Rule 7.11—Form 3: Guardian's Initial Care Plan for Protected Person

Instructions:

- Guardian must complete, sign, and file this form with the court within sixty (60) days of appointment.
- Do not include protected information on this form. For protected information, complete Rule 7.11—Form 1: Protected Information Disclosure.
- The purpose of the Initial Care Plan is to provide the court with a complete picture of Protected Person's current situation, Protected Person's needs, and Guardian's plan to meet those needs.
- Provide as much detailed information as possible.

If you do not understand how to use this form, or if you are unsure whether you should use this form, talk to an attorney.

In the Iowa District Court fo	or County
In the Matter of the Guardianship of:	Probate no
Full name: first, middle, last Protected Person.	Guardian's Initial Care Plan for Protected Person
	Iowa Code § 633.669(1)(a)
Guardian states as follows:	
1. Guardian's information	
A. Guardian's name:	
Full name: first, middle, last	
B. Guardian is Protected Person's: Check	one
☐ Spouse	
☐ Adult child	
☐ Parent	
☐ Adult sibling	
Other:	

2. Protected Person's information A. Protected Person's age: ______. B. Reason for guardianship: Check this box if you have attached a sheet with additional information. C. Protected Person's highest education level attained: ☐ High school ☐ College or university Other: D. Does Protected Person have a Living Will? ☐ Yes ☐ No If you checked Yes, complete (1)–(2). (1) Do you have a copy of Protected Person's Living Will? ☐ Yes ☐ No (2) Where is the Living Will located? Full name: first, middle, last / business name Mailing address City ZIP code State Phone number Email address Additional email address, if applicable

E. Does Protected Person have a Hea	althcare Power of Att	orney?
☐ Yes ☐ No		
If you checked Yes, complete (1)–(2).		
(1) Who is serving as the agent	(attorney-in-fact)?	
Full name: first, middle, last		
Mailing address		
City	State	ZIP code
()_ Phone number		
Email address		email address, if applicable
(2) Where is the Healthcare Po	wer of Attorney locate	ed?
Full name: first, middle, last / busine Mailing address	ess name	
City	State	ZIP code
()_ Phone number		
Email address		email address, if applicable
3. Protected Person's residence and in	nteraction with Gua	rdian
A. Does Protected Person currently liv	ve with Guardian? Ch	eck Yes or No below.
□Yes		
If you checked YeS, complete the next se	ection.	
Describe Guardian's daily intera	action with Protected	Person:
Check this box if you have attached a	sheet with additional inform	ation.

	u checked No, complete (1)–(5).
	u checked No, complete (1)–(5).
(1) [
(1) 1	Protected Person's current residence:
\bar{I}	Mailing address
.	City State ZIP code
	Date Protected Person began living at current residence:
· · ·	${Month}$, ${Day}$, $\frac{20}{Year}$.
(3) I	How often does Guardian plan to visit or have other contacts (e.g., by mail, email, social media, and phone) with Protected Person? Check all that apply
[□ Daily
[☐ Weekly
[☐ Monthly
[Other:
, ,	How does Guardian plan to interact with Protected Person? Check all that apply
[☐ In person
[☐ Mail, email, or social media
[☐ Phone
[Other:
` '	Describe the types of activities with or on behalf of Protected Person that Guardian plans:
-	
-	
-	
-	
[Check this box if you have attached a sheet with additional information.
- - -	

/ . 1 1	— Form 5. Guardian's Initial Care I tan joi I rolected I erson, continued
В.	Does Protected Person's current living situation best meet Protected Person's future needs?
	☐ Yes ☐ No
	If No, describe Guardian's plan for meeting those needs:
	Check this box if you have attached a sheet with additional information.

