

Commonwealth of Massachusetts  
The Trial Court

Division \_\_\_\_\_

Probate and Family Court Department

Docket No. \_\_\_\_\_

**GUARDIANSHIP PETITION  
GUARDIAN OF PERSON — AND ESTATE**

Name of proposed ward \_\_\_\_\_

Please check applicable box and/or strike out inapplicable language where appropriate.

Basis for the Guardianship:

- Mental Illness*
- Mental Retardation*
- Physical Incapacity or Illness*

Special Requests:

- for court authorization to treat with antipsychotic medication(s) in accordance with the treatment plan
- for court authorization to admit or commit to a mental health or mental retardation facility
- extraordinary medical authority

To the Justices of the Probate and Family Court:  
RESPECTFULLY represents

PETITIONER (1)

PETITIONER (2)

\_\_\_\_\_  
(PRINT name of petitioner)

\_\_\_\_\_  
(PRINT name of petitioner)

that they are — he/she is:

- parent(s)
- a nonprofit corporation organized under the laws of the Commonwealth
- two (or more) relatives or friends
- an agency within the Executive Office of Human Services or Educational Affairs.

AND that \_\_\_\_\_ whose address is \_\_\_\_\_  
(name of proposed ward)

\_\_\_\_\_  
(street address) (city or town) (county) (state) (zip code)

- is incapable of taking care of himself/herself by reason of mental illness.
- is mentally retarded to the degree that he/she is incapable of making informed decisions with respect to the conduct of his/her personal and/or financial affairs.
- is unable to make or communicate informed decisions due to physical incapacity or illness.

List all heirs apparent or presumptive of ward:

| NAME<br><small>(Please indicate if person is a minor or incompetent)</small> | RESIDENCE | RELATIONSHIP |
|--|-----------|--------------|
|  |           |              |
|  |           |              |
|  |           |              |
|  |           |              |

The ward is — is not — entitled to benefits, estate, or income paid or payable through the United States Veterans Administration.

**[Guardianship of mentally retarded persons ONLY]**

- A Clinical Team report is filed with this petition. (See, G.L.M. c. 201, §6A and Uniform Probate Court Practice XXII(A))

(GUARDIANSHIP PETITION BACK)

WHEREFORE, the petitioner(s) pray(s) that \_\_\_\_\_ (name of proposed guardian(1))
(street address) (city or town) (state) (zip code)

— and \_\_\_\_\_ (name of proposed guardian(2), if applicable)
(street address) (city or town) (state) (zip code)

— or some other suitable person — be appointed the guardian of the person — and — the estate of the ward.

FURTHERMORE the petitioner(s) request(s):

[ ] court authorization to treat with antipsychotic medication(s) in accordance with the treatment plan.

[ ] court authorization to admit or commit to a mental health or mental retardation facility.

[ ] court authorization for the following extraordinary medical procedure(s): \_\_\_\_\_

The Petitioner(s) certify(ies) under the penalties of perjury that — the ward's estate does not exceed \$100.00 and that — the statements contained herein are true to the best of his/her/their knowledge and belief.

Dated: \_\_\_\_\_

PETITIONER (1)

PETITIONER (2)

(signature of petitioner)
(street address)
(city or town) (state) (zip code)

(signature of petitioner)
(street address)
(city or town) (state) (zip code)

Tel. No. ( ) \_\_\_\_\_

Tel. No. ( ) \_\_\_\_\_

The undersigned hereby assent(s) to the foregoing petition.

PETITION — DECREE

Filed: \_\_\_\_\_

Citation issued: \_\_\_\_\_

Returnable: \_\_\_\_\_

Allowed: \_\_\_\_\_

For Petitioner(s):

For Respondent:

(name)
(street address)
(city or town) (state) (zip code)

(name)
(street address)
(city or town) (state) (zip code)

Tel. No. ( ) \_\_\_\_\_

Tel. No. ( ) \_\_\_\_\_

B.B.O. # \_\_\_\_\_

B.B.O. # \_\_\_\_\_

INSTRUCTIONS

- 1. Refer to G.L.M. c. 201, §§ 6, 6A, 6B, 7; Probate Court Rule 29B; and, Uniform Probate Practice XXII and XXII(A).
2. A bond must be furnished.
3. If certified that the ward's estate is less than \$100.00, no filing fee is required. If the ward's estate is \$100.00 or more, a \$150.00 filing fee, a \$50.00 bond and, a \$15.00 surcharge must be paid upon filing.
4. A Medical Certificate must be filed in accordance with Uniform Probate Practice XXII.

