ACCOUNTING SUMMARY FORM #1 – GENERAL PURPOSE
FOR NON-PROFESSIONAL GUARDIANS
(Estates in excess of $80,000.00 in liquid assets and/or real estate)

14. Estate Information

For Accounting Period starting _____ and ending_____.

Description and last four digits of account #	**Value at Beginning of Accounting: Date: _____**	**Value at End of Accounting: Date: _____**	**Difference**
Real Estate			
Bank and Investment Accounts (include financial institution and last four digits of account # only)			
Money Owed TO the Incapacitated Person (Mortgages, Contracts, Promissory Notes Payable to the Incapacitated Person)			
Furniture, Vehicles, Boats, and Other Personal Property			
15. Total Value of Assets			

Liabilities (List all debts or obligations of the Incapacitated Person and the Estate)			
16. Total of Liabilities			

17. Net Totals (Item 15 minus Item 16)			

SET FORTH TOTAL FIGURES FOR ENTIRE ACCOUNTING PERIOD. DO NOT USE MONTHLY FIGURES.

18. Income Received From All Sources During the Reporting Period

	Current Monthly Benefit	**Total Received**
a. Wages	$	$
b. Social Security	$	$
c. Retirement Benefits	$	$
d. Disability	$	$
e. Health Insurance Benefits	$	$
f. Other Monthly Income	$	$
g. Gain on Sale of Asset: Asset: Asset:	$	$
h. Interest on Certificate(s) of Deposit	$	$
i. Income on Mutual Funds	$	$
j. Savings Account Interest	$	$
k. Money Market/Checking Account Income	$	$
l. From Trust or Spousal Maintenance	$	$
m. Adjustment for Increase in Value of:	$	$
n. Adjustment for Increase in Value of:	$	$
o. Other:	$	$
19. Total Income	$	$

20. Disbursements and Outgoing Payments

Personal Living Expenses	
a. Housing (Rent/Mortgage) at:	$
b. Heat/Lighting/Water/Sewer/Cable/Telephone	$
c. Household Maintenance	$
d. Food and Household Supplies	$
e. Clothing	$
f. Personal Care and Services (Other than Medical Attendants)	$
g. Insurance for:	$
h. Allowance or Money Given Directly to Incapacitated Person	$
i. Auto and Transportation	$
j. Travel	$
k. Other:	$
Healthcare Expenses	
l. Health Insurance Premium	$
m. Doctor Fees	$
n. Hospital and Health Care Providers	$
o. Prescription and Pharmacy	$
p. Medical Transportation	$
q. Visiting Nurse/Companion Services	$
r. Other:	$
Professional Fees	
s. Guardian Fees	$
t. Attorney Fees for Guardian	$
u. Attorney Fees for Petitioner	$
v. Guardian ad Litem Fees and Costs	$
w. Trustee Fees	$
x. Bond Premium	$
y. In-Home Services	$
z. Accounting Fees	$
aa. Other:	$
Other Expenses	
bb. Subscriptions	$
cc. Bank Charges	$
dd. Federal Income Tax	$
ee. Gifts	$
ff. Adjustments for Decrease in Value of:	$
gg. Adjustments for Decrease in Value of:	$
hh. Other:	$
21. Total Disbursements Outgoing From Incapacitated Person's Estate	$

22. Net Total of Income and Disbursements (Item 19 minus Item 21)	$

Supporting Documents: Cancelled checks, (if not available, copies or images of cancelled checks or copies of check registers), monthly bank statements, brokerage statements, and an itemized list of all transactions **must be included** for each account for the reporting period to support the declarations made in this report. The supporting documents must be submitted to the Guardianship Monitoring Program Office with **a copy** of this report. **Do not** file the supporting documentation in the court legal file.

I certify (or declare) under penalty of perjury under the laws of the State of Washington that to the best of my knowledge the statements in this Guardian's Report, Accounting, and Proposed Budget and attached Accounting Summary are true and correct and hereby petition the Court for approval.

SIGNED AT _____, WASHINGTON THIS _____ DAY OF_____, 20_____.

_____	_____
Signature of Guardian	Printed Name of Guardian, WSBA/CPG#
_____	_____
Address	City, State, Zip Code
_____	_____
*Telephone/Fax Number	Email Address

***Under GR 22 (b) (6), parties' personal telephone number(s) are confidential information. If you do not want your personal phone number(s) on this public form, complete form #S2-Sealed Confidential Information and file in the confidential file.**