PROPOSED AMENDMENTS TO THE RULES OF SUPERINTENDENCE FOR THE COURTS OF OHIO

Comments Requested: The Supreme Court of Ohio will accept public comments until November 18, 2024, on the following proposed amendments to the Rules of Superintendence for the Courts of Ohio.

Comments on the proposed amendments should be submitted in writing to: Keely McWhorter, Legal Counsel, Supreme Court of Ohio, 65 South Front Street, 7th Floor, Columbus, Ohio 43215-3431, or RuleAmendments@sc.ohio.gov not later than November 18, 2024. Please include your full name and mailing address in any comments submitted by e-mail.

Key to Proposed Amendment:

1. Existing language appears in regular type. Example: text

2. Existing language to be deleted appears in strikethrough. Example: ~~text~~

3. New language to be added appears in underline. Example: <u>text</u>

1 **PROBATE COURT OF ____________________ COUNTY, OHIO**
2
3 **ESTATE OF ____, DECEASED**
4
5 **CASE NO. __________**
6
7 **NOTICE OF WILL LOCATION**
8
9 Applicant hereby notifies this court and the public that the original, executed wills in the possession of
10 attorney _______________________, Supreme Court of Ohio Registration Number _________________,
11 are located as follows:
12
13 ☐ With Ohio-licensed attorney _______________________, Supreme Court of Ohio Registration Number
14 ________________ (contact information available through Supreme Court of Ohio Attorney Registration
15 Database);
16
17 ☐ With the Supreme Court of Ohio Office of Disciplinary Counsel;
18
19 ☐ With the law firm ____________________________________ located at ________________________
20
21 ____;
22
23 ☐ With the Probate Court of _____________________________________ County, Ohio;
24
25 ☐ Have been destroyed.
26
27 For wills that have not been destroyed. Applicant has prepared an alphabetical listing of all testators covered
28 by this notice. That list and this notice shall be filed with the Office of Disciplinary Counsel. That office will
29 keep a record of all notices received and post the attorney's name and the location of that attorney's wills,
30 as indicated above, on its website (www.odc.ohio.gov). Applicant requests that this notice document be
31 made a public record in this court under the deceased attorney's estate or under a miscellaneous case
32 number for an attorney who is deceased (if no estate has been filed). retired, disabled. disappeared,
33 disciplined. or deported per Gov.Bar R. V/26).
34
35
36 ____
37 Applicant Signature Typed or Printed Name
38
39
40 ____
41 Address
42
43
44 ____ (______)__________________________
45 Email Address Phone Number
46
47 ☐ Check here if Applicant wishes name and contact information redacted.
48
49 By applying his/her signature above. Applicant certifies that this notice and the alphabetical listing of all
50 testators covered by this notice was provided to the Office of Disciplinary Counsel at 65 East State Street.
51 Suite 1510, Columbus, Ohio 43215. (614) 397-0700, fax (614) 387-9709, www.odc.ohio.gov on the______
52 day of _____________________________, 20__.

PROBATE COURT OF ________________ COUNTY, OHIO

________________, JUDGE

IN THE MATTER OF THE GUARDIANSHIP OF ____________________________________

CASE NO. ______________________

STATEMENT OF EXPERT EVALUATION

[Sup.R. 66 & R.C. 2111.49]

Definition of Incompetent (R.C. 2111.01(D)): "Incompetent" means any person who is so mentally impaired, as a result of a mental or physical illness or disability, ~~or~~ as a result of intellectual disability, or as a result of chronic substance abuse, that the person is incapable of taking proper care of the person's self or property or fails to provide for the person's family or other persons for whom the person is charged by law to provide, or any person confined to a correctional institution within this State. The examiner shall complete this statement using personal observations and prior history obtained during the examiners course of treatment / interaction with the proposed Ward.

The Statement of Evaluation does not declare the individual competent or incompetent ~~but~~. It is evidence to be considered by the Court. The ~~fee for completing this evaluation~~ Probate Court **WILL NOT** ~~be paid by the Probate Court~~ pay the fee for completing this evaluation. ~~Each~~ The evaluator should secure payment from the Applicant~~/~~ or Guardian.

1. This Statement of Expert Evaluation is to be filed with or attached to:

☐ A. Guardianship Application: ~~Completed~~ [Evaluation must be completed before the filing of an attached to the application.]

Evaluation completed by: ☐ Licensed Physician ~~or~~ ☐ Licensed Clinical Psychologist ~~prior to the filing and attached to the application.~~

A physician's assistant or nurse practitioner is NOT ACCEPTABLE for an initial application. Sup.R. 66(A)

☐ B. Application for Emergency Guardianship:

Evaluation completed by: ☐ Licensed Physician ☐ Licensed Clinical Psychologist

[NOTE: If this Statement relates to an emergency guardianship of the person, a Licensed Physician or a Licensed Clinical Psychologist must complete the Supplement for Emergency Guardian, Form 17.1A, specifying the details of the emergency, and why immediate action is required to prevent significant injury or death to the person. The Supplement must be signed by a Licensed Physician or a Licensed Clinical Psychologist, dated, and attached to this completed Statement.]

