING ANNUAL REPORT
OF GUARDIAN OF THE PERSON

On the date indicated below came on to be considered the Annual Report of the Guardian of the Person on the Location, Condition and Well-being of _____ and the Court having examined said report, it is THEREFORE APPROVED AND ORDERED ENTERED OF RECORD.

SIGNED this _____ day of _____, 20____.

_____
JUDGE PRESIDING