PROBATE COURT OF TRUMBULL COUNTY, OHIO
JAMES A. FREDERICKA, 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 present address: _____
   City _____ State _____
   Zip _____ Telephone (_____) _____

3. 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 (_____)_____

4. The Ward will be at the address given in Item 2.

☐ 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 (_____) _____

CASE NO. _____

5. 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: _____

6. 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 _____
   _____
   _____

7. The care given to the ward is ☐ Adequate ☐ Not Adequate
   If "Not Adequate" is checked, explain. _____
   _____
   _____

8. The guardianship should be ☐ Continued ☐ Not Continued
   If "Not Continued" is checked, explain. _____
   _____
   _____

9. 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 _____

10. ☐ 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 for this Ward.

11. ☐ 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 social worker, 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)

If an attorney has been consulted on this report: Date: _____

_____	_____
Attorney for Guardian	Guardian's Printed Name
_____	_____
Street	Guardian's Signature
_____	_____
City, State, Zip Code	Street
_____	_____
Phone Number	City, State, Zip Code
_____	_____
Attorney Registration No.	Phone Number

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

PROBATE COURT OF TRUMBULL COUNTY, OHIO
JAMES A. FREDERICKA, JUDGE

GUARDIANSHIP OF _____

CASE NO. _____

ANNUAL GUARDIANSHIP PLAN - PERSON
[Sup.R. 66.08 (G)]

[Attach as addendum to Form 17.7-Guardian's Report]

I am the guardian of the person for the above-named ward. I have identified the following goal(s) for the next year and how I intend the goal(s) to be met.

☐ Attached is the Individual Service Plan (ISP) through the county board of development disabilities.

For the Person

Goal – (for example: address medication issues; obtain assistance devices; secure medical and rehab services, meet mental health service needs; secure personal care services; enhance nutrition; improve social skills, etc.)

_____

_____

_____

Means to Meet the Goal – (for example: educate on benefits of medications and compliance; obtain walker, wheelchair, hearing aid, schedule semi-annual checkups/exams; secure outpatient examinations and mental health counseling; arrange for shopping and/or meals on wheels; enroll in sheltered workshop/socialization programs, etc.)

_____

_____

_____

[Attach additional pages if necessary.]

_____ _____

Guardian's Printed Name Guardian's Signature

_____ _____

Street Phone Number

_____

City, State, Zip Code