STATE OF SOUTH CAROLINA COUNTY OF

IN THE MATTER OF:

PLAN OF CARE FOR PROTECTED PERSON

a protected person.

- 1. Where is the protected person living? Please provide the complete address.
- NO YES 2. Is this a private home? Is this a Comm. Residential Care Facility (CRCF) or a Community Training Home (CTH)? NO YES YES Is this an Assisted Living Facility? NO Is this a Nursing Home? NO YES Type of Facility: _____ NO Other type of facility? YES
- 3. What is the opinion of the protected person's physician regarding his or her ability to <u>recover</u> the capacity for independent decision-making?
- 4. What is the opinion of the protected person's physician regarding his or her ability to <u>develop</u> the capacity for independent decision-making?
- 5. If the physician for the protected person has indicated the ability to recover and/or develop the capacity of independent decision-making, what steps have you taken to identify any benefits or programs that could assist in helping the ward develop that capacity?

- 6. If the protected person is residing in an assisted living, nursing care facility, or other residential facility are there programs available at the facility that could assist the ward in developing that capacity?
- 7. What medical or other professional care or treatment, housing, education, therapy, social, or training needs do you foresee the protected person needing during the upcoming year?
- 8. Are there other needs the protected person has of which NO YES you are aware?(If yes, please describe.)
- 9. Describe the protected person's current abilities to make some decisions with support, training and/or education; to offer input into decisions about his or her life; and to develop the ability to exercise independent decision making.
- 10. Describe the specific steps you plan to take in the upcoming year to assist the protected person in recovering and/or developing the capacity to exercise independent decision making.

SWORN to before me thisday of	Print Name:	
Print Name: Notary Public for: My Commission Expires:	Telephone: Email: Relationship to the Protected Person:	
Executed thisday of		
SWORN to before me thisday of, 20	Co-Guardian's Signature: _ Print Name: _ Address: _	
Print Name: Notary Public for: My Commission Expires:	Telephone: Email: Relationship to the Protected Person:	
Executed thisday of	, 20	