

Insert Court Examiner's Name

INITIAL REPORT OF GUARDIAN

_____ COURT OF STATE OF NEW YORK

COUNTY OF _____

In the Matter of the Initial Report of _____,

As Guardian for _____, Index No. _____

An Incapacitated Person

General Instructions

1. All guardians must complete **Section I**.
2. All guardians must attach a copy of the order of appointment.
3. If you have been appointed guardian for the personal needs of the incapacitated person, please complete **Section II**.
4. If you have been appointed guardian for the property management of the incapacitated person, please complete **Section III, the summary and attached schedules** pertaining to the guardianship assets and financial resources.
 - (a) When listing property on a schedule, please be specific. For instance - with bank accounts, list name and address of bank, number of account and balance; with stocks, list number of shares, name of stock, type and value.
 - (b) If a schedule does not provide enough space, attach additional sheets with a reference to the schedule to which the information applies.
 - (c) In any schedule, when there is nothing to list, state "NONE".
5. Your initial report must be filed with the county clerk's office no later than ninety (90) days after the issuance by the county clerk of your commission as guardian.

6. You must send a copy of your initial report to the Court Examiner assigned to this matter. If you are not aware of the name and address of the Court Examiner, the information may be obtained from the New York State Supreme Court, Appellate Division, Fourth Department at (585)530-3225.
7. You must send a copy of your initial report to the incapacitated person by mail; send a copy of your report to the court evaluator and send a copy to counsel for the incapacitated person, unless the Court has ordered otherwise.
8. If the incapacitated person resides in a facility, send a duplicate of your initial report to the chief executive officer of that facility.
9. If the incapacitated person resides in a mental hygiene facility, send a duplicate of your initial report to Mental Hygiene Legal Service at M. Dolores Denman Courthouse 50 East Avenue - Suite 402 Rochester, New York 14604.

SECTION I GENERAL INFORMATION
(all guardians must complete this section).

1. **DATE OF THIS REPORT:** _____

2. **GUARDIAN:**

Name: _____

Address (include mailing address, if different):

Telephone no.: _____

3. **INCAPACITATED PERSON:**

Name: _____

Address (if a residential facility, include name of director or person responsible for person's care):

Telephone no.: _____

Date of Birth: _____

4. **APPOINTMENT:**

Date of order: _____

Court: _____

Name of Judge/Justice: _____

Date Commission was filed: _____

5. **BOND:**

Bonding company name: _____

Bonding company address:

Value of bond (If the bonding requirement has been waived, so state):

6. **EDUCATIONAL REQUIREMENTS:**

Have you fulfilled the educational requirements set forth in Mental Hygiene Law § 81.30(a) by completing a training program approved by the chief administrator? Attach certificate(s).

Yes ___ No ___

Have the educational requirements been waived by the court?

Yes ___ No ___

If you have not fulfilled the educational requirements and the requirements have not been waived by the court, please explain:

7. **VISITS:** (guardians are required to visit the incapacitated person at least four [4] times a year or more frequently as specified by court order).

Have you visited the incapacitated person?

Yes ___ No ___

If yes, please provide the date and location of such visits:

	<u>Date</u>	<u>Location</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

If no, please explain:

8. **TYPE OF GUARDIANSHIP:**

Have you been granted powers over the personal needs of the incapacitated person?

Yes ___ No ___

If yes, please complete **Section II**.

Have you been granted powers regarding property management of the incapacitated person?

Yes ___ No ___

If yes, please complete **Section III**.

9. **CHANGE IN POWERS:**

Is there any reason for any alterations in your powers as guardian as authorized by the order appointing you?

Yes ___ No ___

If yes, please specify change requested:

If you want to change your authorized powers, you must make an application within TEN (10) days of filing this report and provide notice to the persons specified in your order of appointment as entitled to such notice. If you fail to comply with this provision, any person entitled to commence a proceeding under this article may petition the court for a change in the powers on notice to you, the guardian, and the persons entitled to such notice as stated in the order of appointment.

