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| STATE OF SOUTH CAROLINA | IN THE PROBATE COURT |
| COUNTY OF GREENVILLE | CASE NUMBER: |
|  |  |
| IN THE MATTER OF: | **ANNUAL REPORT OF GUARDIAN** |
|  | (Quarterly/Semi-Annual/Annual |
|  |  |
| protected person. |  |
|  |  |

**Guardianship Established:**  **Date of Last Report:**

**PLEASE ANSWER ALL QUESTIONS ON THIS REPORT. NO QUESTION MAY BE LEFT UNANSWERED. REPORTS WITH UNANSWERED QUESTIONS WILL BE RETURNED.**

**(Attach additional sheets if necessary. Please type or print in black ink.)**

**NO WHITE OUT OR PENCIL-THIS IS A LEGAL DOCUMENT**

**PLEASE ATTACH A CURRENT PHOTO OF THE PROTECTED PERSON**

**AS GUARDIAN, I SWEAR OR AFFIRM, UNDER THE PENALTY OF PERJURY, THAT THE INFORMATION IN THIS REPORT IS TRUE TO THE BEST OF MY KNOWLEDGE.**

Check all that apply:

I am a Professional Guardian with       active cases.

The Conservatorship Case Number is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

There is not a Conservatorship associated with this case

**RESIDENCE**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | Describe the residential situation where the protected person currently lives: | | | | |  |  |  |
|  |  | Assisted Living (ALF) | | | | |  |  |
|  |  |  | Facility Name and Contact Person: |  | | | | |
|  |  | Group Home | | | | |  |  |
|  |  |  | Facility Name and Contact Person: |  | | | | |
|  |  | Intermediate | | | | |  |  |
|  |  |  | Facility Name and Contact Person: |  | | | | |
|  |  | Private Residence | | | | |  |  |
|  |  | Skilled Nursing/CP | | | | |  |  |
|  |  |  | Facility Name and Contact Person: |  | | | | |
|  |  | Specialized | | | | |  |  |
|  |  |  | Facility Name and Contact Person: |  | | | | |
|  |  | State Hospital | | | | |  |  |
|  |  | Other (explanation required if “other is checked): | | |  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 2. | **Beginning with the current residence during the last 12 months.** | The PROTECTED PERSON |  |
|  | lived or stayed at the following locations: |  |  |

|  |  |  |
| --- | --- | --- |
| a. | **Current Residence:** |  |
|  | Street Address: |  |
|  | City: |  |
|  | How long at this address: |  |
|  | Why this address: |  |

|  |  |  |
| --- | --- | --- |
| b. | Type of Residence: |  |
|  | Street Address: |  |
|  | City: |  |
|  | How long at this address: |  |
|  | Why this address: |  |
| c. | Type of Residence: |  |
|  | Street Address: |  |
|  | City: |  |
|  | How long at this address: |  |
|  | Why this address: |  |
| d. | Type of Residence: |  |
|  | Street Address: |  |
|  | City: |  |
|  | How long at this address: |  |
|  | Why this address: |  |

|  |  |
| --- | --- |
| 3. | Considering the location, cost, and safety, I rate their living arrangement as  excellent |
|  | average  below average  UNSAFE |
|  | If any answer is anything besides excellent, please explain and give your plan of action: |
|  |  |
|  |  |

|  |  |
| --- | --- |
| 4. | I believe they are  content with the living situation  unhappy with the living situation |
|  | If you did not answer content, please explain and give your plan of action: |
|  |  |
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| --- | --- | --- | --- | --- |
| 5. | I recommend a more suitable living arrangement for the protected person as follows: | | |  |
|  | No Changes | |  |
|  | Assisted Living | |  |
|  | Group Home | |  |
|  | Private Residence | |  |
|  | Halfway House | |  |
|  | Skilled Nursing | |  |
|  | In-Home/Sitter | |  |
|  | Hospital | |  |
|  | Rehabilitation Center | |  |
|  | Other: |  | |

