

COURT OF COMMON PLEAS  
 \_\_\_\_\_ 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)**

- 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)
<b>TOTAL</b>	\$ 0.00	

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	
	<b>TOTAL</b>	\$ 0.00



**PART VI: PERSONAL CARE PLAN**

1. Can the Incapacitated Person remain in his or her 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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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.

Effective June 1, 2019, I further acknowledge the Notice of Filing must be served within 10 days of the filing of this report pursuant to Pa. O.C. Rule 14.8(b).

\_\_\_\_\_  
*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*