

IN THE COURT OF CHANCERY FOR THE STATE OF DELAWARE

\_\_\_\_\_, C.M.# \_\_\_\_\_  
Disabled Person

ANNUAL UPDATE & MEDICAL STATEMENT  
**(GUARDIAN must complete the section below.)**

I, \_\_\_\_\_, was appointed Guardian of \_\_\_\_\_  
Guardian's name Disabled person's name  
on \_\_\_\_\_.  
Date of Final Order for Appointment of Guardianship

1. My current mailing address is the following: \_\_\_\_\_  
\_\_\_\_\_
2. My current telephone number is: \_\_\_\_\_
3. Name of Disabled Person: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
4. Disabled Person's Residence: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Type of facility:  Disabled Person's Home  Guardian's Home  
 Group Home  Foster Home  
 Nursing Home  State Facility  Other (specify)

Agency providing care (i.e. Easter Seals, Chimes, DDDS, etc.): \_\_\_\_\_  
\_\_\_\_\_

Other agencies involved with the disabled person: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If there has been a change in residence since last review, give reason for the change: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Describe the management of the disabled person's financial affairs: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If the Guardian(s) do(es) not manage the disabled person's financial affairs, who does? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Have burial arrangements been established for the disabled person?  
 Yes       No  
If so, through what provisions? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Describe relationship with family (or interested parties): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Any additional information the Guardian desires to share with the Court: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Explain why this guardianship should be continued: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-Guardian's signature

***(PHYSICIAN must complete the section below)***

The attending physician, \_\_\_\_\_, last examined  
Physician's name  
\_\_\_\_\_ on the following date \_\_\_\_\_.  
Disabled person's name

Describe physical health of the disabled person/diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Significant changes since last review: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations/Surgical procedures since last review: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Consequently, there is a continued need for guardianship of the disabled person:  
 Yes       No

If No, why not? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's signature