IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT
IN AND FOR FRANKLIN COUNTY, FLORIDA
PROBATE DIVISION

IN RE: THE GUARDIAN ADVOCACY OF CASE NO.: _____

_____/
Name of Person with a Developmental Disability

ANNUAL GUARDIANSHIP PLAN OF GUARDIAN ADVOCATE OF THE PERSON WITH PHYSICIAN'S REPORT
(Form L)

_____, (Guardian's name), the Guardian Advocate of the Person of _____, (Ward's name), and submits the following Annual Plan for the period beginning _____ _____ and ending on _____.

1. Ward's address at the time of filing this Plan is: _____ _____.

2. During the prior 12 months the Ward resided or was maintained at (include dates, names, addresses, and length of stay at each location):

Date	Name	Address	Length of Stay

3. The residential setting best suited for the current needs of the Ward is (Check one):

☐ a. group home
☐ b. assisted living
☐ c. nursing home
☐ d. live with parents
☐ e. at Ward's private residence; or
☐ f. other:_____

4. Plans for ensuring that the Ward is in the best residential setting to meet the Ward's needs during the coming year are as follows:

5. The following is a list of any medical treatment given to the Ward during the preceding year:

Date	Provider	Treatment Provided

6. Attached is a report of a physician who examined the Ward no more than 90 days before the end of the report period, including that physician's evaluation of the Ward's condition and a statement of the current level of capacity of the Ward.

7. The plan for provision of medical, dental, mental health, and rehabilitative services (for example, occupational therapy, physical therapy, speech therapy, applied behavioral analysis) in the coming year is.

Date	Provider	Treatment Provided

8. The following information is submitted concerning the social condition of the Ward:

a. The Ward is currently using the following social and personal services (include name, services rendered, and address of each provider), including any groups in which the Ward is participating:

Date	Provider	Service Provided

b. The following is a statement of the social skills of the Ward, including how well the Ward maintains interpersonal relationships with others:

c. The following is a description of the social needs of the Ward, if any:

9. The following is a summary of activities during the preceding year designed to increase the capacity of the Ward, including involvement in groups or group activities: _____

10. Is the Ward now capable of having some or all of the Ward's rights restored?

☐ If yes, identify the rights that should be restored: _____

11. Do you plan to seek the restoration of any rights to the Ward?

☐ If yes, identify the rights that you are seeking to be restored: ___

12. This plan ____ has or ____ has not been reviewed with the Ward.

(Please use additional sheets of paper if necessary.)

13. The following is a list of pre-existing orders not to resuscitate, health care surrogate designation, living will, or anatomical gift.

#	Title	Date	Suspended by Court? (Yes or No)	Steps Taken to Locate any Pre-existing Document

1._____

2._____

3._____

(Please use additional sheets of paper if necessary.)

Under penalties of perjury, I declare that I have completed and read the foregoing, and the facts set forth are true, to the best of my knowledge and belief.

Signed on _____, 20____.

[A certificate of service is required unless Ward has been declared totally incapacitated.]

I certify that the foregoing document has been furnished to _____ _____ (name, address used for service, mailing address, and e-mail address) by _____(e-mail, mail) on _____ _____, 20___).

_____
Guardian Advocate's Signature

_____
Guardian Advocate's Printed Name

_____
Guardian Advocate's Address

_____
Guardian Advocate's Phone Number

_____
Guardian Advocate's Email Address

PHYSICIAN'S REPORT

(Form N)

(Required by section 744.3675, Florida Statutes)

1. Name of Physician:_____
Address:_____

2. Name of Ward:_____

3. Date of Examination:_____

4. Purpose of Examination:

a. Regular Check-up:_____

b. Treatment:_____

5. Evaluation of Ward's condition: (Specify mental and physical condition a time of examination)

_____

_____

_____

6. Description of Ward's capacity to live independently:

_____

7. The Ward ____ does _____does not continue to need assistance of a guardian.

8. Is the Ward capable of being restored to capacity at this time?

☐ Yes ☐ No

☐ **a.** to marry;
☐ **b.** to vote;
☐ **c.** to personally apply for government benefits;
☐ **d.** to have a driver license;
☐ **e.** to travel;
☐ **f.** to seek or retain employment;
☐ **g.** to contract;
☐ **h.** to sue and defend
☐ **i.** to apply for government benefits;
☐ **j.** to manage property or to make any gift or disposition of property;
☐ **k.** to determine the Ward's residence;
☐ **l.** to consent to medical and mental health treatment; or
☐ **m.** to make decisions about the Ward's social environment or other social aspects of the Ward's life.

9. Date of this Report: _____

10. Signature of Physician completing this report:_____

_____