☐ C. Guardian's Report: ~~Completed~~ [Evaluation must be completed within three months before the date of this Report. R.C. 2111.49]

Evaluation completed by: ☐ Licensed Physician ☐ Licensed Clinical Psychologist
☐ Licensed Independent Social Worker ☐ Licensed Professional Clinical Counselor ~~or~~
☐ ~~Intellectual~~ Developmental Disability Team~~.~~ ☐ Certified Nurse Practitioner ☐ Physician's Assistant
~~The evaluation or examination shall be completed within three months prior to the date of the Report. R.C. 2111.49~~

~~☐ C. Application for Emergency Guardian: ☐ of the person: a Licensed Physician shall complete the Supplement for Emergency Guardian, form 17.1A with specificity indicating the emergency, and why immediate action is required to prevent significant injury to the person. The Supplement shall be signed, dated, and attached as part of this completed Statement.~~

2. Statement completed by: (Please print clearly)
   Name & Title/Profession: ______________________________
   Business Address: ______________________________
   Business Telephone Number: ______________________________
3. Date(s) of evaluation: ______________________________

CASE NO. ___________

Place(s) of evaluation: ____________________
Amount of time spent on evaluation: ____________________
Length of time the ~~individual~~ proposed Ward has been your patient: ____________________
Proposed Ward's language preference: ____________________

4. Is the ~~individual~~ proposed Ward presently ~~under~~ taking medication? ☐ Yes ☐ No If yes, what is the medication, dosage, and purpose? [Continue on page 4]

____

____

Are there any signs of physical and/or mental impairments caused by the medications themselves?

____

____

5. Is the ~~individual~~ proposed Ward mentally impaired? ☐ Yes ☐ No If yes, indicate the diagnosis below:
☐ Intellectual ~~Disability/~~ or Developmental Disabilities: *(Please check the severity)*
☐ Profound ☐ Severe ☐ Moderate ☐ Mild
☐ Mental Illness: Type and Severity ____________________

____

☐ Substance Abuse: Description ____________________

____

☐ Dementia: ~~Description~~ Type and Severity ____________________

____

☐ Other: Description, Type, and Severity ____________________

____

~~Please provide additional comments and test scores if available.~~ ~~(~~[Continue comments on page 4~~)~~]: ___

____

6. During the examination did you notice an impairment of the individual's:

a) Orientation	☐ Yes	☐ No	☐ Unknown
b) Speech	☐ Yes	☐ No	☐ Unknown
c) Motor Behavior	☐ Yes	☐ No	☐ Unknown
d) Thought Process	☐ Yes	☐ No	☐ Unknown
e) Affect	☐ Yes	☐ No	☐ Unknown
f) Memory	☐ Yes	☐ No	☐ Unknown
g) Concentration ~~and comprehension~~	☐ Yes	☐ No	☐ Unknown
h) Comprehension	☐ Yes	☐ No	☐ Unknown
~~h)~~ i) Judgment	☐ Yes	☐ No	☐ Unknown

7. Please describe any impairments identified in question six. ~~(~~[Continue comments on page 4~~)~~].

____

8. Is the ~~individual~~ proposed Ward physically impaired? I.e. visual, mobility, hearing, etc. ☐ Yes ☐ No If yes~~:~~ ~~Description~~, please describe: ____________________

____

9. Are there any special characteristics of the ~~individual~~ proposed Ward which should be considered in evaluating the ~~individual~~ proposed Ward for guardianship: ☐ Yes ☐ No If yes~~: Explain~~, please explain: ____________________

____

10. Are there any indication of abuse, neglect, or exploitation of the ~~individual~~ proposed Ward? ☐ Yes ☐ No If yes~~:~~ ~~Explain~~, please explain: ____________________

____

11. Do you believe the ~~individual~~ proposed Ward is capable of caring for ~~the individual's~~ his or her activities of daily living or making decisions concerning his or her own medical treatments, living arrangements, and diet?
☐ Yes ☐ No If no~~: Explain~~, please explain: ____________________

____

CASE NO. ___________

111 12 Do you believe ~~this individual~~ the proposed Ward is capable of managing ~~the individual's~~ his or her finances and
112 property? ☐ Yes ☐ No If no~~: Explain~~, please explain: ______________________________
113 ______________________________
114
115 13. What is the recommended level of are for the proposed Ward?
116 ☐ Independent living arrangement ☐ Assisted living facility or group home
117 ☐ A nursing home ☐ A memory care facility or lockdown unit
118 ☐ Other: ______________________________
119
120 14. Prognosis of the proposed Ward:
121 A. Is the condition stabilized? ☐ Yes ☐ No ☐ Unknown
122 B. Is the condition reversible: ☐ Yes ☐ No ☐ Unknown
123
124 ~~14.~~15. In my opinion a guardianship should be:
125 If this is a new application for appointment of guardian: ☐ Established~~/Continued~~ ☐ Denied
126 If this is an existing guardianship: ☐ Continued ☐ ~~Denied/~~Terminated
127
128 I certify that I have evaluated the individual on ______________________________, 20 ______.
129
130 Date: ______________________________ ______________________________
131 Signature of Evaluator
132
133 ______________________________
134 Printed Name of Evaluator
135
136

137 **GUARDIAN'S REPORT ADDENDUM**
138 (Not to be used with initial Application)
139
140 It is my opinion, based upon a reasonable degree of medical or psychological certainty that the mental capacity of
141 this ward will not improve.
142
143 Date ______________________________ ______________________________
144 Signature – Licensed Physician/Clinical Psychologist
145
146 ______________________________
147 Printed Name of Licensed Physician/Clinical Psychologist

