

The forms are in bilingual format for your convenience, but must be completed and filed with the court in English.  
为了提供便利，表格用双语格式提供；但是，向法院提交的表格必须用英语填写。



CIRCUIT COURT FOR \_\_\_\_\_, MARYLAND  
巡回法院 \_\_\_\_\_, 马里兰州

City/County  
市/县

Located at \_\_\_\_\_ Telephone \_\_\_\_\_  
地址 \_\_\_\_\_ 电话 \_\_\_\_\_

Court Address  
法院地址

In the Matter of  
关于

Case No. \_\_\_\_\_  
案件编号 \_\_\_\_\_

Name of Disabled Person  
残疾人士姓名

Docket Reference  
案卷参考

## ANNUAL REPORT OF GUARDIAN OF DISABLED PERSON

### 残疾人士监护人年度报告

(Md. Rule 10-206(e))

(《马里兰州规则》第 10-206(e) 条)

**NOTE:** Guardians of the person of disabled persons must complete and file this form each year within 60 days of the anniversary of their appointment, or as the court otherwise directs. Attach additional sheets if needed.

**注意:** 财产监护人必须每年在获得任命的周年纪念日后 60 天内或依照法院的其他指示，填写并提交此表。如有必要请另附页。

If a section of this form does not apply, write “Not applicable” or “N/A.”

如果此表的某一部分不适用，请注明“不适用”或“N/A”。

Disabled person’s Date of Birth: \_\_\_\_\_

残疾人士出生日期: \_\_\_\_\_

Gender: \_\_\_\_\_

性别: \_\_\_\_\_

### REPORTING PERIOD

#### 报告期

I/We, \_\_\_\_\_ and (if applicable) \_\_\_\_\_,

Name of Guardian

Name of Guardian 2

我/我们, \_\_\_\_\_ 和(如适用) \_\_\_\_\_,

监护人姓名

监护人 2 姓名

make this annual report for the period of \_\_\_\_\_ to \_\_\_\_\_.

Date

Date

就 \_\_\_\_\_ 到 \_\_\_\_\_ 期间提交此年度报告。

日期

日期

### Part I. Information about the disabled person

#### 第 I 部分。残疾人士相关信息

##### A. RESIDENCE AND HOUSING

##### 居住地和住房

Disabled person’s address (where that person lives or is physically present):

残疾人士地址(此人居住或实际身处的地方):

Street Address  
街道地址

City, state, zip  
市、州、邮政编码

Select all that apply:  
请选择所有适用项:

- This is the disabled person's permanent residence.  
此为该残疾人士的永久居住地。
- This is not the disabled person's permanent residence. The disabled person's permanent residence is: \_\_\_\_\_ , \_\_\_\_\_ .  
Street Address City, state, zip  
此并非该残疾人士的永久居住地。该残疾人士的永久居住地位于:

\_\_\_\_\_ , \_\_\_\_\_ .  
街道地址 市、州、邮政编码

- This is a new address (check if the disabled person's address changed since the last annual report or since your appointment as guardian if this is your first report).  
此为新地址(请核实自上一次年度报告以来,或如果这是您的第一次报告,则自您被任命为监护人以来,该残疾人士的地址是否发生了变动)。

Explain why the address changed:  
请说明地址变动的原因:

Type of housing (select one):  
住房类型(请选择一项):

- Own home  Guardian 1's home  Guardian 2's home  
自己的住房 监护人 1 的住房 监护人 2 的住房

- Relative's home: \_\_\_\_\_  
亲戚的住房 \_\_\_\_\_

Name of relative  
亲戚姓名

Relationship to disabled person  
与该残疾人士的关系

- Hospital or medical facility: \_\_\_\_\_  
Name of hospital or facility

医院或医疗设施: \_\_\_\_\_  
医院或医疗设施名称

Type of facility (select one):  nursing home  assisted living  
设施类型(请选择一项): 疗养院 辅助生活设施

- group home  residential treatment facility  
集体住房 全托式治疗设施

other (describe): \_\_\_\_\_  
其他(请说明): \_\_\_\_\_

- School: \_\_\_\_\_  
Name of school

学校: \_\_\_\_\_  
学校名称

Do you plan to change the place where the disabled person lives?  Yes\*  No  
您是否打算让该残疾人士搬迁? 是\* 否

If yes, explain why:  
如果是,请说明理由:

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**\*You may need permission from the court before you move the disabled person from one location to another (Estates & Trusts, Art., § 13-708).**

**\*您需要获得法院的许可才能让该残疾人士搬迁(遗产和信托条款第 13-708 条)。**

**B. MEDICAL AND PERSONAL CARE**

**医疗和个人护理**

**Conditions.** List significant health or mental health issues the disabled person has (asthma, diabetes, anxiety, etc.):

**健康状况。**请列出该残疾人士的重大健康或心理健康问题(哮喘、糖尿病、焦虑等):

<u>Issue(s)</u> 问题	<u>Treatment/treatment plan</u> 治疗/治疗计划
_____	_____
_____	_____
_____	_____
_____	_____

**Hospitalizations.** Was the disabled person hospitalized during the reporting period?  Yes  No

**住院治疗。**在报告期内,该残疾人士是否曾接受住院治疗? 是 否

If yes, explain:

如果是,请详细说明:

<u>Date</u> 日期	<u>Hospital</u> 医院	<u>Reason</u> 原因
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Providers.** Which medical professional(s) did the disabled person see during the reporting period?

