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.

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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	☐	☐	☐	☐	☐
Emotional Health	☐	☐	☐	☐	☐
Intellectual Functioning	☐	☐	☐	☐	☐
Living Situation	☐	☐	☐	☐	☐

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

   _____

   _____

   _____

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 njcourts.gov, 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

Guardian's Name: _____ Docket Number: _____

Certification of Examining Professional

Name: _____

Address: _____

_____

Telephone: _____ ext. _____

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