148

CASE NO. __________

149 # ADDITIONAL COMMENTS
150
151 ____
152 ____
153 ____
154 ____
155 ____
156 ____
157 ____
158 ____
159 ____
160 ____
161 ____
162 ____
163 ____
164 ____
165 ____
166 ____
167 ____

168 Date ________________________________ ____
169 Signature ~~– Licensed Physician/Clinical Psychologist~~ of
170 Evaluator

1 **PROBATE COURT OF ______________COUNTY, OHIO**
2 **_________________, JUDGE**
3
4 **GUARDIANSHIP OF:____**
5
6 **CASE NO: ________________**
7
8 # COURT INVESTIGATOR'S REPORT ON PROPOSED GUARDIANSHIP
9 **[R.C. 2111.041]**
10
11 ## GENERAL INFORMATION
12 [To be compiled by Probate Court Investigator]
13
14 Individual's age___________________ Relationship to applicant__________________
15
16 Individual's residence____
17
18 Individual's highest level of education________________ Individual's marital status__________
19
20 Individual's residence____
21
22 Grounds for application (R.C.2111.01 (D)):
23
24 The individual is alleged to be:
25
26 ☐ mentally impaired as a result of a mental illness or disability.
27
28 ☐ mentally impaired as a result of a physical illness or disability.
29
30 ☐ mentally impaired as a result of intellectual disability.
31
32 ☐ mentally impaired as a result of chronic substance abuse.
33
34 ☐ any person confined to a correctional institution within this state.
35
36 so that
37
38 ☐ the individual is incapable of taking proper care of the individual's self.
39
40 ☐ the individual is incapable of taking proper care of the individual's property.
41
42 ☐ the individual fails to provide for the individual's family or other individual for whom the
43 person is charged by law to provide.
44
45 Documentation submitted and date of evaluation_________________________________
46
47 Referral Source: ____
48

Amended: May 1, 2021
Discard all previous versions of this form

CASE NO. __________

INVESTIGATOR'S REPORT

I. Service of Notice

☐ Made at Individual's home

☐ Made in Hospital, Nursing Facility, or Community-Based Care Facility:

Name of Facility____

Address of Facility____

Administrator or representative served____

☐ Other____

Date of Service of Notice:________________

Others present during the contact (if yes, list name and relationship) _______________________

____

A. Individual's understanding of the concept of guardianship:

☐ Good ☐ Fair ☐ Poor ☐ Unable to determine. ~~Explain:~~

Explain ____

____.

B. Individual's attitude to the concept of guardianship:

☐ Consenting ☐ Opposed ☐ Unable to Determine. ~~Explain:~~

Explain ____

____.

C. Specific requests of the individual concerning enumerated rights: _________________

____.

II. Mental and Physical Conditions of Individual

A. Individual's reported mental and physical diagnosis: ____________________________

____.

CASE NO. __________

Individual's reported medications: ____

____.

Reported by whom: ____

B. Mental Status Observations: During interview were impairments noted in the Individual's:

	Yes	No	Unable to Determine
1. Orientation (Person, Place and Time)	☐	☐	☐
2. Speech	☐	☐	☐
3. Thought Process	☐	☐	☐
4. Affect	☐	☐	☐
5. Memory	☐	☐	☐
6. Concentration & Comprehension	☐	☐	☐
7. Judgment	☐	☐	☐

Explain further if necessary:____

____.

C. Describe the Physical Condition of Individual

1. Isolation____

2. Eating Habits____

3. Significant Weight Loss or Gain_______________________________________

4. Sleep Habits____

5. ~~Motor Behavior~~ Mobility / any issues ___________________________________

Explain further if necessary:____

____

D. Describe the Environmental or Living Condition of the Individual:

CASE NO. __________

142 1. Housing & Sanitation____
143
144 2. Risk of Accidents____
145
146 3. Physical Barriers____
147
148 4. Resource Availability____
149
150 Explain further if necessary:_____________________________________
151
152 ____.
153
154
155 **III. Functional Capacities**
156
157 **Activities and Instrumental Activities of Daily Living**
158

	Capable	Incapable	Unable to Determine
1. Eating	☐	☐	☐
2. Dressing	☐	☐	☐
3. Transfer from bed	☐	☐	☐
4. Toileting	☐	☐	☐
5. Bathing	☐	☐	☐
6. Handling personal finances	☐	☐	☐
7. Shopping	☐	☐	☐
8. Driving	☐	☐	☐
9. Meal preparation	☐	☐	☐
10. Doing housework	☐	☐	☐
11. Using telephone	☐	☐	☐
12. Taking medications	☐	☐	☐

185
186 Explain further if necessary:
187 ____

CASE NO. __________

188
189 ____.
190
191

192 IV. Additional Items Affecting Guardianship Plan Development

193
194 A. Are there any indications or allegations of substance abuse by the individual or
195 significant others that could impact the guardianship issue? Yes ☐ No ☐ Explain and
196 recommend actions needed:
197 ____
198
199 ____
200
201 ____.
202
203 B. Are there any special characteristics of the individual (including aggressive, violent,
204 or sexual behaviors, or other vulnerabilities) that pose a risk to self or others, which should
205 be considered as guardianship decisions on living arrangements and supervision are
206 made? Yes ☐ No ☐ Explain the characteristics and make recommendations:
207
208 ____
209
210 ____
211
212 ____.
213
214
215 C. Are there any allegations or indications of abuse, neglect, or exploitation of the
216 individual? Yes ☐ No ☐ Explain and recommend needed actions:
217 ____
218
219 ____
220
221 ____.
222
223 D. Is there a need for additional medical, psychiatric, or psychological testing?
224 Yes ☐ No ☐ If yes, give specific recommendations:
225
226 ____
227
228 ____
229
230 ____.
231
232 E. Are there inconsistencies between the Expert Evaluation and the Court
233 Investigator's findings that need further review by the Court? Yes ☐ No ☐ If yes,
234 identify the inconsistencies and make a recommendation(s) to the Court:
235
236 ____
237

