

Instructions: Report of Guardian Cover Page

All guardians required to file periodic reports must complete the Report of Guardian Cover Page. This is a one-page document to which the appropriate report(s) will be attached.

The date of appointment should be filled in prior to the first numbered paragraph, even if the reporting period is different than that date. The start date and end date of the reporting period must be stated in the caption. Make sure to select appropriately as to the nature of your guardianship: Guardian of Person, Guardian of Estate, or Guardian of Both Person and Estate. This selection will guide you in choosing the appropriate reporting form(s) to attach to the Cover Page.

You must file the original report with the Surrogate. Check the judgment to see if you need to send copies of the report to anyone else. In most cases, this is not required because other individuals considered interested in the guardianship will be authorized to review the report at the Surrogate's Court. Remember that there is a fee of \$5/page for all documents filed with the Surrogate, including the Cover Page.

In a co-guardianship, all co-guardians must report as required by the judgment. Co-guardians may file a single Cover Page with all required information, but if the co-guardians reside in different places, it may be necessary to attach a separate page with the address and contact information for the additional co-guardian(s).

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: _____

Daytime Telephone Number: _____ Evening Telephone Number: _____

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

Guardian's relationship to the Incapacitated Person? _____

* If needed: attach a separate page with the current information 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: _____

Contact Name: _____ Telephone Number: _____

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

List all other responsibilities assumed:

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

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

Instructions: Report of Well-Being

If you are a guardian of the person, you may be required to file the Report of Well-Being. This document includes ten (10) questions and space to provide additional information. For any question that cannot be answered fully in the space provided, you should attach additional sheets, writing or typing on only one side of the page.

Item #1 requests a description of the incapacitated person's overall situation. This item should be answered either by describing any significant changes in the incapacitated person's physical health, intellectual functioning, emotional health and/or living conditions, or by stating affirmatively that there has been no substantial change in these areas since the prior reporting period. **This item should not be left blank** even if there has been no change to the incapacitated person's overall situation since the establishment of the guardianship or the filing of the prior report.

Item #2 addresses the incapacitated person's residential setting. If you respond that the current setting is not suitable to the needs of the incapacitated person, then you must explain that response and should specifically state whether the unsuitability is temporary and being addressed (i.e., the incapacitated person's apartment flooded due to a storm, and from ____ to ____ he or she was placed in alternate housing while the damage was repaired) or an ongoing issue (i.e., the incapacitated person is no longer ambulatory but remains in _____ facility which lacks operational elevators, however, alternate housing has not yet been secured).

Item #3 asks whether suitable social activities are available to the incapacitated person and whether he or she partakes in such activities. Both aspects of this question should be answered taking into consideration the abilities and needs of the incapacitated person.

Item #4 requests information regarding a recent medical evaluation of the incapacitated person. A written statement of an examining professional (i.e., medical doctor (M.D.), doctor of osteopathic medicine (D.O.), etc.) must be attached to the Report of Well-Being.

A Certification of Examining Professional (CN 12042) is provided on the last page. The Certification of Examining Professional is a form certification which should be provided to the professional who has performed a recent medical evaluation of the incapacitated person. Complete the top portion of the form by filling in your name, address, and telephone number. Insert the incapacitated person's name in the blank spot under "In the Matter of:".

Provide this form to the examining professional to be filled out. Additional pages may be attached if more space is needed. Should the examining professional wish to utilize their own form, make sure that the statement addresses the same information.

Item #5 requires a list of other professional medical treatment provided to the incapacitated person. If the reporting period is other than a year, then this question should be answered to address the period covered by this report.

Item #6 addresses substantial changes to the incapacitated person's medication. If the incapacitated person is not prescribed any medication, then this should be stated. If there has been no substantial change to the incapacitated person's prescriptions, then you should state "no change to prescriptions." If the incapacitated person is subject to a regimen of over-the-counter medications, then any substantial change in this regard should also be noted.

Item #7 provides for a description of the incapacitated person’s treatment plan going forward. For any area that does not apply, you should note “N/A” (not applicable). Examples of additional related services include speech therapy, occupational therapy, therapeutic massage, etc.

Item #8 directs the guardian to assess various areas of the incapacitated person’s functioning. Please provide further explanation if you select “Don’t Know” for any area.

Item #9 asks if you have investigated eligibility for public benefits to which the incapacitated person may be entitled. If you have investigated all listed programs, then you should answer “Yes” even if the incapacitated person has been determined ineligible for some/all benefits.

Item #10 allows you as guardian to identify any assistance required from the court or a community agency. Please be as specific as possible in describing any help that you need on behalf of the incapacitated person.

Following item #10 is an *optional* section in which you can add additional information about the incapacitated person and/or the guardianship.

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	<input type="checkbox"/>				
Emotional Health	<input type="checkbox"/>				
Intellectual Functioning	<input type="checkbox"/>				
Living Situation	<input type="checkbox"/>				

9. Has eligibility for such programs as Social Security, Medicare, Medicaid, SSI or Food Stamps been investigated? Yes No
If No, state reason.

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

Certification of Examining Professional

Name: _____

Address: _____

Telephone: _____

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

_____,

an Incapacitated Person.

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