ANNUAL REPORT OF GUARDIAN

_____ COURT OF STATE OF NEW YORK

COUNTY OF _____

In the Matter of the Annual Report of

_____,

As Guardian for _____, Index No. _____
An Incapacitated Person.

Accounting Period:_____ _____ to _____ _____.

General Instructions

1. All guardians must complete **Sections I and II**

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 III.**

4. If you have been appointed guardian for the property management of the incapacitated person, please complete **Section IV, the summary and the attached schedules**.

   (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) Gains or losses should be listed in Schedule B or C, whichever applies. If a schedule does not supply enough space, attach additional sheets with reference to the schedule to which the information applies.

   (c) In any schedule, if there is nothing to list, state "NONE".

5. If the incapacitated person was a resident of New York City at the time of your appointment, file the original annual report in the office of the Clerk of the County in which the incapacitated person last resided before your appointment. If the incapacitated person was not a resident of New York City at the time of your appointment, the original annual report should be filed in the office of the Clerk of the Court which appointed you as guardian.

6. Send a copy of the annual report to the incapacitated person by mail. If the incapacitated person resides in a facility, hospital, school or alcoholism facility in New York State, a substance abuse program, an adult care facility, a residential health care facility or a general hospital, send a duplicate of the annual report to the chief executive office of the facility and Mental Hygiene Legal Service if the incapacitated person resides in a psychiatric facility:

Mental Hygiene Legal Service has an office located at:
Marvin Bernstein
Director, First Department
Mental Hygiene Legal Service
60 Madison Ave.
New York, New York 10010

Also send a copy of the annual report to the examiner assigned to your case. The name and address of the examiner for your case may be located in the Order and Judgement or from the Guardianship/Fiduciary Dept. of the Supreme Court, Bronx County by calling (718) 618 1330.

SECTION I INFORMATION PERTAINING TO THE GUARDIAN (all guardians must complete this section).

1. **REPORT**:

Date of initial report:

Date of last annual report:

Date of this report:

Period covered by this report: _____, _____ through _____, _____. (INSTRUCTIONS: except for the first and last year of guardianship, the accounting covers the period from January until the end of December of the year preceding the report, or any other period upon order of the court).

2. **GUARDIAN**:

Name:

Address (include mailing address, if different):

Telephone no.:

3. **APPOINTMENT**:

Date of order:

Court:

Name of Judge/Justice:

4. **BOND**:

Bonding company name:

Bonding company address:

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

5. **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 place of such visits:

Date	Place

If no, please explain:

6. **EARNINGS**:

Have you used or employed the services of the incapacitated person?

Yes ___ No ___

Have any moneys been earned by or received on behalf of the incapacitated person based upon such services?

Yes ___ No ___

If yes, please set forth date, source and amount of moneys earned or derived from such services:

Date	Source	Amount

7. **WILL**:

To your knowledge, has the incapacitated person executed a will?

Yes ___ No ___

If yes, please provide location of the will:

8. **POWER OF ATTORNEY**:

To your knowledge, has the incapacitated person executed a Power of Attorney?

Yes ___ No ___

If yes, please provide the name and address of the person with the Power of Attorney:

9. **ADDITIONAL INFORMATION**:

Please provide any additional information which is required by your order of appointment as guardian (In addition to information provided in Sections I, II, III, and IV of this report).

10. **TYPE OF GUARDIANSHIP**:

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

Yes ___ No ___

If yes, please complete Sections II and III

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

Yes ___ No ___

If yes, please complete Sections II and IV

11. **CHANGE IN POWERS**:

Is there any reason for any alteration of your powers as guardian?

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 annual 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 and the persons entitled to such notice as specified in the order of appointment.

SECTION II INFORMATION PERTAINING TO THE INCAPACITATED PERSON (all guardians must complete this section)

1. **INCAPACITATED PERSON**:

Name:

Address (If residential facility, include name of the Director or person responsible for care):

Telephone no.:

Has there been any substantial change in the incapacitated person's mental or physical condition?

Yes ___ No ___

If yes, please explain:

Has there been any substantial change in the incapacitated person's medication?

Yes ___ No ___

If yes, please explain:

2. **EXAMINATION**:

Please state the date and place the incapacitated person was last examined or otherwise seen by a physician and the purpose of such visit:

Date	Physician	Purpose

Please attach a statement by a physician, psychologist, nurse clinician or social worker, or other person who has evaluated or examined the incapacitated person within three (3) months prior to the filing of this report, regarding an evaluation of the incapacitated person's condition and current functional level.

SECTION III PERSONAL NEEDS

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

1. **RESIDENTIAL SETTING**:

Is the current residential setting suitable to the needs of the incapacitated person?

Yes ___ No ___

If no, please explain:

2. **TREATMENT**:

What professional medical treatment, if any, has been given to the incapacitated person during the preceding year?