CASE NO. __________

238 ____
239
240 ____.
241
242 F. Are there unresolved issues/conflicts/ differences among the parties? Yes ☐ No ☐
243 If yes, would mediation be of assistance? Yes ☐ No ☐ ~~Explain:~~
244 Explain ____
245
246 ____.
247
248 G. Is there a power of attorney for financial affairs? Yes ☐ No ☐ Unknown ☐ If
249 yes, where is it located? ____.
250
251 Who is the attorney-in-fact?____.
252
253 H. Is there a last will and testament? Yes ☐ No ☐ Unknown ☐
254 If yes, where is it located? ____.
255
256 I. Is there a durable power of attorney for health care/living will? Yes ☐ No ☐
257 Unknown ☐ If yes, where is it located? _________________________________.
258
259 Give name and address of attorney-in-fact:_______________________________.
260
261 J. Is there an advance directive for mental health care? Yes ☐ No ☐ Unknown ☐ If
262 yes, where is it located? ____.
263
264 Give name and address of attorney-in-fact:_______________________________.
265
266 K. Is the individual a veteran? Yes ☐ No ☐
267
268 L. Does the individual have regular visitors? Yes ☐ No ☐
269
270 Source of the Information:____.
271
272 M. If yes, who:____.
273
274 Relationship of visitor(s) to individual:___________________________________.
275
276 N. Did the individual express a desire to have visitors? Yes ☐ No ☐
277
278 If yes, who?____.
279
280 If no, why not?____.
281
282
283

CASE NO. __________

284 **V. RECOMMENDATIONS: Given the above information and Expert**
285 **Evaluation(s):**
286
287 **A. IS A GUARDIANSHIP NECESSARY?**
288 ☐ Yes
289 ☐ Person Only
290 ☐ Estate Only
291 ☐ Person and Estate
292 ☐ Limited List Duties____
293
294 ____
295
296 ____
297
298
299 ☐ No Explain and recommend a less restrictive ~~alternative~~ alternative(s):____________
300
301 ____
302
303 ____
304
305 ~~Are any of the mental, physical, or environmental conditions reversible? Yes ☐ No ☐~~
306 ~~Unknown ☐~~
307
308 ~~If yes, explain and recommend a date for the Court to review the guardianship.~~ _______
309
310 ____
311
312 **B. NECESSITY FOR THE APPOINTMENT OF:**
313
314 Attorney ☐ Independent Expert Evaluator ~~☐~~
315
316 Are there special urgency needs? Explain:________________________________
317
318 ____
319
320 ____
321
322 **C. VISITATION RECOMMENDATION:**
323
324 ____
325
326 ____
327
328 ____
329
330 ____
331
332 ____

CASE NO. __________

333 Remarks:
334 ____
335
336 ____
337
338 ____
339
340 ____
341
342 ____
343
344 ____
345
346 I certify that I have served notice to the alleged incompetent as required by statute and I
347 have communicated to the individual in a language and method best understandable by
348 the individual the individual's right to be present at the hearing, the right to contest any
349 application for the appointment of a guardian for his or her person, estate, or both, and
350 the right to be represented by counsel.
351
352
353
354
355 ________________________ ________________________________
356 Date Investigator

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53

PROBATE COURT OF ____________ COUNTY, OHIO

____________, JUDGE

GUARDIANSHIP OF ______________________________

CASE NO. __________

GUARDIAN APPLICANT QUESTIONNAIRE

Name: ______________________________ D.O.B: ____________________

Address: ____

Phone: ________________ Occupation/Employment: ________________________

Alt. Phone: ______________ Highest Education: __________________________

1. What is your relationship to the proposed ward? ______________________

2. Are you a service provider to the proposed ward? ☐ Yes ☐ No
   If yes, explain: ____

3. Are you any of the following? ☐ 1st time Guardian ☐ Professional Guardian ☐ Other ☐ Public Guardian ☐ Financial Institution

4. **GUARDIAN APPLICANT HISTORY:**

Number of Guardianship Cases: __________ previous: __________

Current: [Please check all that apply to you]

☐ Removed as a Guardian ☐ Driver's license revoked ☐ Surcharge imposed

☐ Served/serves as Representative Payee ☐ Bonded/Insured ☐ Criminal history

☐ Bankruptcy against you ☐ Poor credit history ☐ Protective Orders

☐ Adult Protective Services complaints against you. If checked, explain: ____________

