IN THE CIRCUIT COURT OF THE EIGHTEENTH JUDICIAL

CIRCUIT IN AND FOR SEMINOLE 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) \_\_\_\_\_\_\_ (Year) and ending \_\_\_\_\_\_\_\_\_\_\_ (Month) 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 ninety (90) days before the date this plan is filed. 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:

1. 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 L)***

(Required by Florida Statute §744.3675)

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

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1. Description of person with a developmental disability’s capacity to live independently: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. The person with a developmental disability (does) (does not) continue to need assistance of a Guardian.
3. Is the person with a developmental disability capable of being restored to capacity at this time? (Yes) or (No)
4. Date of this Report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Signature of Physician completing this Report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_