

COURT OF COMMON PLEAS
BUCKS COUNTY, PENNSYLVANIA
ORPHANS' COURT DIVISION

GUARDIAN'S INVENTORY FOR AN INCAPACITATED PERSON

Estate of: _____, an Incapacitated Person
Name of Incapacitated Person

Case File No: _____

DATE COURT APPOINTED YOU AS GUARDIAN: _____

PART I: INTRODUCTION

Inventory type:

Initial

Amended

PART II: ASSETS (PRINCIPAL)

1. List all bank accounts, real estate, burial accounts, and other personal property below. If the property is owned by both the incapacitated person and others, indicate in the last column the name of the co-owner.

Asset	Value	Name of Co-Owner(s)
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
TOTAL	\$	

2. Is any property (specifically bank accounts or real estate) co-owned by the Incapacitated Person and the guardian?

Yes

No

If yes:

a. On what date was the property acquired? _____

b. On what date was the guardian's name added? _____

c. The guardian is:

an individual having access or control over the account

an owner of the account

3. Does the Incapacitated Person have a homeowners insurance policy for real property?

Yes (Copy of policy to be provided upon request)

No

If yes:

a. Carrier: _____

b. Coverage period: _____

4. Does the Incapacitated Person have an automobile insurance policy?

Yes (Copy of policy to be provided upon request)

No

If yes:

a. Carrier: _____

b. Coverage period: _____

5. Does the Incapacitated Person have a safe deposit box?

No

Yes, in sole name

Yes, in joint name(s). List the name(s) of joint owner(s): _____

If yes:

a. Location of safe deposit box: _____

b. Are there plans to inventory the contents?

Yes

No

PART III: ANNUAL INCOME

1. List all sources of income for the Incapacitated Person:

Does the Incapacitated Person receive any of the following as income?		Specify Amount
Alimony or Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Annuity Payments	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dividends	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Interest Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	
IRA Distributions	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Long Term Care Insurance Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pension/Retirement Benefits (for example: 401(k), 403(b), etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Public Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rental Property Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Royalties (including from mineral and land rights)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Social Security Benefits (Retirement, Disability, SSI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tax Refund	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Trust Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Veterans Benefits (disability/pension/aid and attendance)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Wages	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Workers' Compensation Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	TOTAL	

PART VI: PERSONAL CARE PLAN

1. Can the Incapacitated Person remain in their current residence with assistance, or in the home of a relative?

Yes

No

N/A - The Incapacitated Person is already in a supervised residential setting.

If yes:

a. List the name of the responsible family member:

b. What services does the Incapacitated Person require?

Services from local Area Agency on Aging

Private Companion/Assistance Service

Number of days per week: _____

Number of hours per week: _____

Assistance from family members

Will compensation be provided?

Yes

No

If yes, indicate compensation amount: _____

2. Will the Incapacitated Person be moved into a supervised residential setting?

Yes

No

N/A - The Incapacitated Person is already in a supervised residential setting.

If yes:

a. Indicate the type of supervised residential setting:

Domiciliary Care

Personal Care

Boarding Home / Group Home

Assisted Living Facility

Nursing Home

Other: _____

b. Describe the steps that are being taken to move the Incapacitated Person into a supervised residential setting.

PART VII: FINANCIAL PLAN

1. Complete the following table using initial inventory or most recent amended inventory.

<p>a. Total Annual Income (Part III, Question 1) \$ _____</p> <p>b. Annual estimated expenses \$ _____</p> <p>c. Net Income (a minus b) \$ _____</p>	<p>d. Total assets (principal) (Part II, Question 1) \$ _____</p>
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2. Is the net income listed above sufficient to care for the needs of the Incapacitated Person?

- Yes
- No, but assets (principal) are available if a court order approves expenditures
- No, and assets (principal) are not available

3. Indicate any applications for government benefits that have been submitted:

Application Type	Date of Submission
Social Security Disability Insurance (SSDI)	
Supplemental Security Income (SSI)	
Social Security Retirement Benefits	
Veteran's Benefits	
Medical assistance, long term care	
Medical assistance, Home Waiver	
Other (Explain: _____)	

4. Describe all real estate included in the estate and how it will be maintained or sold:

5. Prior to the appointment of a guardian, has an agent under a Power of Attorney been serving?

Yes

No

If **yes**, has an accounting ever been requested or filed with the Orphans' Court?

Yes

No

If **yes**, was the agent the same person as the guardian?

Yes

No

PART VIII: MEDICAL INFORMATION

1. Is a "no-code" (Do Not Resuscitate) provision in place for the incapacitated person?

Yes

No

2. When still capacitated, did the Incapacitated Person execute a durable power of attorney for health care or some other health care directive (including, but not limited to, a POLST, a living will, or a mental health care power of attorney)?

Yes

No

If **yes**, identify the authorized agent for making health care decisions:

3. Are you aware of any will or trust executed by the Incapacitated Person, or any funeral or burial wishes of the Incapacitated Person?

Yes

No

If **yes**, please explain:

Has a burial account been established for the Incapacitated Person?

Yes

No

If **yes**, what is the value of the burial account? \$ _____

I verify that the foregoing information is correct to the best of my knowledge, information and belief; and that this Verification is subject to the penalties of 18 Pa.C.S. §4904 relative to unsworn falsification to authorities.

I further acknowledge the Notice of Filing must be served within 10 days of the filing of this report, pursuant to proposed rule Pa. O.C. Rule 14.8(b). Service shall be in accordance with Pa. O.C. Rule 4.3.

Date

Signature of Guardian of the Estate

Name of Guardian of the Estate (type or print)

Address

City, State, Zip

Home Phone Number

Office Phone Number

Cell Phone Number

Email

Date

Signature of Co-Guardian of the Estate (if applicable)

Name of Co-Guardian of the Estate (type or print)

Address

City, State, Zip

Home Phone Number

Office Phone Number

Cell Phone Number

Email