____

5. Are you financially dependent or emotionally dependent on the proposed ward? ☐ Yes ☐ No
   If yes, explain: ____

   ____

54 a. Do you receive money, from any source, for your involvement or care of the proposed ward?
55 ☐ Yes ☐ No If yes, please list source(s) below.
56
57 ____
58
59 ____
60
61 6. How long have you known the proposed ward? ______________________________________
62
63 7. Did anyone recommend a guardianship application be filed? ☐Yes ☐ No
64
65 If yes, who recommended and why? ____
66
67 ____
68
69 8. What do you believe are the behaviors that make the appointment of a guardian necessary?
70
71 ____
72
73 ____
74
75 9. What solutions to these problems have been tried before filing for guardianship?
76
77 ____
78
79 ____
80
81 10. Why do you want to become guardian of the proposed ward?
82
83 ____
84
85 ____
86
87 11. Are you in sufficiently good health, mentally and physically, and with sufficient energy to meet
88 guardianship duties? ☐Yes ☐ No If no, please explain below:
89
90 ____
91
92 12. Do you know of anyone else who would also be interested in becoming the guardian or will be
93 helping you fulfill guardianship responsibilities? ☐Yes ☐ No
94
95 Explain: ____
96
97 ____
98
99 13. In general, what is your plan for overseeing the care of the proposed ward?
100
101 ____
102
103 ____
104
105
106
107

108 a. Do you have sufficient time to fulfill guardianship duties? ☐Yes ☐ No
109
110 Explain:____
111
112 ____
113
114 b. Are you familiar with the proposed ward's medical problems and medications? ☐Yes ☐ No
115
116 ____
117
118 ____
119
120 c. List the names of any community service providers and the nature of the services they provide
121 (APS, VA, Senior Services, Local DD Board)____
122
123 ____
124
125 d. Where will the proposed ward live? ____
126
127 ____
128
129 e. Is this an adequate setting? ☐Yes ☐ No
130
131 f. Does this setting meet the needs of the proposed ward? ☐Yes ☐ No
132
133 g. What is the distance from your residence? ______________________________________
134
135 h. How often do you plan to visit, and how will you oversee these living arrangements?
136
137 ____
138
139 ____
140
141 i. Have social activities, recreation, and entertainment been considered? Please explain:
142
143 ____
144
145 ____
146
147 k. If the proposed ward will be living with you, what arrangements will you make or have made to
148 care for the proposed ward? ____
149
150 ____
151
152 ____
153
154
155
156
157
158
159
160
161

162 14. **MENTAL STATUS OBSERVATION CHECKLIST:** Record your observational impressions of the
163 proposed ward on a scale of 1 for significant impairment to 5 for average/normal functioning. Comments
164 are encouraged.
165

	Rating	**Comment**
167 a. Orientation (Person, Place, and Time)	______________	____________________
169 b. Speech	______________	____________________
171 c. Motor Behavior	______________	____________________
173 d. Thought Process	______________	____________________
175 e. Affect (mood and emotions)	______________	____________________
177 f. Memory	______________	____________________
179 g. Concentration and Comprehension	______________	____________________
181 h. Judgement	______________	____________________

166
168
170
172
174
176
178
180
182
183 15. **FUNCTIONAL LIMITATIONS:**
184
185 Cognitive concerns:____
186
187 ☐ Behavioral Disturbance ☐ Confusion ☐ Concentration ☐ Memory ☐ Unknown
188
189 Mental health concerns:____
190
191 ☐ Anxiety ☐ Delusions ☐ Depression ☐ Hallucinations
192
193 ☐ Hoarding ☐ Impulsive behavior ☐ Substance abuse ☐ Unknown
194
195 Physical concerns:____
196
197 ☐ Frequent falls ☐ Hearing ☐ Mobility ☐ Pain
198
199 ☐ Physical frailty ☐ Verbal Communication ☐ Vision ☐ Unknown
200
201 16. Is the proposed ward aware of the plans for guardianship as outlined in the above information?
202 ☐Yes ☐ No
203
204 If yes, is the proposed ward in agreement with the plans for guardianship as outlined in the above
205 information? Explain below. ____
206
207 ____
208
209 17. Do you currently have a power of attorney for the proposed ward? ☐Yes ☐ No
210
211 If yes, describe:____
212
213 If no, who does and what is their relationship to the proposed ward?__________________________
214
215

216 18. Do you now or have you ever assisted the proposed ward with his or her finances? ☐Yes ☐ No
217
218 Please explain: ____________________
219
220 19. Is the proposed ward a veteran? ☐Yes ☐ No
221
222 20. Have you completed the *Service of Notice Information for Adult Guardianship* (SPF 17.10)?
223
224 ☐Yes ☐ No ***Hearing may not be scheduled until it is filed.***
225
226 **Remarks:**
227
228 ____________________
229
230 ____________________
231
232 ____________________
233
234 ____________________
235
236 ____________________
237
238 ____________________ ____________________
239 Date Signature of person completing the form
240
241 ____________________ ____________________
242 Title Printed Name
243
244
245 ____________________
246 Email Address