4. Protected Person's expenses

A. Estimate of Protected Person's expenses:

Type of expense	Amount estimated Check one ☐ monthly ☐ annual
(1) House payment or rent	\$
(2) Food At home and restaurants	\$
(3) Transportation (gas, bus fare) Not car loan payments – see (14).	\$
(4) Clothing	\$
(5) Medical, dental Not health insurance payments – see (10).	\$
(6) Utilities (gas, electric, water)	\$
(7) Phone	\$
(8) Cable / satellite television / internet	\$
(9) Car insurance payment	\$

B.

(10) Health insurance payment	\$	
(11) Transportation	\$	
(12) Educational or vocational training expenses	\$	
(13) Credit card payments	\$	
(14) Car loan payments	\$	
(15) Other loan payments	\$	
(16) Other expense Identify:	\$	
(17) Other expense Identify:	\$	
(18) Other expense Identify:	\$	
(19) Other expense Identify:	\$	
(20) Totals from attached sheets, if any Check this box if you have attached a sheet with additional information regarding expenses.	\$	
Total expenses	\$	
Who will pay Protected Person's expenses? Check all that apple	ly	
☐ Guardian		
☐ Spouse		
☐ Adult sibling or siblings		
☐ One or both of Protected Person's parents		
☐ A court-appointed conservator		
☐ Other:		

C. Information regarding payer of Protected Person's expenses:

Full name: first, middle, last Mailing address ZIP code City State Email address Additional email address, if applicable D. If Guardian is responsible for paying Protected Person's expenses, describe Guardian's plan for payment of Protected Person's living expenses and other expenses: Check this box if you have attached a sheet with additional information. 5. Protected Person's health A. Protected Person's physical health (1) Describe Protected Person's current medical health status, identifying any medical concerns: ☐ *Check this box if you have attached a sheet with additional information.* (2) Guardian's plan for meeting Protected Person's medical care needs: Check this box if you have attached a sheet with additional information. Continued on next page

B. Protected Person's dental health (1) Describe Protected Person's current dental health status, identifying any dental health concerns: Check this box if you have attached a sheet with additional information. (2) Guardian's plan for meeting Protected Person's dental health care needs: Check this box if you have attached a sheet with additional information. C. Protected Person's mental health (1) Describe Protected Person's current mental health status, identifying any mental, cognitive, behavioral, or emotional concerns: Check this box if you have attached a sheet with additional information. (2) Guardian's plan for meeting Protected Person's mental, cognitive, behavioral, or emotional needs: Check this box if you have attached a sheet with additional information.

	D.	Oth	ther health concerns		
		(1)) Identify any other health care concerns	related to Prote	ected Person:
			Check this box if you have attached a sheet with a	additional informati	on.
		(2)) Guardian's plan for meeting other healtl	n care concerns	s identified:
			Check this box if you have attached a sheet with a	additional informati	on.
6.			ected Person's education, training, and oyment status	l other vocation	onal services and
	A.	ls F	Protected Person enrolled in or attending	g school?	
	[<u></u>	Yes □ No		
		If yo	you checked Yes, complete (1)–(2).		
		(1)) School information:		
			School name where Protected Person is enrolled or	attending	
			School mailing address		
			City	State	ZIP code
) Does Protected Person receive or need services?	special educat	tion or related
			☐ Yes ☐ No		
			If Yes, describe:		
			Check this box if you have attached a sheet with a	additional informati	on.

Check this box if you have attached a sheet with additional information.

кин	e /.1.	(2) Guardian's plan for meeting educational, training, and vocational needs identified:
		Check this box if you have attached a sheet with additional information.
7.	Ot	her professional services
		Does Protected Person require any professional services other than those listed above?
		☐ Yes ☐ No
		If you checked Yes, complete B and C, otherwise skip to 8 .
	B.	Other professional services Protected Person requires:
		☐ Check this box if you have attached a sheet with additional information.
	C.	Guardian's plan to provide the professional services required:
		Check this box if you have attached a sheet with additional information.
8.	Pr	otected Person's social activities
	A.	Does Protected Person require assistance with participation in social activities?
		☐ Yes ☐ No
		If you checked Yes, complete the next section.

