PROBATE COURT OF _____ COUNTY, OHIO

_____, JUDGE

IN THE MATTER OF THE GUARDIANSHIP OF _____

CASE NO. _____

STATEMENT OF EXPERT EVALUATION

[Sup.R. 66 & R.C. 2111.49]

Definition of Incompetent (R.C. 2111.01(D)): "Incompetent" means any person who is so mentally impaired, as a result of a mental or physical illness or disability, as a result of intellectual disability, or as a result of chronic substance abuse, that the person is incapable of taking proper care of the person's self or property or fails to provide for the person's family or other persons for whom the person is charged by law to provide, or any person confined to a correctional institution within this State. The examiner shall complete this statement using personal observations and prior history obtained during the examiners course of treatment / interaction with the individual.

The Statement of Evaluation does not declare the individual competent or incompetent. It is evidence to be considered by the Court. The Probate Court **WILL NOT** pay the fee for completing this evaluation, unless otherwise ordered by the Court. The evaluator should secure payment from the Applicant or Guardian.

1. This Statement of Expert Evaluation is to be filed with or attached to:

   ☐ A. Guardianship Application: [Evaluation must be completed before the filing of the attached application.]

   Evaluation completed by: ☐ Licensed Physician ☐ Licensed Clinical Psychologist

   ☐ B. Application for Emergency Guardianship:

   Evaluation completed by: ☐ Licensed Physician ☐ Licensed Clinical Psychologist

   [NOTE: If this Statement relates to an emergency guardianship of the person, a Licensed Physician or a Licensed Clinical Psychologist must complete the Supplement for Emergency Guardian, Form 17.1A, specifying the details of the emergency, and why immediate action is required to prevent significant injury or death to the person. The Supplement must be signed by a Licensed Physician or a Licensed Clinical Psychologist, dated, and attached to this completed Statement.]

   ☐ C. Guardian's Report: [Evaluation must be conducted within three months before the date of this Report. R.C. 2111.49]

   Evaluation completed by: ☐ Licensed Physician ☐ Licensed Clinical Psychologist
   ☐ Licensed Independent Social Worker ☐ Licensed Professional Clinical Counselor
   ☐ Developmental Disability Team ☐ Certified Nurse Practitioner ☐ Licensed Clinical Nurse Specialist

2. Statement completed by: (Please print clearly)
   Name & Title/Profession: _____
   Business Address: _____
   Business Telephone Number: _____

3. Date(s) of evaluation: _____
   Place(s) of evaluation: _____
   Amount of time spent on evaluation: _____
   Length of time the individual has been your patient: _____
   Individual's language preference: _____

4. Is the individual presently taking medication? ☐ Yes ☐ No If yes, what is the medication, dosage, and purpose? [Continue comments on page 4]

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Are there any signs of physical and/or mental impairments caused by the medications themselves? _____

5. Is the individual mentally impaired? ☐ Yes ☐ No If yes, indicate the diagnosis below:
☐ Intellectual or Developmental Disabilities: *(Please check the severity)*
☐ Profound ☐ Severe ☐ Moderate ☐ Mild

☐ Mental Illness: Type and Severity _____

☐ Substance Abuse: Description _____

☐ Dementia: Type and Severity _____

☐ Other: Description, Type, and Severity _____
[Continue comments on page 4]

6. During the examination did you notice an impairment of the individual's:

a) Orientation	☐ Yes	☐ No	☐ Unknown
b) Speech	☐ Yes	☐ No	☐ Unknown
c) Motor Behavior	☐ Yes	☐ No	☐ Unknown
d) Thought Process	☐ Yes	☐ No	☐ Unknown
e) Affect	☐ Yes	☐ No	☐ Unknown
f) Memory	☐ Yes	☐ No	☐ Unknown
g) Concentration	☐ Yes	☐ No	☐ Unknown
h) Comprehension	☐ Yes	☐ No	☐ Unknown
i) Judgment	☐ Yes	☐ No	☐ Unknown

7. Please describe any impairments identified in question six. [Continue comments on page 4].

8. Is the individual physically impaired? I.e. visual, mobility, hearing, etc. ☐ Yes ☐ No If yes, please describe: ___

9. Are there any special characteristics of the individual which should be considered in evaluating the individual for guardianship: ☐ Yes ☐ No If yes, please explain: _____

10. Is there any indication of abuse, neglect, or exploitation of the individual? ☐ Yes ☐ No If yes, please explain:

11. Do you believe the individual is capable of caring for his or her activities of daily living or making decisions concerning his or her own medical treatments, living arrangements, and diet?

☐ Yes ☐ No If no, please explain:_____

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12 Do you believe this individual is capable of managing his or her finances and property? ☐ Yes ☐ No If no, please explain: _____

13. What is the recommended living situation for the individual?

☐ Independent living arrangement ☐ Assisted living facility or group home
☐ A nursing home ☐ A memory care facility or lockdown unit
☐ Other: _____

14. Prognosis of the individual:
A. Is the condition stabilized? ☐ Yes ☐ No ☐ Unknown
B. Is the condition reversible: ☐ Yes ☐ No ☐ Unknown

15. In my opinion a guardianship should be:
If this is a new application for appointment of guardian: ☐ Established ☐ Denied
If this is an existing guardianship: ☐ Continued ☐ Terminated

I certify that I have evaluated the individual on _____, 20_____.

Date:_____

_____
Signature of Evaluator

_____
Printed Name of Evaluator

GUARDIAN'S REPORT ADDENDUM

(Not to be used with initial Application)

It is my opinion, based upon a reasonable degree of medical or psychological certainty that the mental capacity of this ward will not improve.

Date_____

_____
Signature – Licensed Physician/Clinical Psychologist

_____
Printed Name of Licensed Physician/Clinical Psychologist

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ADDITIONAL COMMENTS

Date_____

_____
Signature of Evaluator