1 **PROBATE COURT OF ____________________ COUNTY, OHIO**
2
3 **__________________, JUDGE**
4
5 **GUARDIANSHIP OF ____**
6
7 **CASE NO. ____________**
8
9 **SERVICE OF NOTICE INFORMATION**
10 **FOR ADULT GUARDIANSHIPS**
11 **[R.C. 2111.04]**
12
13 **You are asking to be appointed guardian for an adult. Ohio law requires that the prospective**
14 **ward be visited and personally served notice of the application by a Probate Court Investigator.**
15 **The below information is required in order to assist the Court Investigator in this process.**
16
17 *Please provide the requested information with your application. Do not answer "Unknown."*
18
19 1. At the time of the filing of the Application for Guardianship, the proposed ward is physically at:
20 ☐ Home ☐ Facility ☐ Other
21
22 Address:____
23
24 ____
25
26 2. Does the proposed ward leave the above location on a regular basis (day care, etc.) during the day?
27 ☐ Yes ☐ No
28
29 If yes, explain:____
30
31 ____
32
33 3. Other community or government services offered to proposed ward:________________________
34
35 ____
36
37 4. Please provide a name and phone number of a person who can be contacted by the Court
38 Investigator so that the Court Investigator may arrange a visit with the proposed ward (case manager,
39 social worker, nurse, parent, applicant, or attorney)
40
41 a. Contact person's name: ____
42
43 b. Contact person's relation to proposed ward: ________________________________
44
45 c. Telephone number:____
46
47 d. Best time for Court Investigator to contact:________________________________
48
49 5. Has the proposed ward been told of the pending action? ☐ Yes ☐ No
50
51 6. To ensure safety, should the Court Investigator be accompanied by someone or require assistance?
52 ☐ Yes ☐ No

53 If yes, explain:____
54
55 ____
56
57
58 Date:______________________ ______________________________
59 Applicant's Signature
60
61 **CAUTION: The hearing may not be held unless this visit is completed at least 7 days prior to**
62 **the hearing date.** If there is any change in the location of the proposed ward from the time the
63 application is filed to the hearing date, please contact______________________ at
64 ______________________.

1 **PROBATE COURT OF ______________________ COUNTY, OHIO**
2 **_______________________, JUDGE**
3
4 **ADOPTION OF ____**
5 **(Name after adoption)**
6 **CASE NO. ________________**
7

8 # NOTICE OF HEARING ON PETITION FOR ADOPTION

9 Notice must be served not less than 20 days before the date of the hearing
10 [R.C. 3107.11]
11

12 To: ____
13 (Give Names and Addresses)
14

15 You are hereby notified that on the _________ day of ________________, 20___, ___________________
16 _______________________, filed in this Court a Petition for Adoption of __________________________,
17 a minor, whose date of birth is ______________________, and for change of the name of the minor
18 to_______________________. This Court, located at ____
19 ______________________________ will hear the petition on the _________ day of _________________,
20 20____, at __________ o'clock _____.M.
21

22 It is alleged in the petition, pursuant to R.C. 3107.07, that the consent of ___________________________
23 is not required due to the following: (Name)
24

25 ☐ That person is a parent who has failed without justifiable cause to provide more than de minimis contact with the
26 minor for a period of at least one year immediately preceding the filing of the adoption petition or the placement of the
27 minor in the home of the petitioner.
28

29 ☐ That person is a parent who has failed without justifiable cause to provide for the maintenance and support of the
30 minor as required by law or judicial decree for a period of at least one year immediately preceding the filing of the
31 adoption petition or the placement of the minor in the home of the petitioner.
32

33 ☐ State other grounds under R.C. 3107.07 (includes putative father of the minor born prior to January 1, 1997).
34 ____
35

36 **"A FINAL DECREE OF ADOPTION, IF GRANTED, WILL RELIEVE YOU OF ALL PARENTAL RIGHTS**
37 **AND RESPONSIBILITIES, INCLUDING THE RIGHT TO CONTACT THE MINOR, AND, EXCEPT WITH**
38 **RESPECT TO A SPOUSE OF THE ADOPTION PETITIONER AND RELATIVES OF THAT SPOUSE,**
39 **TERMINATE ALL LEGAL RELATIONSHIPS BETWEEN THE MINOR AND YOU AND THE MINOR'S**
40 **OTHER RELATIVES, SO THAT THE MINOR THEREAFTER IS A STRANGER TO YOU AND THE**
41 **MINOR'S FORMER RELATIVES FOR ALL PURPOSES, WITH THE EXCEPTION OF DIVISIOIN**
42 **(A)(1)(b) OF SECTION 3107.15 OF THE REVISED CODE. IF YOU WISH TO CONTEST THE**
43 **ADOPTION, YOU MUST FILE AN OBJECTION TO THE PETITION WITHIN FOURTEEN DAYS AFTER**
44 **PROOF OF SERVICE OF NOTICE OF THE FILING OF THE PETITION AND OF THE TIME AND**
45 **PLACE OF HEARING IS GIVEN TO YOU. IF YOU WISH TO CONTEST THE ADOPTION, YOU MUST**
46 **ALSO APPEAR AT THE HEARING. A FINAL DECREE OF ADOPTION MAY BE ENTERED IF YOU**
47 **FAIL TO FILE AN OBJECTION TO THE ADOPTION PETITION OR APPEAR AT THE HEARING."**
48

49 **RIGHT TO AN ATTORNEY:**
50 You have the right to be represented by an attorney of your choice. If you are unable to afford an attorney, you must request an attorney when you
51 receive this Notice and complete an affidavit of indigency form at the Court to determine if you qualify for an appointed counsel. You may contact
52 the Court at ________________.
53 ___________________________________,**Probate Judge**
54
55
56 By:____
57 Deputy Clerk

