

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:

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:

d. A list of any preexisting orders not to resuscitate, executed under s. 401.45(3) or preexisting advance directives, as defined in s. 765.101, the date an order or directive was signed, whether such order or directive has been suspended by the court, and a description of the steps taken to identify and locate the preexisting order not to resuscitate or advance directive:

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)

7. Declaration of any and all payment or other benefit made directly or indirectly, overtly or covertly, or in cash or in kind to the guardian: _____

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:
 - 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: _____