SECTION II PERSONAL NEEDS

If you have been granted powers with respect to personal needs of the incapacitated person, please provide the following information, consistent with the order appointing you:

1. Please explain the steps you have taken, consistent with the order appointing you, to provide for the personal needs of the incapacitated person.

2. Please describe the plan for providing for the personal needs of the incapacitated person by setting forth information regarding:
 - (a) Provisions for medical, dental, mental health, or related services:

(b) Provisions for any personal and social services:

(c) Medical, dental and mental health examinations necessary to determine the health needs of the incapacitated person:

<u>Date</u>	<u>Type of Examination</u>	<u>Diagnosis/Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(d) Utilization of health and accident insurance and any other private or government benefits to which the incapacitated person may be entitled:

(e) Any additional provisions of the plan for providing for the personal needs of the incapacitated person:

3. Please indicate whether the incapacitated person has any of the following. If so, attach a copy to this report:

- | | | |
|---|---------|--------|
| (a) living will | Yes ___ | No ___ |
| (b) health care proxy | Yes ___ | No ___ |
| (c) surrogate decision-making directive | Yes ___ | No ___ |
| (d) any other advance directive | Yes ___ | No ___ |

SECTION III PROPERTY MANAGEMENT

If you have been granted powers regarding the property management of the incapacitated person, please provide the following information, consistent with the order which appointed you, pertaining to the fulfillment of your responsibilities to the incapacitated person to provide for property management.

1. Please describe the plan for the management of the property and financial resources of the incapacitated person.

2. Has the incapacitated person executed a will?

Yes ___ No ___

If yes, please provide location of will.

Complete the following schedules and summary. If you have nothing to list on a schedule, state "NONE".

SCHEDULE A

Please provide a complete inventory of the property of the incapacitated person over which you have control. List all guardianship assets you had on the first day of the accounting period.

I. PERSONAL PROPERTY

1. Bank accounts and cash - please list the name and address of the institution, account numbers and balance at the time of your appointment. Please also list any cash on hand not in bank accounts. You must send a copy of any and all bank statements along with this report.

<u>Institution</u>	<u>Account Number</u>	<u>Balance</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Total Value \$ _____

2. Corporate and government securities (e.g., corporate stocks and bonds; Federal, State or municipal bonds and notes).

Total Value \$ _____

II. REAL PROPERTY - please give the address, description and approximate value of any real property. Please also provide the date of filing of statement identifying real property with the County Clerk as required by Mental Hygiene Law § 81.20(a)(6)(vi).

<u>Address</u>	<u>Description</u>	<u>Value</u>	<u>Date of filing</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TOTAL VALUE OF REAL PROPERTY \$ _____

SCHEDULE A SUMMARY

Assets on hand at date of appointment

- I. Personal property..... \$ _____
- II. Real property..... \$ _____

TOTAL SCHEDULE A \$ _____

SCHEDULE B

Provide a complete inventory and identification of all sources of income or periodic payments the incapacitated person is entitled to receive, including: interest, dividends, pension plans, social security benefits, trust income, etc. and any rental income.

<u>Type of income or payment</u>	<u>Amount per month</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Total Monthly Income/Payment \$ _____

VERIFICATION

STATE OF NEW YORK)

SS:

COUNTY OF _____)

_____, being duly sworn, state that I am the guardian of the within named incapacitated person and that the attached initial report and schedule(s) contain, to the best of my knowledge and belief, a complete and true statement of my activities as such guardian; receipts and payments on behalf of such incapacitated person; money and other property which has come into by possession or has been received by other persons by my order or authority since the date of my appointment; and the value of such property. I do not know of any error or omission in this report to the prejudice of such incapacitated person.

Signature

(Your name, address and telephone number)

Sworn to before me this _____ day
of _____, 2_____.

Notary Public