CASE NO. ____________

58 The State of Ohio, ____________________________Probate Court
59
60 I hereby certify that I caused a copy of the within notice to be mailed, by certified mail, to the last
61 known address of
62 ____
63
64 At ____
65
66 ____
67
68 At ____
69
70 ____
71
72 ____________________________,Probate Judge
73
74 By: _____________________________________
75 Deputy Clerk
76
77 **RETURN**
78
79 ____________________________, County, Ohio
80
81 _______________________________, 20_____
82
83 Received this writ on the ______ day of ______________________, 20___, at _________o'clock
84 __. M., and on the ________ day of _______________________, 20___, I served the same by delivering a
85 true copy thereof personally to ____
86 ____
87
88 _______________________________
89 FEES Sheriff
90
91 _______________________________
92 Service and return, 1st name, $ _________ Deputy Sheriff
93
94 ____ Additional names, at $ _________
95
96
97 _______________________________
98 ____ Miles traveled, at $ _________ Name
99
100 _______________________ _________
101 _______________________________
102 Title
103 Total $ _________
104 ___________________________________

~~Eff. Date: January 1, 2010~~
Amended: ____________
Discard all previous versions of this form

PROBATE COURT OF________________ COUNTY, OHIO

_________________, JUDGE

DISINTERMENT OF______________________________________, DECEASED

CASE NO. _______________________

APPLICATION FOR ORDER TO DISINTER REMAINS

[R.C. 517.24 ~~and~~, 517.25, 2108.70 et seq.]

The Applicant states that this Application is made to disinter the remains of the above-named Decedent by Court Order. The Decedent's remains are currently located in _________________ cemetery, _______________________ County.

Applicant further states that the following information is true:

1. Applicant is an interested person of sound mind who is at least eighteen years old.

2. Applicant ☐ did or ☐ did not assume/have financial responsibility for the funeral and burial expenses of the decedent.

3. Applicant's relationship to Decedent is _________________________________.

4. The remains will be reinterred at _______________________________________

   ____.
   (Name and Address)

5. Attached is Form 1.0 listing all persons who would have been entitled to inherit from the Decedent under R.C. Chapter 2105, and if the Decedent had a Will, all legatees and devisees named in that Will, and if applicable, the person who has been assigned the rights of disposition for the deceased person under R.C. 2108.70 to 2108.90.

6. Notice of this Application and Hearing on the Application shall be given by certified mail return receipt requested to Decedent's surviving spouse, to all persons entitled to inherit if Decedent died without a Will, to all legatees and devisees named in Decedent's Will, and to the cemetery in which the Decedent's remains are interred in accordance with R.C. Section 517.24 unless waived. If notice is not given to any person specified above, Applicant shall file an affidavit specifying which persons were not given notice and the reason for not giving notice to those persons (see R.C. 517.24(B)(2)(d)).

7. Attached to this application are any written waivers waiving the right to receive the notice stated above.

CASE NO.______________

52 8. Applicant states that the disinterment is not against Decedent's religious beliefs.
53
54 9. Decedent's cause of death was ____.
55
56 10. The Decedent did not die of a contagious or infectious disease, or if so, a permit
57 has been issued by the appropriate Board of Health, attached.
58
59 11. To the best of Applicant's knowledge, the Decedent
60
61 ☐ ~~had ☐ had~~ Had not executed a written Declaration of Assignment of Right of
62 Disposition pursuant to R.C. 2108.70 *et seq*.
63
64 ☐ Had executed a written Declaration of Assignment of Right of Disposition
65 pursuant to R.C. 2108.70 et seq. and a true and correct copy is attached.
66
67 ☐ The written Declaration of Assignment of Right of Disposition is not available to
68 Applicant.
69
70 ___________________________________ ___________________________________
71 Attorney for Applicant Applicant
72
73 ___________________________________ ___________________________________
74 Typed or Printed Name Typed or Printed Name
75
76 ___________________________________ ___________________________________
77 Address Address
78
79 ___________________________________ ___________________________________
80
81
82 ___________________________________ ___________________________________
83 Telephone Number (include area code) Telephone Number (include area code)
84
85
86 ___________________________________ ___________________________________
87 Email address Email address
88
89
90
91 Attorney Registration No.__________________
92
93 Sworn to and subscribed in my presence this __________ day of ______________________,_________
94
95
96 ___________________________________
97 Notary Public

PROBATE COURT OF ________________ COUNTY, OHIO

________________, JUDGE

DISINTERMENT OF____________________________________, DECEASED

CASE NO. ______________________

ORDER TO DISINTER REMAINS

An application for Order to Disinter Remains came on for hearing on the ________ day of__________________________, _________.

The Court finds that all interested parties, whose names and addresses are known, have been notified according to law or have waived notice of hearing on the application.

The Court further finds that the statements contained in the application are true and that no testimony was adduced to establish that disinterment would be against the decedent's religious beliefs.

The Court further finds that a permit ☐ has ☐ has not been issued pursuant to R.C. 517.23(B) by the Board of Health (or other authorized agency) and that if issued, has been filed herein.

It is the Order of this Court that:

(1) Applicant is hereby authorized to disinter the remains of the decedent from ____________________________________ Cemetery;

(2) Applicant is hereby authorized to reinter the remains of the decedent at ____________________________________ Cemetery;

(3) Unless the gravestone or marker is relocated to the site of reinterment, Applicant shall cause said gravestone or marker to remain at the site of original interment; ~~and~~

(4) Applicant shall file a Verification of Reinterment within thirty (30) days that the remains of the decedent have been reinterred;

(5) The board of township trustees, the trustees or board of the cemetery association, or the other officers having control and management of the municipal cemetery shall have a period of at least thirty (30) days from receipt of the order to perform the ordered disinterment.

