

**IN THE CIRCUIT COURT FOR THE 14<sup>TH</sup> CIRCUIT, STATE OF FLORIDA  
GUARDIANSHIP, PROBATE AND MENTAL HEALTH DIVISION**

**IN RE: THE GUARDIANSHIP OF**

**CASE NO.: \_\_\_\_\_-GA**

\_\_\_\_\_  
*(Name of Ward)*

*Reference: Florida Statute 744.363*

**INITIAL GUARDIANSHIP PLAN OF GUARDIAN OF THE PERSON (adult) rvd 2/16**

**If limited guardianship, check rights which were removed:**

- |                                      |  |   |   |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> to marry    | <input type="checkbox"/> determine residency       | <input type="checkbox"/> to sue/defend        | <input type="checkbox"/> to travel        |
| <input type="checkbox"/> to contract | <input type="checkbox"/> apply for gov't benefits  | <input type="checkbox"/> to give gifts        | <input type="checkbox"/> driver's license |
| <input type="checkbox"/> vote        | <input type="checkbox"/> choose social environment | <input type="checkbox"/> consent to treatment | <input type="checkbox"/> seek employment  |

\_\_\_\_\_, the guardian of the person of \_\_\_\_\_ (the ward),  
submits the following plan as the Initial Guardianship Plan of this guardian:

1. During the upcoming period beginning \_\_\_\_\_, 20\_\_\_\_ and ending \_\_\_\_\_, 20\_\_\_\_, the guardian proposes the following plan for the benefit of the ward, which is based upon the recommendations of the examining committee's comprehensive examination, as incorporated into the Court's order determining incapacity.

a.) Medical, mental or personal care services to be provided for the best welfare of the ward  
*(Which doctor(s) does the ward visit regularly? What kind of assistance does the ward require for activities of daily living? Does the ward require any mental health care?):*

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b.) Social and personal service to be provided for the best welfare of the ward: *(The guardian must detail all services provided to or for the ward, including any services provided by friends, family, paid caregivers or facility staff.)*

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c.) Place and kind of residential setting best suited for the needs of the ward: *(Please list the ward's address, name and type of facility, if applicable, and describe why this is the best, least restrictive, living arrangement for the ward)*

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d.) Description of health and accident insurance and any other private or governmental benefits to which the ward may be entitled to meet any part of the costs of medical, mental health or related services provided to the ward *(list all types of income/benefits received by or for the ward, for example, Social Security, pensions, Medicare, Medicaid, etc...):*

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e.) Physical and mental examinations necessary to determine the ward's medical and mental health treatment needs, including names of those who will provide examinations and approximate dates for examinations *(Do NOT include examining committee physicians or reports. What care providers does the guardian intend to have the ward see in the coming reporting period?):*

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. The guardian hereby attests that the guardian has consulted with the ward, and, to the extent reasonable, honored the ward's wishes consistent with the rights retained by the ward under the plan, and to the maximum extent reasonable, the plan is in accordance with the wishes of the ward.

3. This Initial Guardianship Plan does not restrict the physical liberty of the ward more than is reasonably necessary to protect the ward or others from serious physical injury, illness or disease and provides the ward with medical care and mental health treatment for the ward's physical and mental health.

Under penalties of perjury, I declare that I have read the foregoing and the facts alleged are true, to the best of my knowledge and belief.

Signed on \_\_\_\_\_ day \_\_\_\_\_ 20\_\_\_\_\_.

\_\_\_\_\_  
*Guardian's Signature*  
**Print Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
\_\_\_\_\_  
**Phone Number:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  
*Attorney for Guardian*  
**Print Name:** \_\_\_\_\_  
**Florida Bar No.** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
  
**Phone Number:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**CERTIFICATE OF SERVICE**

**I certify that a copy of this Initial Plan has been served on:**

- 1. Name \_\_\_\_\_ address \_\_\_\_\_
- 2. Name \_\_\_\_\_ address \_\_\_\_\_
- 3. Name \_\_\_\_\_ address \_\_\_\_\_

**This \_\_\_\_\_ day \_\_\_\_\_ 20\_\_\_\_\_**

\_\_\_\_\_  
*Signature*