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IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF KING

In the Guardianship of: _____) Case No.: _____)
) GUARDIAN'S REPORT AND)
) ACCOUNTING)
)
) (ANR)

NOTE: This form is to be used for estates valued at less than \$80,000.00. If you need more room to answer any item, please attach an additional page.

1. Date of Appointment and Reporting Period: The Guardian was appointed on _____ . This Report covers the period from _____ through _____ . The closing date for all reports is (*anniversary date of appointment*) _____ , and the Guardian is required to file reports within 90 days of that date. The Guardian is to file a report every [] 12, [] 24, [] 36 months.

2. Continued Certification of Qualifications: The Guardian hereby certifies under penalty of perjury that he or she is over the age of eighteen, of sound mind, and has never been convicted of a felony or a misdemeanor involving moral turpitude, filed personal bankruptcy or been removed as a fiduciary in any proceeding for cause.
(Please explain the circumstances if any you do not meet any of the conditions above.)

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_____.

3. Scope of Guardianship: [Check all boxes that are appropriate.]

- [] Full Guardianship of the Person [] Full Guardianship of the Estate
- [] Limited Guardianship of the Person [] Limited Guardianship of the Estate
- [] The Incapacitated Person is a beneficiary of a Trust, which was approved by the Court or is subject to court supervision. The Trustee's name, address, and court case no. are:

_____.

4. Contact Information for Incapacitated Person, Guardian and Standby Guardian:

	Incapacitated Person	Guardian	Standby Guardian
Full Name:			
Mailing Address:			
City, State & Zip:			
Telephone Number:			
Fax Number:			
Email Address:			

5. Interested Parties: *(List each person who has filed a Request for Special Notice of Proceedings and those whom the Court has designated to receive copies of reports.)*

Name	Mailing Address	Relationship to Incapacitated Person

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///
///

1 **6. Personal Care Plan:** (To be filled out by all Guardians of the Person.)

2 **a. Status:** The Incapacitated Person is now _____ years of age.

3 [] The Guardian believes that the Incapacitated Person is receiving satisfactory care
4 OR

5 [] the Guardian has the following concerns for which a change is requested
6 _____.

7 **b. Change in Residence:** The following changes in residence of the Incapacitated
8 Person occurred during the reporting period: _____.

9 **c. Medical Condition:** The medical condition of the Incapacitated Person is (*list all
10 disabilities and changes that occurred during the report period*):
11 _____

12 **d. Mental Condition:** The mental condition of the Incapacitated Person (*list diagnosis,
13 if any, and changes that occurred during the report period*):
14 _____

15 **e. Changes in Incapacitated Person's Functional Ability:** A description of changes,
16 if any, in the functional abilities of the Incapacitated Person:
17 _____

18 **f. Activities of the Guardian Taken on Behalf of the Incapacitated Person:** The
19 following is a description of the activities in which the Guardian has engaged for the
20 benefit of the Incapacitated Person: _____

21 **g. Description of Recommended Changes in Scope of Authority of Guardian:** The
22 scope of authority of the Guardian

23 [] remains the same, OR

24 [] should be changed as follows: _____

25 **h. Names of Professionals Who Have Aided the Incapacitated Person:** The
26 following professionals have assisted the Incapacitated Person during the period
covered by this report: _____

i. Guardian's Plan for Future Care. The Guardian's care plan, [] remains the
same, OR [] is changed as follows: _____

1 **7. Estate Information** (To be filled out by all Guardians of the Estate. If you serve as
2 Guardian of the person only, you do not have to complete the following section. Please
3 make sure that you have signed where indicated below.)

4 **a. Interested Governmental Agencies:** (Check each box that is applicable.)

5 [] The Incapacitated Person is a veteran who has served in the United States
6 Military. Notice must be provided to: The Department of Veteran Affairs, Henry M.
7 Jackson Federal Building, 915 Second Avenue, Seattle, WA 98174 fifteen days prior
8 to filing this Report with the Court.

9 [] The Incapacitated Person is receiving Medicaid long-term funded care from
10 the Department of Social and Health Services. Fees and costs of the Guardian or the
11 Guardian's attorney are being sought as an adjustment to the Incapacitated Person's
12 amount of participation. Notice must be provided to the Department of Social and
13 Health Services regional administrator of the program that is providing services to
14 the Incapacitated Person ten days prior to filing this Report with the Court.

15 **b. Benefits Received.** The Guardian receives the following benefits on behalf of
16 the Incapacitated Person: [] SSDI/SSA; [] SSI; [] Medicaid; []
17 Medicare; [] Copes; [] TANF; [] HUD; [] Food Stamps; []
18 GAU; [] Public Assistance; [] VA; [] CSA; []
19 Other-Specify: _____

20 **c. Inventory.** An inventory of all property of the Incapacitated Person's estate at the
21 commencement of the Guardianship [] is, or [] is not on file herein. An
22 updated inventory is contained in this Report.

23 **d. Bond/Blocked Accounts.** There is \$_____ in unblocked accounts
24 and \$_____ in blocked financial accounts. The Guardianship bond
25 issued by _____ identified by bond number
26 _____, and is in the amount of \$_____ .

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1 For Accounting Period starting _____ and ending _____.

2 Total Assets at Market Value as of the beginning of review period \$ _____.

Income:	
Social Security:	\$ _____
SSI:	\$ _____
VA/Railroad/CSA Pension:	\$ _____
Retirement Pension:	\$ _____
Wages:	\$ _____
Interest and Dividends:	\$ _____
Other:	\$ _____
Total Income:	\$ _____

8

Disbursements:	
Room and Board: (<i>Rent, Nursing Home</i>)	\$ _____
Personal Funds:	\$ _____
Entertainment & Travel:	\$ _____
Transportation (<i>mileage, bus pass, taxi scrip, etc.</i>)	\$ _____
Medical and Dental:	\$ _____
Guardian Fees:	\$ _____
Attorney Fees:	\$ _____
Other:	\$ _____
Total Disbursements:	\$ _____

15 **Adjustments:**
(Net gain/loss in value of assets over accounting period) \$ _____

16 **Total Assets:** (as of closing date of accounting period) \$ _____

17 **Explanation:** (for any large or unusual expenditures, adjustments, or purchases)

_____.

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22 ///

1 **Asset List:** (For all financial accounts, include the type of account, account number, bank
 2 or company name, and branch location. You may use the figures from the last statement
 3 received from a bank or company prior to the ending date of the accounting period.)

4 (Please use only last four digits of the account numbers.)

			Balance/Market Value
5 Account #:	Type:	With:	\$
6 Account #:	Type:	With:	\$
7 Account #:	Type:	With:	\$
8 Other:			\$

9

10 I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE
 11 STATE OF WASHINGTON THAT TO THE BEST OF MY KNOWLEDGE THE
 12 STATEMENTS IN THIS GUARDIAN'S REPORT AND ACCOUNTING AND ALL
 13 ATTACHMENTS HERETO ARE TRUE AND CORRECT.

14 Signed at _____, Washington, _____, ____ 200__.

15 _____
 Signature of Guardian Printed Name of Guardian, WSBA/CPG#

16 _____
 Address Telephone/Fax Number

17 _____
 City, State, Zip Code Email Address

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