**提供者。**在报告期内,该残疾人士接受过哪些医疗专业人员的问诊?

	<u>Name</u> 姓名	<u>City, state</u> 市、州	<u>Date(s) seen</u> 问诊日期
<input type="checkbox"/> Primary care 初级护理	_____	_____	_____
<input type="checkbox"/> Dentist 牙医	_____	_____	_____
<input type="checkbox"/> Eye doctor 眼科医生	_____	_____	_____
<input type="checkbox"/> Ear doctor 耳科医生	_____	_____	_____
<input type="checkbox"/> Psychiatrist 精神科医生	_____	_____	_____
<input type="checkbox"/> Psychologist 心理学家	_____	_____	_____
<input type="checkbox"/> Therapist (mental health)	_____	_____	_____

治疗师  
(心理健康)

Physical or  
occupational therapist

物理或  
职业治疗师

Speech therapist

言语治疗师

Other (describe):

其他(请说明):

**Medications.** List medications the disabled person takes on a regular basis:

**药物。**请列出该残疾人士定期服用的药物:

<u>Name</u> 名称	<u>Purpose</u> 目的	<u>Dosage/Schedule</u> 剂量/时间表

**Personal care.** Are there problems providing meals, clothing, housing, or transportation for the disabled person?  Yes  No

**个人护理。**在为该残疾人士提供衣食住行时,是否遇到了问题? 是 否

If yes, explain:

如果是,请详细说明:

### C. SCHOOL AND JOB TRAINING

#### 上学和就业培训

**School.** Does the disabled person attend school?  Yes  No

**上学。**该残疾人士是否上过学? 是 否

If yes: \_\_\_\_\_

Name of school

\_\_\_\_\_

City, state, zip

如果是: \_\_\_\_\_

学校名称

\_\_\_\_\_

市、州、邮政编码

Is there a care plan or an Individualized Education Program (IEP)?  Yes  No

是否制定了护理计划或个别化教育计划 (IEP)? 是 否

If yes, did you participate in developing the care plan or IEP?  Yes  No

如果是, 您是否参与了制定该护理计划或 IEP? 是 否

Do you believe the care plan or IEP is good or appropriate for the disabled person (in that person's best interest)?  Yes  No (explain):

您是否认为该护理计划或 IEP 对该残疾人士来说是不错或合适的(符合该残疾人士的最佳利益)? 是 否(请说明理由):

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**Job training.** Is the disabled person in a job training program?  Yes  No

**就业培训。**该残疾人士是否参与了就业培训计划? 是 否

If yes: \_\_\_\_\_

Name of program

City, state, zip

如果是: \_\_\_\_\_

计划名称

市、州、邮政编码

Describe: \_\_\_\_\_

请说明: \_\_\_\_\_

#### D. EMPLOYMENT

##### 就业

Does the disabled person have a job?  Yes  No

该残疾人士是否有工作? 是 否

If yes: \_\_\_\_\_

Name of employer

City, state, zip

Hours worked per week

如果是: \_\_\_\_\_

雇主名称

市、州、邮政编码

每周工作时长

Type of job: \_\_\_\_\_

工作类型: \_\_\_\_\_

#### E. SOCIAL AND RECREATIONAL ACTIVITIES

##### 社交和娱乐活动

Describe social or recreational activities the disabled person enjoyed during the reporting period (sports, hobbies, clubs, adult day care, etc.).

请描述该残疾人士在报告期内参与过的社交或娱乐活动(体育、爱好、俱乐部、成人日托等)。

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#### F. CONTACTS

##### 接触

**Contact with you.** If the disabled person does not live with you, how often did you visit the disabled person during the reporting period?

