PROBATE COURT OF FRANKLIN COUNTY, OHIO
JEFFREY D. MACKEY, JUDGE

IN THE GUARDIANSHIP OF _____

CASE NO. _____

STATEMENT OF EXPERT EVALUATION

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

"**Incompetent**" means any person who is so mentally impaired—as a result of a mental or physical illness or disability, of intellectual disability, or of chronic substance abuse—that the person is incapable of taking proper care of the person's self or property, or the person 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. R.C. 2111.01(D).

The examiner shall complete this statement using personal observations and prior history obtained during the examiner's course of treatment and/or interaction with the individual alleged to be incompetent. This statement does not declare the individual competent or incompetent, but is evidence to be considered by the probate court.

The Probate Court **will not** pay the fee for completing this evaluation. The evaluator should secure payment from the Applicant or Guardian.

Please type or print clearly. If you need extra room for any answer, continue your additional comments on Page 4.

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

☐ A Guardianship Application – evaluation completed by:

☐ Licensed Physician ☐ Licensed Clinical Psychologist

[Note: This evaluation must be completed before the application is filed.]

☐ An Application for Emergency Guardianship – evaluation completed by:

☐ Licensed Physician ☐ Licensed Clinical Psychologist

[Note: For an emergency guardianship, the evaluator must **also** 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 to the individual.]

☐ A Guardian's Report – 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

[Note: This evaluation must be completed within three months before the date of the report. R.C. 2111.49.]

2. Statement completed by:

Name & Title/Profession: _____

Business Address: _____

Business Telephone Number: _____

3. Evaluation:

Date(s) of evaluation: _____

CASE NO. _____

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 [describe medication, dosage, and purpose below] ☐ No

_____

_____

_____

5. Is the individual mentally impaired? ☐ Yes [describe relevant diagnoses below] ☐ No

☐ Intellectual and/or developmental disabilities: ☐ Profound ☐ Severe ☐ Moderate ☐ Mild

☐ Mental illness: _____

_____

☐ Substance abuse: _____

_____

☐ Dementia: _____

_____

☐ Other: _____

_____

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

Orientation?	☐ Yes	☐ No	☐ Unknown/unable to determine
Speech?	☐ Yes	☐ No	☐ Unknown/unable to determine
Motor behavior?	☐ Yes	☐ No	☐ Unknown/unable to determine
Thought process?	☐ Yes	☐ No	☐ Unknown/unable to determine
Affect?	☐ Yes	☐ No	☐ Unknown/unable to determine
Memory?	☐ Yes	☐ No	☐ Unknown/unable to determine
Concentration?	☐ Yes	☐ No	☐ Unknown/unable to determine
Comprehension?	☐ Yes	☐ No	☐ Unknown/unable to determine
Judgment?	☐ Yes	☐ No	☐ Unknown/unable to determine

7. Please describe any impairments or history identified above, including test scores if available.

_____

_____

8. Is the individual physically impaired? (Visual, mobility, hearing, etc.) ☐ Yes [describe below] ☐ No

_____

_____

9. Are there any special characteristics of the individual which should be considered in evaluating the individual for guardianship? ☐ Yes [explain below] ☐ No

_____

10. Is there any indication of abuse, neglect, or exploitation? ☐ Yes [explain below] ☐ No

_____

11. Do you believe the individual is capable of caring for their activities of daily living or making decisions concerning their own medical treatments, living arrangements, and diet? ☐ Yes [explain below] ☐ No

_____

12. Do you believe the individual is capable of managing their finances and property? ☐ Yes [explain below] ☐ No

_____

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

☐ Independent living arrangement ☐ Assisted living facility or group home ☐ Nursing home

☐ A memory care facility or lockdown unit ☐ Other: _____

14. Prognosis:

Is the condition stabilized? ☐ Yes ☐ No ☐ Unknown

Is the condition reversible? ☐ Yes ☐ No ☐ Unknown

15. In my opinion, a guardianship should be: ☐ Established/Continued ☐ Denied/Terminated

I hereby certify that I evaluated the individual as described above.

_____ _____

Date Signature of Evaluator

_____ _____

License Number of Evaluator Typed or Printed Name of Evaluator

GUARDIAN'S REPORT ADDENDUM

[Do not use with initial guardianship application]

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

_____ _____

Date Signature of Evaluator – Licensed Physician/Clinical Psychologist

_____ _____

License Number of Evaluator Typed or Printed Name of Evaluator

CASE NO. _____

ADDITIONAL COMMENTS

Date of Signature

Signature of Evaluator