Date	Treatment

3. **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

4. **SOCIAL SKILLS**:

Please provide information concerning the social condition of the incapacitated person, such as the incapacitated person's social skills and needs and the social and personal services used by the incapacitated person.

SECTION IV PROPERTY MANAGEMENT

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

1. Have you identified, traced and collected assets of the incapacitated person since your appointment?

   Yes ___ No ___

   If no, please explain:

2. Have all of the incapacitated person's past and current income tax returns and payments been brought up to date?

   Yes ___ No ___

   If no, please explain:

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

SCHEDULE A
Assets on Hand at the Beginning of the Accounting Period

Please list all assets of the incapacitated person over which you had sole control as guardian as of the beginning of the accounting period. Do not include in this schedule trust principal in which the incapacitated person has an income interest, property under joint control of any court or real property not transferred to the guardian.

1. **BANK ACCOUNTS AND CASH -** please list the name and address of institutions, account numbers and balance deposited in banks or other financial institutions. Please also list any cash on hand not in bank accounts.

Name of Bank	Acct #	Amount
	Total	

2. **CORPORATE AND GOVERNMENT SECURITIES (e.g., CORPORATE STOCKS AND BONDS; FEDERAL, STATE OR MUNICIPAL BONDS AND NOTES)**

Name of Securities/Bond		Amount
	Total	

3. **PRESENT OR FUTURE INTERESTS (e.g., INTERESTS IN PARTNERSHIPS, TRUSTS, LITIGATION SETTLEMENT FUNDS OR PENSIONS)** - please list the estimated values of all present and future interests the incapacitated person has in property that has not been transferred to your control.

Names	Acct #	Amount
	Total	

4. **OTHER PERSONAL PROPERTY - (e.g., FURNITURE, JEWELRY, ARTWORK)** - please list and describe other personal property and indicate estimated value.

Description of Item	Date of Appraisal	Value
	Total	

5. **REAL PROPERTY** - please describe location and type of real property, type of interest and market value. Please also provide the date of filing of a statement identifying the real property with the County Clerk as required by Mental Hygiene Law § 81.20(a)(6)(vi).

SCHEDULE B

Assets Received During Accounting Period

Please list all principal assets received during the period of this report (show date received, source and amount or value).

Name of Bank/Securities	Account #	Amount
	Total	

SCHEDULE C

Income Received During Accounting Period

Please list all income received during the period from property interests listed in Schedules A and B (show date received, source and amount).

Source of Income	Nature of item	Amount
	Total	

SCHEDULE D
Losses Incurred During Accounting Period

Please list all realized losses incurred on principal assets, whether due to sale or liquidation, indicating the asset involved, the date and amount of loss.

Name of Securities	Date of Sale	Amount
	Total	

SCHEDULE E
Moneys Paid Out During Accounting Period

Please list all disbursements, excluding investments, during the period, including date of payment, payee and amount.

Date	Check #	Payee	Purpose	Amount

SCHEDULE F
Assets On Hand At End Of The Accounting Period

Please list assets of the type listed in Schedule A on hand at the end of the period and value thereof (see Schedule A for further instructions)

1. **BANK ACCOUNTS AND CASH.**

Name of Bank	Acct #	Amount
	Total	

2. **CORPORATION AND GOVERNMENT SECURITIES.**

Name of Securities/Bond		Amount
	Total	

3. **PRESENT OR FUTURE INTERESTS**.

Names	Acct #	Amount
	Total	

4. **OTHER PERSONAL PROPERTY**.

Description of Item	Date of Appraisal	Value
	Total	

5. **REAL PROPERTY**

SUMMARY

PART I.

Total beginning balance, as shown on Schedule A, $_____

Total additional assets, as shown on Schedule B, $_____

Total income received during accounting period,
as shown on Schedule C $_____

TOTAL PART I: $_____

PART II.

Total losses during accounting period,
as shown on Schedule D $_____

Total moneys paid out during accounting period,
as shown on Schedule E $_____

TOTAL PART II: $ _____

BALANCE ON HAND AT END OF ACCOUNTING PERIOD
(Total Part I minus Total Part II) $ _____

(This amount should be the same as Schedule F)

VERIFICATION

STATE OF NEW YORK)
ss:

COUNTY OF _____)

_____, being duly sworn, states that I am the Guardian of the within named incapacitated person and that the attached annual report and schedule(s) are, 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 my possession or has been received by others pursuant to my order or authority since the date of my appointment or last report; and the value of such property. I do not know of any error or omission in the report or schedule(s) to the prejudice of such incapacitated person.

_____
Guardian

_____

_____

_____

_____
(Your name, address and telephone number)

Sworn to before me this ____ day

of _____, 20___.

Notary Public

Affidavit of Mailing

I, the undersigned, being sworn, say

On the day of ,20

I delivered the within Annual Report of Guardian by mailing a true copy to each person named below at the address indicated:
*List parties and their addresses here

_____
Print name below signature

Sworn before me on the

_____day of _____, 20_____

Notary Public