Commonwealth of Massachusetts

The Trial Court

Division

Probate and Family Court Department

Docket No.

Plaintiff/Petitioner

v.

Defendant/Respondent

MOTION FOR

APPOINTMENT FOR TEMPORARY GUARDIAN

Now comes (name of moving party), the plaintiff/defendant/petitioner/respondent, in this action who moves this Honorable Court as follows: to allow the appointment of a temporary guardian for the above-named ward. My affidavit is filed herewith.

NOTICE OF HEARING

This Motion will be heard at the Probate & Family Court in

(city)

on (month/day/year)

at (time of hearing)

(signature)

(PRINT name)

(street address)

(city or town)

(state) (zip code)

Date:

Tel. No. ( )

The within motion is hereby ALLOWED — DENIED.

Date

Justice of the Probate and Family Court

INSTRUCTIONS

- 1. Generally, refer to Mass.R.Civ.P./Mass.R.Dom.Rel.P. 6 and 7; Probate Court Rules 6.29 and 29B.
2. If the opposing party is represented by an attorney who has filed an appearance, service of this motion MUST be made on the attorney.
3. Certificate of Service on Reverse side must be completed.
4. All motions shall be accompanied by a proposed order which shall be served with the motion.

Commonwealth of Massachusetts  
The Trial Court

Division \_\_\_\_\_

Probate and Family Court Department

Docket No. \_\_\_\_\_

**AFFIDAVIT FOR TEMPORARY GUARDIANSHIP**

Guardianship of \_\_\_\_\_

I / We, \_\_\_\_\_ of \_\_\_\_\_  
Print Name(s)

hereby state that:

1. On or about \_\_\_\_\_, the situation of the proposed ward which  
Date  
requires emergency attention is \_\_\_\_\_

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

2. The petitioner(s) seek(s) to avoid the particular harm of: \_\_\_\_\_

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

3. The actions with regard to the proposed ward which are reasonably necessary to avoid the occurrence  
of that harm are: \_\_\_\_\_

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

4. Check one of the following: (NOT applicable to minors)

The proposed ward has executed a Health Care Proxy and/or a Durable Power of Attorney (copy attached)

The proposed ward has not executed a Health Care Proxy and/or a Durable Power of Attorney

I have been unable to determine if the proposed ward has executed a Health Care Proxy and/or a Durable Power of Attorney

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, under the penalties of perjury.

\_\_\_\_\_  
\_\_\_\_\_  
Signature(s)

Commonwealth of Massachusetts  
The Trial Court  
Probate and Family Court Department

Division \_\_\_\_\_

Docket No. \_\_\_\_\_

Bond of \_\_\_\_\_ (type of fiduciary) \_\_\_\_\_  
( ) without  
( ) with Personal Surety  
( ) with Corporate Surety

Name of Estate \_\_\_\_\_

Name and Address of Fiduciary \_\_\_\_\_

Estimated Real Estate \_\_\_\_\_ Estimated Personal Estate \_\_\_\_\_

Penal Sum of Bond, (if applicable) \_\_\_\_\_

I, We, the undersigned fiduciary accept appointment as \_\_\_\_\_  
and stand bound — in the aforesaid penal sum — with the undersigned surety or sureties — (if applicable) to per-  
form the statutory conditions of said bond and declare the above estimate to be to my — our best knowledge and  
belief.

Date \_\_\_\_\_

Signature of Fiduciary — Principal \_\_\_\_\_

(complete below only if this is a bond with personal sureties)

We, the undersigned, as sureties, stand bound jointly and severally in the aforesaid penal sum to perform the  
statutory condition.

Personal Surety's Name and Address \_\_\_\_\_

Signature \_\_\_\_\_

Personal Surety's Name and Address \_\_\_\_\_

Signature \_\_\_\_\_

The above sureties are in my opinion sufficient.

