**ANNUAL REVIEW OF PROTECTIVE PLACEMENT/SERVICES**

1. **DEMOGRAPHIC INFORMATION**

CLIENT NAME BIRTHDATE

CLIENT ADDRESS CLIENT PHONE

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CONTACT PERSON CONTACT PHONE

REVIEW PERIOD

1. **COURT INFORMATION**

NAME OF CIRCUIT COURT COURT FILE#

PRIMARY TARGET GROUP

Degenerative Brain Disorder Serious & Persistent Mental Illness

Developmentally Disabled (DD) Other Like Capacities:

**APPLICABLE COURT ORDERS COURT & DATE OF ORDER**

Full Guardianship – Person

Limited Guardianship – Person

Full Guardianship – Estate

Successor Guardianship

Change of Guardian

Protective Placement

Protective Services

Change of Venue

Chapter 51 Commitment

**III. GUARDIAN (S)**

GUARDIAN OF PERSON

NAME RELATIONSHIP TO WARD

ADDRESS DAY PHONE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EVENING PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GUARDIAN OF ESTATE

NAME RELATIONSHIP TO WARD

ADDRESS DAY PHONE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EVENING PHONE

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**IV. LIVING SITUATION**

TYPE OF LIVING ARRANGEMENT

Hospital (unlocked area) Hospital (locked area)

Nursing Home (unlocked area) Nursing Home (locked area)

Adult Family Home With Relatives

Independent Other:

CHANGES DURING THE REVIEW PERIOD

**V. MEDICAL AND MENTAL CONDITION**

PRIMARY CARE PHYSICIAN

NAME TELEPHONE

ADDRESS DATE LAST SEEN

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DIAGNOSES

CLIENT’S HEALTH CONDITION DURING REVIEW PERIOD

CLIENT’S CURRENT PSYCHIATRIC/BEHAVIORAL TREATMENTS & MEDICATIONS

LEVEL OF SUPERVISION NEEDED

**VI. SOCIAL AND REHABILITATIVE CONDITION**

CLIENT’S CURRENT SOCIAL PROGRAMMING

CLIENT’S CURRENT REHABILITATIVE PROGRAMMING

CHANGES IN FUNCTIONING DURING REVIEW PERIOD

**VII. ASSESSMENT AND REFERRAL**

WAS THE CLIENT ASSESSED FOR ELIGIBILITY OR PARTICIPATION IN ANY PROGRAM PROVIDING LONG-TERM COMMUNITY SUPPORT SERVICES DURING THE REVIEW PERIOD?

No

Yes, (Describe assessment & results):

DOES THE CLIENT HAVE THE ABILITY TO LIVE IN A LESS RESTRICTIVE OR COMMUNITY SETTING?

Yes No, Explain reasons:

If yes, what services are available to support the individual?

Case Management Adult Day Care Personal Emergency Response System

Personal Care Adaptive Aids Community Based Residential Facility

Respite Care Vocational Services Home Modifications

Adult Family Home Supportive Home Care Specialized Medical Supplies

Skilled Nursing Services Other:

What is the estimated cost of these services?

**VIII. RECOMMENDATIONS**

DOES THE CLIENT CURRENTLY MEET THE STANDARDS FOR PROTECTIVE PLACEMENT UNDER CHAPTER 55, WISCONSIN STATUTES?

Yes

No, Explain reasons:

IS ANY CHANGE RECOMMENDED IN THE CLIENT’S CURRENT LIVING ARRANGEMENT?

Yes, please explain:

No

IS ANY CHANGE RECOMMENDED IN THE CURRENT PROTECTIVE SERVICES?

Yes, please explain:

No

IS CONTINUATION OF GUARDIANSHIP WITH THE SAME GUARDIAN RECOMMENDED?

Yes

No, please explain:

IS ANY CHANGE RECOMMENDED IN LEGAL RIGHTS AS UNDER CURRENT ORDER?

Yes, please explain:

No

**IX. COMMENTS**

FROM THE FACILITY:

*See attached*

FROM THE GUARDIAN: (Please refer to attached report from the Guardian.)

*See attached*

OTHER COMMENTS:

*See attached*

**X. SOURCE (S) OF INFORMATION**

REVIEW COMPLETED BY:

TITLE:

DATE: