Superior Court of Washington
County of

In the Guardianship of: _____, Incapacitated Person	**No.** **Initial Personal Care Plan (PCP)**

I. ASSESSMENT

Check all that apply to the Incapacitated Person in each category:

1.1 Housing Composition:

[☐] Lives Alone
[☐] Lives with Spouse
[☐] Lives with Children
[☐] Lives with Relative
[☐] Lives with Non-Relative
[☐] Other:

1.2 Primary Means of Transportation:

[☐] Own Car
[☐] Public Transportation
[☐] Friend/Relative
[☐] Other:

1.3 Living Arrangement:

[☐] Home Owner
[☐] Renter
[☐] Adult Family Home
[☐] Cong. Care Facility
[☐] Nursing Home
[☐] Senior Housing
[☐] Other:

1.4 If Lives in Home – Services Needed:

[☐] None
[☐] Chore Services (household chores)
[☐] Other:

1.5 Functional Limitation:

[☐] Walker/Cane
[☐] Speech
[☐] Hearing
[☐] Vision
[☐] Walking

1.6 Prosthetic Devices:

[☐] None
[☐] Wheelchair
[☐] Hearing Aid
[☐] Artificial Limb
[☐] Dentures

1.7 Needs Assistance For:

[☐] Eating
[☐] Toileting
[☐] Ambulation
[☐] Transfer
[☐] Positioning
[☐] Personal Hygiene
[☐] Dressing
[☐] Bathing
[☐] Self Medication
[☐] Essential shopping with Incapacitated Person
[☐] Essential shopping for Incapacitated Person
[☐] Meal Preparation
[☐] Laundry
[☐] Facilities in Home
[☐] Facilities out of Home
[☐] Housework
[☐] Travel to Medical Services

1.8 Needs Assistance to Leave Home:

[☐] Yes [☐] No

Comments:

Circle one of the following codes for each item listed below:

Y=Yes; N=No; CD= Cannot Determine. Y☐N☐CD☐

1.9 Incapacitated Person's Ability To Handle Emergencies:

Knows what to do in the event of a fire.	Y☐	N☐	CD☐
Knows what to do in case of medical emergency (doctor, ambulance).	Y☐	N☐	CD☐
Knows what to do in the event of a break-in or robbery.	Y☐	N☐	CD☐
Knows how to call emergency telephone services (911).	Y☐	N☐	CD☐

1.10 Incapacitated Person Knows How To Seek Help From Others To Keep Supply Of Goods and Obtain Services
(Housekeeper, Lawyer, Community Services): Y☐ N☐ CD☐

1.11 Incapacitated Person's Financial Abilities:

Able to collect benefit, retirement, social security, V.A. benefits.	Y☐	N☐	CD☐
Able to maintain checking accounts with balance greater than $	☐	N☐	CD☐
Able to pay monthly bills for rent, utilities, etc.	Y☐	N☐	CD☐
Willing and able to spend money for necessary goods and services, i.e. food, clothing, sundries, etc.	Y☐	N☐	CD☐
Able to seek help in money management.	Y☐	N☐	CD☐
Able to manage funds.	Y☐	N☐	CD☐

If someone other than the guardian of the person is guardian of the estate, or if the Incapacitated Person's assets are under the control of a trustee, provide the following information:

List sources of income and/or resources to pay for monthly costs and care of the Incapacitated Person:

Estimated monthly costs and care of the Incapacitated Person:

Housing:	$ _____	Other:	$ _____
Food:	$ _____	_____	$ _____
Utilities:	$ _____	_____	$ _____
Clothing and Laundry:	$ _____	_____	$ _____
Medical:	$ _____	_____	$ _____
Recreational:	$ _____	_____	$ _____
Insurance:	$ _____	_____	$ _____

1.12 Incapacitated Person's Psychological/Social/Cognitive Functioning:

Y=Yes; N=No; CD= Cannot Determine.	Y☐	N☐	CD☐

A. Disorientation:

Able to relate to person, place or time:	Y☐	N☐	CD☐

B. Memory Impairment:

Can remember events occurring within the hour:	Y☐	N☐	CD☐
Can remember events occurring within the day:	Y☐	N☐	CD☐
Can remember events occurring within the week:	Y☐	N☐	CD☐

C. Impaired Judgment:

Able to make appropriate decisions, solve problems, and respond to major life changes:	Y☐	N☐	CD☐

D. Communications:

Able to understand what is being said:	Y☐	N☐	CD☐
Able to express thoughts and needs:	Y☐	N☐	CD☐

E. Wandering:

Moves about aimlessly, or in pursuit of an unobtainable goal: Y☐ N☐ CD☐

F. Verbally Abusive Behavior:

Threatens/berates others, yells, uses foul language, etc.: Y☐ N☐ CD☐

G. Disruptive or Inappropriate Behavior:

Makes excessive demands for attention, takes another's possessions, disrobes in front of others, inappropriate sexual behavior, etc.: Y☐ N☐ CD☐

H. Assaultive or Combative Behavior:

Throws objects, strikes or punches, makes dangerous maneuvers with wheelchair, etc.: Y☐ N☐ CD☐

I. Danger to Self:

Indicated by self-neglect or harm, suicidal thoughts or attempts, etc.: Y☐ N☐ CD☐

J. Other Impairments in Thought, Moods, Behavior:

Please Describe:_____.

II. Care Plan

2.1 Incapacitated Person's Residence

Facility Name (if applicable):_____

Address:_____

*Phone:_____

2.2 Plan for Chore Services Provided in Home

(if necessary)

_____
_____
_____

2.3 Plan for nursing services and other medical or personal care services provided in home, adult family home, or congregate care facility

(if necessary):

_____
_____

2.4 Plan for other services, including rehabilitative, educational, social, and recreational services:

_____

_____

2.5 Treating Physician:

Name	Address	Phone/Fax Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

2.6 Current Medications:

_____

_____

2.7 Other Professionals Assisting Incapacitated Person:

Name	Service Provided	Address	Phone/Fax Number
_____			
_____			
_____			

2.8 Other Significant Persons:

Name/Relationship to Incapacitated Person	Address	Phone/Fax Number
_____		
_____		
_____		

2.9 Plan for Financial Management:
(i.e. Person(s) responsible to receive income and pay monthly costs and care of the Incapacitated Person.)

_____

_____

_____

I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signed at (city)_____, (state)_____on (date)_____.

_____ _____

Signature of Guardian Print Name of Guardian [☐]WSBA [☐]CPG#

_____ _____

Address City, State, Zip Code

_____ _____

*Telephone/Fax Number Email Address

***If you do not want your personal phone number on this public form, you may list your telephone number on a separate form which may be available to parties and the court, as well as its staff and volunteers, but will not be made available to the public. Use Form WPF GDN 03.0100, Guardianship Confidential Information form (Telephone Numbers), for this purpose.**

***Note**: **Do not attach records produced and signed by a health care provider to this form**.*