Signature \_\_\_\_\_

Office \_\_\_\_\_

City or Town \_\_\_\_\_

(complete below only if this is a Surety Company Bond)

We, the undersigned surety company, a corporation duly organized by law under the state of \_\_\_\_\_  
and having a usual place of business in \_\_\_\_\_

(Massachusetts address)

stand bound as surety, in the aforesaid penal sum, to perform the statutory condition.

Corporate Surety (name) \_\_\_\_\_

by \_\_\_\_\_

Signature and Title \_\_\_\_\_

, SS. \_\_\_\_\_

, 20 \_\_\_\_\_

examined and approved.

|   |   |            |
|---|---|------------|
| Division                                | Commonwealth of Massachusetts<br>The Trial Court<br>Probate and Family Court Department | Docket No. |
| <b>MEDICAL CERTIFICATE-GUARDIANSHIP</b> |   |            |

**INSTRUCTIONS FOR COMPLETION**

This document will be used by the Probate and Family Court to determine whether to appoint a guardian to assume responsibility for this individual in some or all areas of decision making.

**To the registered physician, licensed psychologist, or certified psychiatric nurse clinical specialist completing this document:**

You must complete this document. If there is any information about which you do not have direct knowledge, you are encouraged to make inquiry of such other persons as may be necessary to complete the entire form. These might include other healthcare professionals and/or others acquainted with the individual (i.e. family members or social service professionals). If you receive information from others, the names of those individuals must be listed in the Certification Section and attribution identified.

If you are completing this form on the computer and additional space is required for any narrative section or listing of medications, etc., the section will expand to permit additional information. If you are completing it in longhand, please attach additional pages as necessary. Do not use medical terminology and/or abbreviations without explaining them in terms which a lay person can understand.

**ALL OF THE ATTACHED PAGES AND SECTIONS CONTAINED THEREIN MUST BE COMPLETED.**

This document must be signed and dated by the person completing it. It does not need to be notarized.

**To the Honorable Justices of the Probate and Family Court:**

The undersigned hereby certifies under the penalties of perjury that I am:

- a registered physician specializing in the area of \_\_\_\_\_
- a licensed psychologist
- a certified psychiatric nurse clinical specialist

I am prepared to present a statement of my qualifications to the Court by written affidavit or personal appearance if directed to do so.

I personally examined \_\_\_\_\_ who resides at \_\_\_\_\_  
PRINT name of proposed ward

\_\_\_\_\_ on \_\_\_\_\_  
Street Address                      City/Town                      State                      Date(s) of Examination(s)

The duration of the most recent examination was \_\_\_\_\_

In my opinion, as described in detail in the attached sections, this individual:

- is a person incapable of caring for his/her personal and/or financial affairs due to **mental illness**.
- is a person unable to make or communicate informed decisions due to **physical incapacity**.

Further, it is my opinion that this person is in need of:

- limited guardianship, as follows:

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- full guardianship. If full guardianship checked, please explain why a limited guardianship would not be sufficient:

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1. PHYSICAL AND MENTAL CONDITIONS

A List Physical Diagnoses and Prognosis (including Nutritional Status):

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Overall physical health:  Excellent  Good  Fair  Poor

B List Mental (DSM) Diagnoses and Prognosis:

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Overall mental health:  Excellent  Good  Fair  Poor

Focusing on the mental diagnoses most impacting functioning, describe relevant history:

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C. List all Medications:

| Name | Dosage/Schedule |
|------|-----------------|
|      |                 |
|      |                 |
|      |                 |
|      |                 |
|      |                 |

Do any of these medications impact mental functioning?  Yes  No  Uncertain

If Yes, please identify which medications and how they impact mental functioning:

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D. Treatable, Reversible Causes and/or Mitigating Factors.

Have temporary or reversible causes of mental impairment been evaluated and treated?

Yes     No     Uncertain

With time and treatment, mental functioning could:     Improve     Worsen     Stay the same

If the condition causing mental impairment is treatable or reversible, explain how functioning may improve. If there are mitigating factors such as hearing loss, vision loss, bereavement that may cause the person to appear incapacitated, describe these:

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If improvement is possible, the individual should be re-evaluated in \_\_\_\_\_ weeks.

