STATE OF CONNECTICUT CONFIDENTIAL

COURT OF PROBATE

TO: COURT OF PROBATE, **DISTRICT NO.**

IN THE MATTER OF Hereinafter referred to as the protected person.	PROTECTED PERSON'S DATE OF BIRTH
PRESENT ADDRESS OF PROTECTED PERSON [***List both residence and domicile, if different.***]	DDS REGION ADDRESS
DEPARTMENT OF DEVELOPMENTAL SERVICES PROFESSIONAL [*Name, job title and telephone number.*]	Date of Evaluation
ASSESSMENT TEAM MEMBERS [***List names, job titles and telephone numbers.***] 1. _____ 2.	Date of Evaluation

The undersigned DDS professional OR the members of the Assessment Team each hereby certify as to having personally examined or observed the protected person and make a report thereof as follows:

Is the protected person a person with intellectual disability as defined in C.G.S. section 1-1g? : Yes No

Is the protected person functioning adaptively and intellectually within the severe or profound range of intellectual disability? (C.G.S. section 45a-681, as amended) Yes No

Provide specific information regarding the severity of the protected person's intellectual disability and those specific areas, if any, in which he or she needs the support and protection of a guardian, together with the reasons therefor.

Complete all boxes (1-5), explaining whether or not the protected person has the ability to assure and/or consent to the following. If possible, provide specific examples.

[1] A place of abode outside of the natural family home.

[2] Specifically designed educational, vocational or behavioral programs.

[3] The release of clinical records and photographs.

[4] Routine, elective and emergency medical and dental care.

[5] Other specific services necessary to develop or regain to the maximum extent possible the protected person's capacity to meet essential requirements.

PERTINENT HISTORY

STATE OF CONNECTICUT

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PHYSICAL CONDITION

[***Describe physical impairments, unless described in diagnosis above. List any medication the*** *protected person* ***may be taking and the common effects of such medication.***]

In my/our opinion, the guardianship should be continued modified terminated. [*Give reasons for your answer.*
[*To give further details, use Second Sheet, PC-180.*]

Each of the undersigned hereby certifies that he or she was appointed by the Commissioner of the Department of Developmental Services or his or her designee, and did personally observe or examine the protected person on the aforementioned date.

SIGNED [***Include Connecticut Professional License Number, if applicable.***]

DDS Professional ..... DATE:

Print Name:

OR:

Member 1 ..... DATE:

Print Name:

Member 2 ..... DATE:

Print Name:

[***Use Second Sheet, PC-180, for additional members***.]

Note: This form must be returned to the court not later than forty-five (45) days after the Probate Court's request for a written report on the condition of the protected person.

RESET