SUPERIOR COURT OF WASHINGTON **COUNTY OF SPOKANE**	
In the Guardianship of: _____, Incapacitated Person	**No.** _____ **Periodic Personal Care Plan (PCP)** ☐ **Annual** ☐ **Final** ☐ **Clerk's Action Required**

Please use additional pages if necessary. It is recognized that people with incapacities have unique abilities and necessities. A care plan is essential to update the court of these needs.

The ☐ Full ☐ Limited Guardian of the Person, respectfully submits the following Personal Care Plan:

1. Custody and Residence of Incapacitated Person

The Incapacitated Person is now_____years of age. He/She presently resides at (name of facility, if applicable, and address): _____
_____.

The Guardian believes that he/she is receiving satisfactory care, and should continue to reside there.

2. Description of Services or Programs Incapacitated Person Receives

The Incapacitated Person receives the following services or programs: _____
_____
_____.

3. Physical and Medical Status and Need of Incapacitated Person

The physical and medical status and needs of the Incapacitated Person are as follows:

_____

_____.

4. Mental and Emotional Status of Incapacitated Person

The mental and emotional status of the Incapacitated Person is as follows: _____

_____

_____.

5. Guardian Narrative: Although some changes may seem slight**,** please think back on this past year *(please describe below or attach additional sheets of paper)* and let the court know:

What are the functional abilities of the Incapacitated Person? _____

_____.

What can they do for themselves or what do they need help with? _____

_____.

Has this changed at all? Declined or improved? How so? _____

_____.

Have there been any changes to the Incapacitated Person's physical or emotional status? _____

_____.

What activities have you as guardian engaged the Incapacitated Person in?

_____

_____.

What have you been doing or do you plan to do to further the IP's access to education or training? _____

_____.

6. Guardian's Specific Plan for Meeting the Identified and Emerging Personal Care Needs of the Incapacitated Person

The Guardian's specific plan for meeting the identified and emerging personal care needs of the Incapacitated Person is as follows: _____

_____.

7. Contact Information for Facility or Home of Incapacitated Person, Guardian, Standby Guardian, and Other Professionals Assisting the Incapacitated Person

	Facility/Home Contact	**Guardian**	**Standby Guardian**
Full Name			
Mailing Address			
City, State, Zip			
*Telephone Number			
	Professional	**Professional**	**Professional**
Full Name			
Mailing Address			
City, State, Zip			
*Telephone Number			

8. **Fees:** Guardian and/or attorney fees for this report period from _____ through _____ are requested, **attach or submit a separate, itemized fee declaration** which describes the specific services rendered, the time required, the rate of compensation, and the out-of-pocket costs incurred:

a. Guardian Total Fees Requested for accounting period: $_____
b. Amount approved & paid for advance (including interim, $_____): $_____
c. Additional fees Requested: $_____
d. Balance due (if approved): $_____
e. Guardian fees approved for advance & unpaid = outstanding liability $_____
(ongoing liability from _____)

f. Administrative Costs $_____
(*Medicaid cases only; hearing & notice to be given per WAC 182-513 et seq.)*
Notice given to DSHS: ☐ Yes, (fees are over allowed amount) $_____
☐ No, (fees do not exceed allowed amount)

g. Attorney (court approval required & invoices) $_____
h. Accountant $_____

The Guardian also seeks authorization for monthly advance of fees during the next reporting period and up to **90 days** thereafter in the amount up to $_____ per month from the ☐ guardianship estate assets (*after basic needs and personal allowance*) OR ☐ as a monthly deduction from the participation in cost of care.

9. Other: _____

_____

_____.

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 No. [ ] 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.