

**PROBATE COURT OF BUTLER COUNTY, OHIO  
JOHN M. HOLCOMB, JUDGE**

**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 Statement of Expert Evaluation does not declare the individual competent or incompetent, but is evidence to be considered by the Court. The fee for completing this evaluation **WILL NOT** be paid by the Probate Court. Each evaluator should secure payment from the Applicant/Guardian.

1. This Statement of Expert Evaluation is being completed for:
  - A. **Initial Guardianship Application:** Must be completed by a \_\_\_ Licensed Physician or a \_\_\_ Licensed Clinical Psychologist, prior to the filing and attached to the application.
  - B. **Bi-Annual Follow-up Evaluations:** Must be completed by a \_\_\_ Licensed Physician \_\_\_ Licensed Clinical Psychologist \_\_\_ Licensed Independent Social Worker \_\_\_ Licensed Professional Clinical Counselor \_\_\_ Licensed Certified Nurse Practitioner \_\_\_ Licensed Clinical Nurse Specialist, or \_\_\_ the Developmental Disability Team  
*The evaluation or examination shall be completed within three months prior to the date it is filed with the Court. R.C. 2111.49.*
  - C. **Application for Emergency Guardian:** Must be completed by a Licensed Physician, who shall also complete the Supplement for Emergency Guardian (Form 17.1A) with specificity indicating the emergency, and why immediate action is required to prevent significant injury to the person and/or their property. The Supplement shall be signed, dated, and attached as part of this completed Statement.

*(please write legibly)*

2. Statement completed by:  
Printed or Stamped 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: \_\_\_\_\_

4. Is the individual presently under medication?  Yes  No If yes, what is the medication, dosage, and purpose? \_\_\_\_\_

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:**

Developmental Disabilities:

Profound  Severe  Moderate  Mild

Mental Illness: Type and Severity: \_\_\_\_\_

Substance Abuse: Description: \_\_\_\_\_

Dementia: Description: \_\_\_\_\_

Other: Description: \_\_\_\_\_

Please provide additional comments and test scores if applicable. (Continue comments on page 4): \_\_\_\_\_

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

- |                                    |                              |                             |                                  |
|------------------------------------|------------------------------|-----------------------------|----------------------------------|
| a) Orientation                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| b) Speech                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| c) Motor Behavior                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| d) Thought Process                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| e) Affect                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| f) Memory                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| g) Concentration and comprehension | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| h) Judgment                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

7. Please describe any impairments identified in question six. (Continue comments on page 4).

8. Is the individual physically impaired?  Yes  No If yes: Description: \_\_\_\_\_  
 \_\_\_\_\_
9. Are there any special characteristics of the individual which should be considered in evaluating the individual for guardianship?  Yes  No If yes: Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
10. Are there any indications of abuse, neglect or exploitation of the individual?  Yes  No  
 If yes: Explain: \_\_\_\_\_  
 \_\_\_\_\_
11. Do you believe the individual you are evaluating is capable of caring for his/her own activities of daily living or making decisions concerning medical treatments, living arrangements and diet?  
 Yes  No If no: Explain: \_\_\_\_\_
12. Do you believe the individual you are evaluating is capable of managing his/her own finances and property?  
 Yes  No If no: Explain: \_\_\_\_\_
13. Prognosis:  
 A. Is the condition stabilized?  Yes  No  
 B. Is the condition reversible?  Yes  No
14. In my opinion a guardianship should be:  
 Established/Continued  
 Denied/Terminated

I certify that I have evaluated the individual on \_\_\_\_\_, 20\_\_

Date: \_\_\_\_\_ Signature of Evaluator: \_\_\_\_\_

**GUARDIAN'S REPORT ADDENDUM**

(Not to be used with initial Application for Appointment -  
Can only be signed by a Licensed Physician/Clinical Psychologist)

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