2. COGNITIVE AND EMOTIONAL FUNCTIONING

A. Alertness/Level of Consciousness

Overall Impairment:     None     Mild     Moderate     Severe     Non Responsive

Please describe:

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B. Memory and Cognitive Functioning

Overall Impairment:     None     Mild     Moderate     Severe

Please describe:

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C. Emotional and Psychiatric Functioning (e.g. mood, anxiety, psychotic, substance use, and other disorders)

Overall Impairment:     None     Mild     Moderate     Severe

Please describe:

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D. Fluctuation. Symptoms vary in frequency, severity, or duration:  Yes  No  Uncertain

3. EVERYDAY FUNCTIONING.

A. Activities of Daily Living (ADL'S)

Ability to Care for Self (e.g. bathing, grooming, dressing, walking, toileting, etc.)

Level of Function:  Independent  Needs Assistance/Support  Needs Total Care

Please describe:

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Is the individual willing to accept assistance?  Yes  No  Uncertain

Please explain:

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B. Instrumental Activities of Daily Living (IADL'S)

Financial Decision-Making (e.g. bills, donations, investments, real estate, wills, protect assets, resist fraud, etc.)

Level of Function:  Independent  Needs Assistance/Support  Needs Total Care

Please describe:

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Medical Decision-Making (e.g. ability to express a choice and understand and appreciate health information, etc.)

Level of Function:  Independent  Needs Assistance/Support  Needs Total Care

Please describe:

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Care of Home and Functioning in Community (e.g. manage home, health, telephone, mail, drive, leisure, etc.)

Level of Function:  Independent  Needs Assistance/Support  Needs Total Care

Please describe:

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Other Relevant Civil, Legal, or Safety Matters (e.g. sign documents, retain legal counsel, etc.)

Level of Function:  Independent  Needs Assistance/Support  Needs Total Care

Please describe:

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**4. VALUES AND PREFERENCES.**

Please describe relevant values, preferences, and patterns. Note whether the person accepts/ opposes guardianship, goals for where/how life is lived, religious or cultural considerations.

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**5. RISK OF HARM TO SELF OR OTHERS**

A. Nature of Risks. Please describe the significant risks facing this person, and note whether these risks are due to this person's condition and/or due to another person harming or exploiting him or her.

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B. Social Network Relationships (Check one box in each category).

Social Support

- Very good supportive network
- Some support from family and friends
- Limited or nonexistent support from family and friends.

Social Skills

- Very good social skills
- Good social skills
- Poor social skills

Please describe:

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C. How severe is risk of harm to self or others:  Mild  Moderate  Severe

D. How Likely is it:  Almost Certain  Probable  Possible  Unlikely

**6. LEVEL OF CARE AND/OR SUPERVISION NEEDED, INCLUDING HOUSING**

Locked facility required  24 hr. supervision required  Some supervision required  No supervision required

If a specific placement is being recommended, please describe:

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**7. THE INDIVIDUAL WOULD BENEFIT FROM:**

Education, training, or rehabilitation  Yes  No  Uncertain

Mental health treatment  Yes  No  Uncertain

Occupational, physical, or other therapy  Yes  No  Uncertain

Home and/or social services  Yes  No  Uncertain

Assistive devices or accommodations  Yes  No  Uncertain

Medical treatment, operation or procedure  Yes  No  Uncertain

Other: \_\_\_\_\_  Yes  No  Uncertain

Describe any specific recommendations:

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8. ATTENDANCE AT HEARING

The individual is able to attend the hearing

- at Court
- at the hospital or other facility or setting

Please specify place and location: \_\_\_\_\_

- at his/her residence

Accommodations, if any, required to facilitate participation:

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It is not in the best interests of the individual that she/he be required to attend the hearing for the following reason(s):

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9. CERTIFICATIONS

This form was completed based on:

- an examination for the purpose of capacity assessment of this individual
- my general clinical knowledge of this individual

who  is  is not a patient under my continuing care and treatment.

Prior to the examination, I informed the patient that communications would not be privileged:

- Yes
- No

Other sources of information for this examination:

- Review of medical record
- Discussion with health care professionals involved in the individual's care
- Discussion with family or friends
- Other

Names and titles of those individuals who assisted in preparation of this report:

| Name | Title |
|------|-------|
|      |       |
|      |       |