## HEALTHCARE

|  |  |  |
| --- | --- | --- |
| 6. | What is the Protected Person’s diagnosis? |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 7. | Has the PROTECTED PERSON has been seen by a physician, dentist, etc, this past year? | | | |  |  |
|  |  |  | Routine examination by Primary Care Physician | | | |
|  | Physician’s Name and dates of service: | | | |  |  |
|  |  | | | | | |
|  |  |  | Routine examination by Dentist | | | |
|  | Dentist’s Name and dates of service: | | | | | |
|  |  | | | | | |
|  |  |  | Routine examination by Ophthalmologist | | | |
|  | Ophthalmologist’s name and dates of service: | | | | | |
|  |  | | | | | |
|  |  |  | Physical Therapy | | | |
|  | Dates of Service: | | | | | |
|  |  | | | | | |
|  |  |  | Speech Therapy | | | |
|  | Dates of Service: | | | | | |
|  |  | | | | | |
|  |  |  | Occupational Therapy | | | |
|  | Dates of Service: | | | | | |
|  |  | | | | | |
|  |  |  | PROTECTED PERSON retains the right to make his or her own decision | | | |
|  |  |  | Other/PROTECTED PERSON was not seen by a doctor or dentist this year | | | |
|  |  | (Explanation is required if this box is check) | |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 8. | List weight of PROTECTED PERSON this year: |  | lbs. |

|  |  |
| --- | --- |
| 9. | What is the PROTECTED PERSON’s current health status including any new diagnoses or new health concerns since the last report? |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Blindness |  | Dementia (Alzheimer’s Vascular, Alcohol Induced, Lewey Body) |
|  | Diabetic |  | Substance Abuse |
|  | Parkinson’s disease |  | Autism |
|  | Severe arthritis |  | Closed head injury |
|  | Restricted mobility |  | Developmental Disabilities |
|  | Bi-Polar |  | Depression |
|  | Other (explanation required): |  | Schizophrenia |
|  |  |  |  |
|  |  |  |  |

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| --- | --- |
| 10. | The PROTECTED PERSON presently is prescribed and takes the following types of medications: |

|  |  |  |
| --- | --- | --- |
| Condition Drug was Prescribed For | Name of Drug Prescribed | Prescribing Physician |
|  |  |  |
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| 11. | The assistive devices or aids used by the PROTECTED PERSON are: | | | | | |
|  | Crutches |  | Walk-in Bath |
|  | Dentures |  | Ramp |
|  | Glasses |  | Pull-up bar in bathtub |
|  | Hearing Aid(s) |  | Medical Alert device |
|  | Prosthetics |  | Special Computer for vision impaired |
|  | Walker/Cane |  | TTY Special Device |
|  | Wheelchair |  | Service Pets |

|  |  |  |
| --- | --- | --- |
| Explanation (optional): | |  |
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| --- | --- | --- | --- | --- |
| 12. | To assist the Court in determining the best interest of the PROTECTED PERSON, please provide the following information: | | | |
|  | (Please rate the ability of the PROTECTED PERSON to engage in activities of daily living or instrumental activities of daily living) | | | |
| **Description** | **Rating** |
| i. Administration of Medication | needs no help  needs some assistance  cannot do at all |
| ii. Bathing | needs no help  needs some assistance  cannot do at all |
| iii. Climbing Stairs | needs no help  needs some assistance  cannot do at all |
| iv. Doing Laundry | needs no help  needs some assistance  cannot do at all |
| v. Dressing | needs no help  needs some assistance  cannot do at all |
| vi. Eating | needs no help  needs some assistance  cannot do at all |
| vii. Grooming | needs no help  needs some assistance  cannot do at all |
| viii. Heavy Chores | needs no help  needs some assistance  cannot do at all |
| ix. Light Housekeeping | needs no help  needs some assistance  cannot do at all |
| x. Managing Money | needs no help  needs some assistance  cannot do at all |
| xi. Prepare Meals | needs no help  needs some assistance  cannot do at all |
| xii. Shopping | needs no help  needs some assistance  cannot do at all |
| xiii. Toileting | needs no help  needs some assistance  cannot do at all |
| xiv. Transferring | needs no help  needs some assistance  cannot do at all |
| xv. Walking Mobility | needs no help  needs some assistance  cannot do at all |

