

IN THE CIRCUIT COURT, SIXTH JUDICIAL CIRCUIT, FLORIDA

PROBATE DIVISION

IN RE: The Guardianship of

File No. 90-2908-GD004

Theresa Marie Schiavo

INITIAL GUARDIANSHIP PLAN

FILED

DECLARER
1990 SEP 20

Name of Ward: Theresa Marie Schiavo

Name of Guardian(s) and Address: Michael Schiavo

2630 Vina Del Mar Boulevard
St. Petersburg Beach, Florida 33706

I. RESIDENCE

Where does the ward live? same

Are special residential services needed such as GRTS (Geriatric Residential Treatment System), Boley Manor, Retardation Group Home, or state institution?

Currently reviewing need to place ward in an extended care facility.

If placement is being arranged in a supervised setting (Foster Home, Residential Treatment Center, etc) is the facility licensed by the State? _____

Is the anticipated placement the least restrictive setting possible for the ward? _____

II. FUNCTIONAL STATUS (IF APPLICABLE)

What specific limitations on functional capacity have been identified?

- a. Personal care Vegetative State
- b. Ambulation _____
- c. Sight, speech, or hearing problems _____
- d. Shopping _____
- e. Handling funds _____
- f. Administering medications _____
- g. Memory impairments _____

What rehabilitative services are planned to assist the ward to regain lost capacities? (If applicable)

- a. Physical/Occupational/Speech therapies Not useful at this time.
- b. Vocational rehabilitation _____
- c. Academic training _____
- d. Sheltered work programs/work evaluation _____
- e. Development service—HRS _____
- f. Others (be specific) _____

III. MEDICAL STATUS

- a. Unless done within the past 6 months, when is a physical examination planned? _____

Name of clinic or physician Dr. Baras/Bay Front Medical Center

Date of last examination, if known _____

b. Current diagnosis/prognosis Poor.

c. Recommended treatment _____

d. Does the ward require dental evaluation, eye examination, hearing evaluation? _____

IV. MENTAL HEALTH STATUS

a. Unless done within the past 6 months, is a mental health examination/psychiatric evaluation indicated? If so, when planned? Vegetative State.

Name of clinic or physician _____

Date of last examination if known _____

b. Current diagnosis/prognosis _____

c. Recommended treatment _____

d. Does the ward have symptoms of a mental illness such as agitation, depression, confusion, disorientation, delusions, hallucinations, alcohol/drug abuse etc.? _____

e. Is there a history of psychiatric hospitalization? If so, when and where? _____

f. List services available for the ward such as private or community mental health services, day treatment, etc., and indicate referrals made or anticipated. _____

V. SERVICES/SOCIAL SUPPORTS

a. Are other family and friends involved? _____

Who are these (name and address) _____

b. List any community services to which a referral would be appropriate. Please be specific. _____

VII.

a. What benefits might be available: Veterans benefits, pensions, Medicare/Medicaid, Supplemental Security Income (SSI), Optional State Supplemental OSS for boarding home, Life/Health, accident insurances, Social Security Disability, etc. Please be specific. Social Security and hopefully Medicaid.

b. Other _____

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Initial Guardianship Report has been furnished by U.S. Mail to the ward, the ward's attorney, if any, the ward's parents, if living and to other interested persons at the addresses designated below on the 5 day of Sept, 1990:

Michael Schiavo
2630 Vina Del Mar Boulevard
St. Petersburg Beach, Florida 33706

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