	B.	I—Form 3: Guardian's Initial Care Plan for Protected Person, continued Guardian's plan for assisting Protected Person's participation in social activities:		
		☐ Check this box if you have attached a sheet with additional information.		
9.	Pr	otected Person's contact with family members and other significant persons		
	A.	Will arrangements be made for regular contacts between Protected Person and Protected Person's family members (e.g., spouse, parents, adult children, and adult spouse)?		
		□Yes		
		If you checked Yes, complete the following sections as appropriate.		
		(1) Family member's name:		
		Relationship to Protected Person:		
		Describe arrangements planned for contact with this person:		
		Check this box if you have attached a sheet with additional information.		

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(2)	Family member's name:
	Relationship to Protected Person:
	Describe arrangements planned for contact with this person:
	Check this box if you have attached a sheet with additional information.
	Check this box if you have attached a sheet with additional family members.
□No	
If ye	ou checked No, complete the next section.
Ex	plain why:
	Check this box if you have attached a sheet with additional information.

	rangements be made for regular contacts between Protected Person and significant persons (e.g., friends, former co-workers, and clergy)?
☐Yes	
If yo	ou checked Yes, complete the following sections as appropriate.
(1)	Significant person's name:
	Relationship to Protected Person:
	Describe arrangements planned for contact with this person:
	Check this box if you have attached a sheet with additional information.
(2)	Significant person's name:
	Relationship to Protected Person:
	Describe arrangements planned for contact with this person:
	Check this box if you have attached a sheet with additional information.
	Check this box if you have attached a sheet with additional significant persons.

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□ No	o .
If	you checked No, complete the next section.
E	explain why:
_	
_	
_	
_	
_	
	Check this box if you have attached a sheet with additional information.
10. Additio	nal information
	al information that may be useful for the court to know in determining what is cted Person's best interest:
Check i	this box if you have attached a sheet with additional information.
11. Fees fo Check one	
☐ Fees	are applied for. Attach affidavit relative to compensation (Iowa Code section 633.202).
☐ Fees	are waived.
12. Fees fo	r Guardian's attorney
	should be set by the court. Attach affidavit relative to compensation (Iowa Code 633.202).
☐ Fees	are not requested.
☐ Fees	are waived or not applicable.

	ney Help Check on	-					
A. 🗆	An attorney did	not help r	me prepare	or fill in this p	aper.		
В. 🗆	An attorney helped me prepare or fill in this paper.						
	If you check B, you must fill in the following information:						
	Name of attorney or o	organization	n, if any				
	Business address of a	uttorney or o	organization				
	City			State	ZIP code		
	()_ Phone number			Fax number			
	Email address			Additional email address, if applicable			
				110000000000000000000000000000000000000	ererer ess, if approcaste		
Oath a	and signature o	f Guardia	an		catal ess, y appareance		
I,	_				Care Plan, and I certify		
I, <u>Print</u> under	your name	y and pui	, have re	ead this Initial (Care Plan, and I certify State of Iowa that the		
I, <u>Print</u> under inform	your name penalty of perjur	y and pui	, have re	ead this Initial (Care Plan, and I certify State of Iowa that the		
I, Print under inform	your name penalty of perjur nation I have prov	y and pui rided in th _, 20	, have re rsuant to th nis Initial Ca	ead this Initial (Care Plan, and I certify State of Iowa that the		
I, Print under inform	your name penalty of perjur nation I have prov	y and pui rided in th _, 20	, have re rsuant to th nis Initial Ca	ead this Initial (Care Plan, and I certify		
I, Print under inform Month	your name penalty of perjurnation I have provenated Day	y and pui rided in th _, 20 Year	, have re rsuant to th nis Initial Ca	ead this Initial (ne laws of the S are Plan is true	Care Plan, and I certify State of Iowa that the and correct.		

Email address

Additional email address, if applicable

^{*}Handwrite your signature on this form. Scan the form after signing it and file it electronically.