____
Judge

CASE NO. __________

1 **PROBATE COURT OF ________________ COUNTY, OHIO**
2
3 **_____________, JUDGE**
4
5 **IN THE INTEREST OF: ____**
6
7 **CASE NO. __________**
8
9 # PETITION FOR INVOLUNTARY TREATMENT FOR
10 # ALCOHOL AND OTHER DRUG ABUSE
11 **[R.C. 5119.93]**
12
13 RESPONDENT:____
14
15 RESPONDENT'S Residence Address: ______________________________
16
17 RESPONDENT'S Current Location (if different): _______________________
18
19 PETITIONER: ____
20
21 PETITIONER'S Address: _____________________________________
22
23 PETITIONER'S Phone Number:_________________________________
24
25 PETITIONER'S E-mail Address:________________________________
26
27 States that he/she is:
28
29 ☐ Spouse; ☐ Relative ____________ ☐ Guardian of the above named Respondent
30
31 PETITIONER further states that the name, address, and residence of person related to the
32 Respondent are (if living and known)
33
34 Parents or guardian: ____
35 Name and complete address
36 Spouse: ____
37 Name and complete address
38
39 Person having custody of Respondent: ____________________________
40 Name and complete address
41 Nearest Relative: ____
42 Name and complete address
43 Friend: ____
44 Name and complete address
45
46 PETITIONER believes that Respondent is a person suffering from alcohol and/or other drug
47 abuse because: (state facts to support belief). If the Petitioner believes the Respondent is
48 suffering from opioid or opiate abuse, the Petitioner shall state whether the Respondent has

~~Effective Date: July 1, 2016~~
Amended: ____________
Discard all previous versions of this form

CASE NO. __________

49 overdosed and been revived by an opioid antagonist one or more times or whether the
50 Respondent has overdosed in a vehicle or in the presence of a minor. Please explain.
51 ____
52 ____
53 ____
54 ____
55 ____
56 ____
57
58 PETITIONER also believes that the Respondent presents an imminent danger or imminent
59 threat of danger to self, family, or others if not treated because: (state facts to support belief)
60 ____
61 ____
62 ____
63 ____
64 ____
65 ____
66
67 Check one:
68
69 ☐ Certificate of Physician is attached. Exam must be within two days prior to filing date of
70 Petition
71
72 OR
73
74 ☐ Respondent has refused all requests made by me, the Petitioner, to undergo a
75 physician's examination.
76
77 Petition is accompanied by: (check one or more)
78 ~~1.)~~ ☐ A security deposit in the amount of $_____________, representing one-half of the
79 estimated cost of treatment;
80
81 OR
82
83 ☐ Documentation establishing that the Petitioner or Respondent will be able to cover at
84 least one-half of the estimated cost of treatment;
85
86 OR
87

CASE NO. __________

88 ☐ Other evidence to the satisfaction of the Court establishing that the Petitioner or
89 Respondent will be able to cover some of the estimated cost of treatment.
90 ~~2.)~~
91
92 Petition shall also be accompanied by: (check one or more)
93
94 ☐ Guarantee of Payment form;
95
96 OR
97
98 ☐ Documentation establishing insurance coverage of Petitioner or Respondent will cover
99 the full cost of treatment;
100
101 OR
102
103 ☐ Documentation that Petitioner or Respondent will cover some of the estimated cost of
104 treatment.
105
106 The Petitioner represents that all of the above information is true and accurate.
107
108 ______________________________ ______________________________
109 Signature of Attorney Signature of Petitioner
110
111 ______________________________ ______________________________
112 Name of Attorney (Please Print) Name of Petitioner (Please Print)
113
114
115 ______________________________
116 Attorney Registration Number
117
118 Sworn before me and signed in my presence on _______of________________, 20_
119
120
121 ______________________________
122 Notary Public
123

124 **VERIFICATION OF TREATMENT BY PETITIONER**

125 *****A statement from Facility MUST accompany this petition*****

126
127 ______________________________, the petitioner, has arranged for the treatment of
128 Name of Petitioner
129
130 ______________________________ to be facilitated by:
131 Name of Respondent
132
133 ______________________________
134 Name of Treatment Provider
135
136 ______________________________
137 Full Address of Treatment Provider (Street, City, State, Zip Code)

CASE NO. __________

138 # GUARANTEE OF PAYMENT
139 **[R.C. 5119.93(D)(2)]**
140
141 Pursuant to R.C. 5119.93(D)(2), either the Petitioner or other authorized person (spouse,
142 relative or guardian) shall guarantee any and all costs and fees for examinations, hearing cost
143 and treatment for the Respondent for alcohol and other drug abuse as may be herein after
144 ordered by the Court. The GUARANTEE below shall be completed by either the Petitioner or
145 other authorized person.
146
147 By my signature below, I do hereby assume responsibility for and GUARANTEE PAYMENT
148 FOR ALL COSTS incurred on behalf of Respondent for all alcohol and other drug abuse
149 treatment, including, but not limited to, initial examination and transportation costs, as
150 hereinafter ordered by the Court.
151
152 ______________________________ ______________________
153 Signature Date
154
155 ______________________________
156 Name (Please Print)
157
158 ______________________________
159 Relationship to Respondent (Petitioner, Spouse, Relative or Guardian)
160
161 ____
162 Complete Billing Address
163
164
165
166 Sworn before me and signed in my presence on __________ of ________________, 20___
167
168
169 ____
170 Notary Public