**与您接触。**如果该残疾人士不与您同住, 您在报告期内多久探望一次该残疾人士?

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Describe your other types of contact with the disabled person:

请描述您与该残疾人士的其他接触:

<u>Type</u> 类型	<u>Frequency</u> 频率
<input type="checkbox"/> Telephone 电话号码	
<input type="checkbox"/> Mail or e-mail 邮寄地址或电子邮箱	
<input type="checkbox"/> Other (describe): _____ 其他(请说明): _____	

**Contact with others.** Describe the disabled person’s contact with family members during the reporting period.  
**与其他人接触。** 请描述该残疾人士在报告期内与家庭成员的接触。

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**Visitation plan.** Is there a formal visitation plan (guidelines for who visits or communicates with the disabled person)?  Yes  No

**探视计划。** 是否制定了正式的探视计划(为谁探视该残疾人士或与该残疾人士交流提供指导)? 是 否

If yes, how is it working?

如果是, 其效果如何?

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## G. DECISION-MAKING

### 决策

Describe any changes in the disabled person’s ability to make decisions affecting their health.

请描述该残疾人士做出影响其健康的决策的能力发生的任何变化。

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Is the disabled person involved in decisions about their housing, medical care, education, employment, social or recreational activities, etc.? (select one)

该残疾人士是否参与了有关其住房、医疗、教育、就业、社交或娱乐活动等事务的决策? (请选择一项)

Yes. Describe how:

是。请描述参与方式:

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No. Explain why:

否。请说明理由:

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## H. COMMUNITY SUPPORT

### 社区支持

List community organizations currently involved with the disabled person (case or care management, community services, government programs, religious programs, charitable organizations, etc.).

请列出目前与该残疾人士有关联的社区组织(个案或护理管理、社区服务、政府计划、宗教计划、慈善组织等)。

<u>Organization/Provider</u> 组织/提供商	<u>Services received</u> 接受的服务	<u>City, state</u> 市、州
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Part II. Information about the guardianship

### 第 II 部分。监护权相关信息

#### A. FUNDS

##### 资金

Did the guardian of the property, if any, provide funds toward the disabled person's support, care, or education?  Yes  No  Not applicable

财产监护人(如有)是否为该残疾人士的支持、护理或教育提供了资金? 是 否 不适用

If yes, describe (Select all that apply):

如果是, 请说明 (请选择所有适用项):

clothing  food  housing  health care (co-pays, insurance, etc.)

衣物 食物 住房 医疗(共付额、保险等)

transportation  education  extracurricular/recreational activities  job training

交通 教育 课外/娱乐活动 就业培训

other (describe):

其他(请说明):

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#### B. HEALTH OF GUARDIAN(S)

##### 监护人的健康状况

Guardian 1 (select one):

监护人 1 (请选择一项):

I have no serious health problems that affect my ability to serve as guardian.

我没有严重的健康问题影响我担任监护人的能力。

I have the following serious health problems that may affect my ability to serve as guardian:

我有以下严重的健康问题影响我担任监护人的能力。

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Guardian 2 (if any) (select one):

监护人 2 (请选择一项):

I have no serious health problems that affect my ability to serve as guardian.

我没有严重的健康问题影响我担任监护人的能力。

I have the following serious health problems that may affect my ability to serve as guardian:

我有以下严重的健康问题影响我担任监护人的能力。

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**C. CONTINUATION OF GUARDIANSHIP**

**监护权延续**

This guardianship (*select one*):

此监护权 (请选择一项):

should be continued.

应当延续。

should not be continued for the following reason(s):

不应延续, 理由如下:

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**D. POWERS OF GUARDIAN(S)**

**监护人的权限**

My/Our powers as guardian should (*select one*):

我/我们享有的监护人权限应当 (请选择一项):

stay the same.

保持不变。

change in the following ways for the following reasons:

作出以下变动, 理由如下:

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**E. OTHER**

**其他**

The court should be aware of the following other matters relating to this guardianship:

法院应当了解以下与此监护权相关的其他事项:

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I/we solemnly affirm under the penalties of perjury that the contents of this document are true to the best of my/our knowledge, information, and belief.

我/我们郑重地确认, 据我/我们所知所信, 本文件中的内容真实无误, 如有不实之处甘愿受作伪证之处罚。

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Date  
日期

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Signature of Guardian 1  
监护人 1 签名



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Printed Name  
楷签

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Street Address  
街道地址

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City, state, zip  
市、州、邮政编码

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Telephone Number  
电话号码

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E-mail  
电子邮箱

Fax  
传真

This is a new address since the last report (or since appointment if this is your first report).  
此为自上次报告以来的新地址(如果这是您的第一次报告, 则为自任命以来的新地址)。

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Date  
日期

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Signature of Guardian 2 (if applicable)  
监护人 2 签名(如适用)

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Printed Name  
楷签

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Street Address  
街道地址

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City, state, zip  
市、州、邮政编码

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Telephone Number  
电话号码

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E-mail  
电子邮箱

Fax  
传真

This is a new address since the last report (or since appointment if this is your first report).  
此为自上次报告以来的新地址(如果这是您的第一次报告, 则为自任命以来的新地址)。