### SOCIAL LIFE / ACTIVITIES / RECREATION

|  |  |
| --- | --- |
| 13. | As Guardian, how would you describe the PROTECTED PERSON’s social skills and ability to maintain personal relationships with others? |

|  |  |
| --- | --- |
|  | High Social Skills, able to maintain friendships |
|  | Moderate Social Skills, able to carry on a conversation |
|  | Low Social Skills, unable to communicate |

|  |  |
| --- | --- |
| 14. | Does the PROTECTED PERSON have any social needs that have not been met? Check all that apply: |

|  |  |
| --- | --- |
|  | Not applicable; all needs are being met |
|  | Does not enjoy socializing and does not care to socialize |
|  | Has the following unmet needs: |

|  |  |
| --- | --- |
|  | Adult Day Care |
|  | Counselling |
|  | Respite Care |
|  | Pet therapy |
|  | Homemaker/Personal Care |
|  | Home Delivered Meals/Meal on Wheels |
|  | Senior Center |
|  | Sheltered Workshop |
|  | Transportation Assistance |
|  | Volunteer Services |
|  | Frequent Visits |
|  | Hair/Salon/Nails |
|  | AA/NA |
|  | Religious Services |
|  | Other, please explain: |
|  |  |
|  | What steps have been taken to address the unmet social needs: |
|  |  |
|  |  |
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|  |  |
| --- | --- |
| 15. | The PROTECTED PERSON’s current level of physical activity is  excellent  good  fair  poor  not applicable |

|  |  |
| --- | --- |
| 16. | During the past year, the activity level for the PROTECTED PERSON: |

|  |  |
| --- | --- |
|  | Not applicable |
|  | Remained about the same |
|  | Improved/Explain: |
|  |  |
|  |  |
|  | Worsened/Explain: |
|  |  |
|  |  |

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| 17. | For the next reporting period, the Guardian believes the following recreational activities would be beneficial: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not Applicable |  | Movies | |
|  | Respite Care |  | Golf Cart | |
|  | Adult Day Care |  | Vacation | |
|  | Exercise, Yoga |  | Moped | |
|  | Crafts, Painting |  | Needs are being met | |
|  | Games |  | Needs are not being met | |
|  | Frequent Visits | Explain: | |  |
|  | Family and Friends |  | Other: | |
|  | Walking |  |  | |
|  | Exercise |  |  | |
|  | Books |  |  | |

|  |  |
| --- | --- |
| 18. | Does the PROTECTED PERSON receive any visits from persons affiliated with the following: |

|  |  |
| --- | --- |
|  | None/Not Applicable |
|  | Members of Church/Synagogue/Mosque |
|  | Senior Center |
|  | Senior Action |
|  | Veteran’s Organizations |
|  | Civic Clubs |
|  | Other/Please explain: |
|  |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
| 19. | How often do you visit the PROTECTED PERSON? |

|  |  |
| --- | --- |
|  | Daily |
|  | Bi-Weekly |
|  | Weekly |
|  | Monthly |
|  | Bi-Monthly |
|  | Quarterly |
|  | Semi-Annually |
|  | Once a year |
|  | I have not seen the PROTECTED PERSON during this reporting period. Please explain: |
|  |  |
|  |  |
|  |  |
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| --- | --- |
| 20. | Who else visits with the PROTECTED PERSON? |
|  |  |
|  |  |

**RESOURCES**

|  |  |
| --- | --- |
| 21. | Does the PROTECTED PERSON receive any Government/Private/Nonprofit Services? If so, please specify name, address, contact person and cost for each (Please attach a separate sheet): |

|  |  |
| --- | --- |
|  | None/Not Applicable |
|  | DDSN |
|  | ABLE |
|  | Appalachian Council of Aging |
|  | VA |
|  | Home Health |
|  | Private caregivers |
|  | Private Sitters |
|  | Hospice |

|  |  |
| --- | --- |
| 22. | Does the PROTECTED PERSON receive any Government Services? If so, please specify: |

|  |  |
| --- | --- |
|  | Thrive Upstate |
|  | EBT/Wic |
|  | SNAP |
|  | TANF |
|  | Child Care Assistance |
|  | SSI |
|  | Social Security Disability Income (SSDI) |
|  | VA |
|  | None |

|  |  |
| --- | --- |
| 23. | Are you in control of any tangible property of the PROTECTED PERSON? |

