IN THE CIRCUIT COURT, EIGHTEENTH
JUDICIAL CIRCUIT IN AND FOR
BREVARD COUNTY, FLORIDA

CASE NO.: _____

IN RE: THE GUARDIAN ADVOCACY OF

_____
Name of Person with a Developmental Disability

ANNUAL GUARDIAN ADVOCACY PLAN
WITH PHYSICIAN'S REPORT
(Form L)

Comes now _____, the Guardian Advocate of the Person of _____ (Person with a Developmental Disability), and submits the following Annual Guardian Advocacy Plan:

The Annual Guardian Advocacy Plan, for the period beginning _____ (Month) _____ (Day) _____ (Year) and ending _____ (Month) _____ (Day) and _____ (Year), shall be as follows:

1. The following information is submitted concerning the residence of the person with a developmental disability:

a. The person with a developmental disability's address at the time of filing this plan is:

_____

_____

_____

b. During the prior twelve (12) months the person with a developmental disability has resided at the following locations (names, addresses, and length of stay at each location):

_____

_____

_____

_____

<space intentionally left blank>

c. The residential setting best suited for the current needs of the person with a developmental disability is as follows:

d. The Plan for the next twelve (12) months to ensure the person with a developmental disability is in the best residential setting to meet the person with a developmental disability's needs is as follows:

2. The following information is submitted concerning the medical and mental health conditions and treatment and rehabilitation needs of the person with a developmental disability:

a. Any professional medical treatment given to the person with a developmental disability during the prior twelve (12) months was as follows:

b. **Attached is a report of a physician who examined the person with a developmental disability no more than 90 days before the beginning of the applicable reporting period. The report contains an evaluation of the person with a developmental disability's physical and mental condition.**

c. The plan for providing medical, mental health and rehabilitative services in the next twelve (12) months is as follows:

3. The following information is submitted concerning the social condition of the person with a developmental disability:

a. The following is a summary of the social and personal services currently used by the person with a developmental disability:

b. The following is a statement of the social skills of the person with a developmental disability, including how well the person with a developmental disability communicates and maintains interpersonal relationships:

c. The following is a description of the social needs of the person with a developmental disability:

4. The following is a summary of activities during the preceding year designed to enhance the capacity of the person with a developmental disability:

5. Can any rights of the person with a developmental disability be restored? (Yes) or (No)

6. Will the Guardian seek restoration of any rights of the person with a developmental disability? (Yes) or (No)

Under penalties of perjury, I, Guardian Advocate, declare that I have read the foregoing and the facts alleged are true to the best of my knowledge and belief, and that I provided a copy of this plan to the person with a developmental disability.

Dated this _____ day of _____,20 ___.

_____
Signature of Guardian Advocate

_____
Printed Name of Guardian Advocate

PHYSICIAN'S REPORT

(Form N)

(Required by §744.3675(1)(b)2), Fla. Stat.)

1. Name of Physician: _____
2. Address: _____
3. Name of Patient: _____
4. Date of Examination: _____
5. Purpose of Examination:
    a. Regular Check-up: _____
    b. Treatment: _____
6. Evaluation of person with a developmental disability's condition: (Specify mental and physical condition at time of examination)

    _____

    _____

    _____
7. Description of person with a developmental disability's capacity to live independently:

    _____
8. The person with a developmental disability (does) (does not) continue to need assistance of a Guardian.
9. Is the person with a developmental disability capable of being restored to capacity at this time? (Yes) or (No)
10. Date of this Report: _____
11. Signature of Physician completing this Report: _____