FORM MUST BE TYPEWRITTEN OR CAN BE FILLED IN ONLINE USING THE FORM AT THE COURT'S WEBSITE

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

IN THE MATTER OF 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 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 Court. Each evaluator should secure payment from the Applicant/Guardian.

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

☐ **A.** **Guardianship Application:** Completed by ☐ Licensed Physician or ☐ Licensed Clinical Psychologist prior to the filing and attached to the application.

☐ **B.** **Guardian's Report:** Completed by ☐ Licensed Physician ☐ Licensed Clinical Psychologist ☐ Licensed Independent Social Worker ☐ Licensed Professional Clinical Counselor or ☐ Intellectual Disability Team.
The evaluation or examination shall be completed within three months prior to the date of the Report. R.C. 2111.49

☐ **C.** **Application for Emergency Guardian:** ☐ of the person: a Licensed Physician shall 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. The Supplement shall be signed, dated, and attached as part of this completed Statement.

2. Statement completed by:

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: _____

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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:

☐ Intellectual Disability/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 available. (Continue comments on page 4):

6. During the examination did you note 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 and comprehension?	☐ Yes	☐ No	☐ Unknown
h)	Judgment?	☐ Yes	☐ No	☐ Unknown

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

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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 is capable of caring for the individual's activities of daily living or making decisions concerning medical treatments, living arrangements and diet? ☐ Yes ☐ No If no: Explain:

_____

_____

_____

12. Do you believe this individual is capable of managing the individual's 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 _____ , _____ .

_____ _____

Date Signature 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

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ADDITIONAL COMMENTS

Date

Signature - Licensed Physician/Clinical Psychologist