

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT,
IN AND FOR _____ COUNTY, FLORIDA

IN RE: GUARDIANSHIP OF

PROBATE DIVISION

CASE NO: 20____ MH _____

An alleged incapacitated person

_____ /

REPORT OF EXAMINING COMMITTEE MEMBER

The undersigned, being a member of the committee appointed to examine _____, reports that such examination, as directed by the Order Appointing Examining Committee, has been completed. The report of the comprehensive examination, with evaluations and recommendations, is as follows:

I. GENERAL INFORMATION

Name of person _____

Date of birth _____

Residence of person _____

Date and time of examination _____

Names of all persons present during the examination _____

Name and address of extended care facility (if any) _____

Alleged incapacity is _____

DIAGNOSIS (short summary) _____

PROGNOSIS (short summary) _____

RECOMMENDED COURSE OF TREATMENT (short summary) _____

II. EVALUATION OF ALLEGED INCAPACITATED PERSON’S ABILITY TO RETAIN HIS OR HER RIGHTS (WITHOUT LIMITATION)

THE EXAMINING COMMITTEE IS CHARGED WITH DETERMINING WHETHER THE ALLEGED INCAPACITATED PERSON HAS THE ABILITY TO EXERCISE THOSE RIGHTS WHICH THE PETITIONER HAS REQUESTED BE REMOVED IN THE PETITION TO DETERMINE INCAPACITY.

[NOTE: Legislative intent in adopting the current version of the Florida Guardianship Law is to make available the least restrictive form of guardianship to assist persons who are only partially incapable of caring for their needs, with incapacitated persons to be able to participate as fully as possible in all decisions affecting them.]

The alleged incapacitated person has the capacity to: (Circle yes or no)

| | | |
|-----|----|--|
| YES | NO | make informed decisions regarding his/her right to marry. |
| YES | NO | make informed decisions regarding his/her right to vote. |
| YES | NO | make informed decisions regarding his/her right to personally apply for government benefits. |
| YES | NO | make informed decisions regarding his/her right to have a driver’s license or operate a motor vehicle. |
| YES | NO | make informed decisions regarding his/her right to travel. |
| YES | NO | make informed decisions regarding his/her right to seek or retain employment. |

| | | |
|-----|----|---|
| YES | NO | make informed decisions regarding his/her right to contract. |
| YES | NO | make informed decisions regarding his/her right to sue, or assist in the defense of suits of any nature against him or her. |
| YES | NO | make informed decisions regarding his/her right to manage property or to make any gift or disposition of property. |
| YES | NO | make informed decisions determining his/her residence. |
| YES | NO | make informed decisions regarding his/her right to consent to medical and mental health treatment. |
| YES | NO | make informed decisions affecting the social environment or other social aspects of his/her life. |

III. PHYSICIAN'S REPORT

Please give the results of the comprehensive examination and the committee member's assessment of information provided by the attending or family physician, if any. Attach extra sheets if necessary. If the attending or family physician is available for consultation, the committee must consult with the physician.

Physical Examination:

Mental Health Examination:

Functional Assessment:

If any of the three parts of the comprehensive examination were not indicated or could not be accomplished for any reason, the reason for the omission must be explained.

Consultation with Family Physician: _____

Yes _____ No _____. If no, why? _____

Assessment of information provided by attending or family physician, if any:

Assessment of prior clinical history, treatment records, social records, and reports, if any:

IV. SCOPE OF GUARDIANSHIP

IMPORTANT: Florida law grants authority to a guardian only in those areas of decision making in which the evidence indicates the person is incapacitated. This allows the individual to retain control over the other aspects of his or her life.

Please indicate those areas in which the person LACKS THE CAPACITY to make informed decisions regarding his/her rights and for which a less restrictive method of protective services is not adequate to protect the person from a substantial risk of harm to his/her personal welfare or financial affairs. **(Circle lacks or has)**

| | | |
|-------|-----|--|
| LACKS | HAS | Decisions concerning travel or where to live. |
| LACKS | HAS | Consent to or refusal of medical or other professional care, counseling, treatment or service. |

| | | |
|-------|-----|--|
| LACKS | HAS | Permitting access to, refusal of access to or consent to release of confidential records and papers. |
| LACKS | HAS | Control or management of real or personal property or income from any source. |
| LACKS | HAS | Management of a business. |
| LACKS | HAS | Acting as a member of a partnership. |
| LACKS | HAS | Making contracts. |
| LACKS | HAS | Payment or collection of debts. |
| LACKS | HAS | Making gifts. |
| LACKS | HAS | Initiation, defense or settlement of lawsuits. |
| LACKS | HAS | Execution of a will or waiving the provisions of an existing will. |
| LACKS | HAS | Decisions concerning education. |
| LACKS | HAS | Admissions to Florida State Hospital or any other public treatment facility on a voluntary basis under the provisions of applicable state law. |
| LACKS | HAS | Other (list) |

Please list specific evidence of the person's incapacity to exercise informed decisions in the categories previously checked:

If the committee member has determined that the alleged incapacitated person is incapacitated, the scope of the guardianship services recommended is: (CIRCLE ONE)

PLENARY

LIMITED

I certify that I have examined the alleged incapacitated person in accordance with the requirements of Section 744.331 of the Florida Guardianship Law, performing the examination necessary to determine which, if any, of the rights the petitioner has requested to be removed the allegedly incapacitated person can no longer sufficiently nor adequately exercise. These conclusions, evaluations and recommendations are hereby presented to the Court.

I do / do not **(circle one)** have knowledge of the type of incapacity alleged in the Petition to Determine Incapacity.

Executed this _____ day of _____, _____.

Signature

Typed or printed name

A copy of this report has been served on the Petitioner's Attorney and the Court appointed Attorney for the alleged incapacitated person by _____ on _____, _____.

[Print or Type Names Under All Signature Lines]

Revised 9/1/2020