|  |  |
| --- | --- |
|  | Yes (if yes, describe and report on its condition) |

|  |  |
| --- | --- |
|  | Jewelry |
|  | Furniture |
|  | Vehicle/Boat/Moped |
|  | Guns/Ammunition |
|  | Cash/CD/Money Market/Investment Account |
|  | Real Estate/Homes/Mobile Home |
|  | Bank Account |
|  | Trust |
|  | Other (explain): |
|  |  |
|  | No | | |

|  |  |  |
| --- | --- | --- |
| 24. | Have you been paid any funds for the care of the PROTECTED PERSON during the reporting time? | |
|  | No |
|  | Yes (list amount and source(s): |
|  |  |
|  |  |

|  |  |
| --- | --- |
| 25. | Have any assets or items of the PROTECTED PERSON been transferred to you during the reporting time? |

|  |  |
| --- | --- |
|  | No |
|  | Yes (list items/assets transferred and dates): |
|  |  |
|  |  |

|  |  |
| --- | --- |
| 26. | Does the PROTECTED PERSON have a pre-paid funeral contract? If so, when was it obtained, what funeral home, how much and who paid for the contract? |
|  |  |
|  |  |
|  |  |

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| --- | --- |
| 27. | Do you believe the PROTECTED PERSON continues to need a guardian (explain)? |
|  |  |
|  |  |

LEGAL

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 28. | Has the PROTECTED PERSON been victimized by any internet or telephone scammers? |  | No |  | Yes | Please explain: |

|  |  |
| --- | --- |
| 29. | Have you or the PROTECTED PERSON been involved in any SC DSS Child or Adult protective proceeding? |

|  |  |  |
| --- | --- | --- |
| No | Yes: | |
| Please explain: | |  |
|  | |  |

|  |  |
| --- | --- |
| 30. | Have you or the PROTECTED PERSON been arrested or convicted of a crime over this reporting period?  No  Yes |

|  |  |
| --- | --- |
| 31. | Has the PROTECTED PERSON been a party to any legal proceeding?  No  Yes |

|  |  |
| --- | --- |
| 32 | Has the PROTECTED PERSON’s marital status changed since the last reporting period?  No  Yes |

|  |  |
| --- | --- |
| 33. | Has the PROTECTED PERSON executed any estate planning documents? |

|  |  |
| --- | --- |
|  | None/Not Applicable |
|  | Last Will and Testament |
|  | Trust |
|  | Power of Attorney |
|  | Health Care Power of Attorney |
|  | Living Will |

|  |  |
| --- | --- |
| 34. | If there is no Successor Guardian in place, what steps have you taken, if any, to put a Successor Guardian in place for the PROTECTED PERSON? |
|  |  |
|  |  |
|  |  |

GUARDIAN OATH

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the duly appointed (Co) Guardian of the PROTECTED PERSON, do solemnly SWEAR OR AFFIRM, that the responses provided herein are true, complete and accurate. Further, I have not intentionally omitted any material fact affecting the health, welfare, services or resources of the PROTECTED PERSON. I understand that a violation of this oath may result in contempt proceedings in the Probate Court in which I may be removed as Guardian, fined for violating this oath, reported to state/county/federal authorities in charge of the protection of vulnerable adults, and/or incarcerated for willful non-compliance after being placed under a court order for compliance. Further, I understand that I sign this under penalty of perjury as set forth in S.C. Code of Laws.

I have attached \_\_\_\_\_\_ pages to this report to supplement my responses.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SWORN to before me this | | |  | day of | Signature: |  |
|  | | | 20 |  | Print Name: |  |
|  | | | | | Address: |  |
|  | | | | |  |  |
| Print Name: |  | | | | Preferred Telephone: |  |
| Notary Public for: | |  | | | Email: |  |
| My Commission Expires: | |  | | | Relationship to protected person: |  |

**---------------------Co-Guardian----------------------**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SWORN to before me this | | |  | day of | Signature: |  |
|  | | | 20 |  | Print Name: |  |
|  | | | | | Address: |  |
|  | | | | |  |  |
| Print Name: |  | | | | Preferred Telephone: |  |
| Notary Public for: | |  | | | Email: |  |
| My Commission Expires: | |  | | | Relationship to protected person: |  |