



c. The incapacitated person has been in the present residence since \_\_\_\_\_ . If the incapacitated person has moved within the past year, state change and reason(s) for change:

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d. Name and address of the incapacitated person's primary care giver:

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4. The major medical or mental problems of the incapacitated person are as follows:

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5. Specify what, if any, social, medical, psychological and support services the incapacitated person is receiving:

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6. It is our opinion as guardian of the person that the guardianship should: (check one)

\_\_\_\_\_ continue, \_\_\_\_\_ be modified, \_\_\_\_\_ be terminated.

(Briefly explain your response)

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7. During the past year, I have visited the incapacitated person \_\_\_\_\_times with the average visit lasting \_\_\_\_\_.  
(State number of hours/minutes, etc.)

The report of a social service organization employed by the guardian to oversee and coordinate the care of the incapacitated person for the period covered by this report may be attached to supplement this report.

I verify that the foregoing information is correct to the best of my knowledge, information and belief; and that this verification is subject to the penalties of 18 Pa. C.S.A. §4904 relative to unsworn falsification to authorities.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Guardian

**\* FILING FEE \$15 MUST ACCOMPANY THIS FILING UNLESS IN  
FORMA PAUPERIS WAS ESTABLISHED BY COURT ORDER**