

**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 20, 2020, 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: John VanNorman, Chief 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 20, 2020. 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: text

49 **INVESTIGATOR'S REPORT**

50

51 **I. Service of Notice**

52

53 Made at Individual's home

54

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

56

57 Name of Facility _____

58

59 Address of Facility _____

60

61 Administrator or representative served _____

62

63 Other _____

64

65 Date of Service of Notice: _____

66

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

68

69 _____

70

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

72

73 Good Fair Poor Unable to determine. Explain:

74

75 _____

76

77 _____

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

79

80 Consenting Opposed Unable to Determine. Explain:

81

82 _____

83

84 _____

85

86 C. Specific requests of the individual concerning enumerated rights: _____

87

88 _____

89

89 **II. Mental and Physical Conditions of Individual**

90

91 A. Individual's reported mental and physical diagnosis: _____

92

93 Individual's reported medications: _____

94

95 Reported by whom: _____

CASE NO. _____

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

	Yes	No	Unable to Determine
100			
101 1. Orientation (Person, Place and Time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
102			
103 2. Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
104			
105 3. Thought Process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
106			
107 4. Affect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
108			
109 5. Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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111 6. Concentration & Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
112			
113 7. Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
114			

115 Explain further if necessary: _____
116 _____
117 _____

120 C. Describe the Physical Condition of Individual

- 121
- 122 1. Isolation _____
- 123
- 124 2. Eating Habits _____
- 125
- 126 3. Significant Weight Loss or Gain _____
- 127
- 128 4. Sleep Habits _____
- 129
- 130 5. Motor Behavior _____
- 131

132 Explain further if necessary: _____
133 _____
134 _____

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

- 138
- 139 1. Housing & Sanitation _____
- 140
- 141 2. Risk of Accidents _____
- 142
- 143 3. Physical Barriers _____

CASE NO. _____

144 4. Resource Availability _____

145

146 Explain further if necessary: _____

147

148 _____

149

150

151 **III. Functional Capacities**

152

153 **Activities and Instrumental Activities of Daily Living**

154

155 Capable Incapable Unable to

156 Determine

157

158 1. Eating

159

160 2. Dressing

161

162 3. Transfer from bed

163

164 4. Toileting

165

166 5. Bathing

167

168 6. Handling personal finances

169

170 7. Shopping

171

172 8. Driving

173

174 9. Meal preparation

175

176 10. Doing housework

177

178 11. Using telephone

179

180 12. Taking medications

181

182 Explain further if necessary:

183 _____

184

185 _____

186

187

188

189

190 **IV. Additional Items Affecting Guardianship Plan Development**

191
192 A. Are there any indications or allegations of substance abuse by the individual or
193 significant others that could impact the guardianship issue? Yes No Explain and
194 recommend actions needed:

195 _____
196 _____
197 _____
198 _____
199 _____

200
201 B. Are there any special characteristics of the individual (including aggressive, violent,
202 or sexual behaviors, or other vulnerabilities) that pose a risk to self or others, which should
203 be considered as guardianship decisions on living arrangements and supervision are
204 made? Yes No Explain the characteristics and make recommendations:

205 _____
206 _____
207 _____
208 _____
209 _____
210 _____
211 _____

212
213 C. Are there any allegations or indications of abuse, neglect, or exploitation of the
214 individual? Yes No Explain and recommend needed actions:

215 _____
216 _____
217 _____
218 _____
219 _____

220
221 D. Is there a need for additional medical, psychiatric or psychological testing?
222 Yes No If yes, give specific recommendations:

223 _____
224 _____
225 _____
226 _____
227 _____
228 _____

229
230 E. Are there inconsistencies between the Expert Evaluation and the Court
231 Investigator's findings that need further review by the Court? Yes No If yes,
232 identify the inconsistencies and make a recommendation(s) to the Court:

233 _____
234 _____
235 _____
236 _____
237 _____
238 _____
239 _____

CASE NO. _____

240 F. Are there unresolved issues/conflicts/ differences among the parties? Yes No
241 If yes, would mediation be of assistance? Yes No Explain:

242 _____
243 _____

244
245 G. Is there a power of attorney for financial affairs? Yes No Unknown If
246 yes, where is it located? _____

247
248 Who is the attorney-in-fact? _____

249
250 H. Is there a last will and testament? Yes No Unknown
251 If yes, where is it located? _____

252
253 I. Is there a durable power of attorney for health care/living will? Yes No
254 Unknown If yes, where is it located? _____

255
256 Give name and address of attorney-in-fact: _____

257
258 J. Is there an advance directive for mental health care? Yes No Unknown If
259 yes, where is it located?
260 _____

261
262 Give name and address of attorney-in-fact: _____

263
264 K. Is the individual a veteran? Yes No

265
266

267 **V. RECOMMENDATIONS: Given the above information and Expert**

268 **Evaluation(s):**

269
270 **A. IS A GUARDIANSHIP NECESSARY?**

- 271 Yes
272 Person Only
273 Estate Only
274 Person and Estate
275 Limited List Duties _____

276
277 _____

278
279 _____

280
281

282 No Explain and recommend a less restrictive alternative: _____

283
284 _____

285
286 _____

CASE NO. _____

287
288 Are any of the mental, physical, or environmental conditions reversible? Yes No
289 Unknown

290
291 If yes, explain and recommend a date for the Court to review the guardianship. _____
292
293 _____

294
295 **B. NECESSITY FOR THE APPOINTMENT OF:**

296
297 Attorney Independent Expert Evaluator

298
299 Are there special urgency needs? Explain: _____
300
301 _____
302
303 _____

304
305 Remarks: _____
306
307 _____
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309 _____
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317 _____
318

319 I certify that I have served notice to the alleged incompetent as required by statute and I
320 have communicated to the individual in a language and method best understandable by
321 the individual the individual's right to be present at the hearing, the right to contest any
322 application for the appointment of a guardian for his or her person, estate, or both, and
323 the right to be represented by counsel.
324
325
326
327

328 _____
329 Date

Investigator

CASE NO. _____

47 WHEREFORE, the Petitioner requests the Court to authorize the implementation of the
48 proposed protective services plan and for such other relief as may be equitable.
49

50
51 _____ County Department of Job and Family Services
52

53
54
55
56

57 _____ By: _____
58 Attorney

59
60 _____

61 Address Title
62

63 _____
64 Address

65
66 _____

67 Phone Number (including area code)
68

69 _____
70 Registration No. Phone Number (including area code)

71
72 _____

73 E-mail E-mail

CASE NO. _____

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State of Ohio, _____ County Probate Court

I hereby certify that I caused a copy of the within notice to be mailed, by certified mail, to the last known address of

at _____

at _____

_____, Probate Judge

By: _____

Deputy Clerk

RETURN

_____ County, Ohio

Received this notice on the ____ day of _____, 20____, at _____ o'clock _____.M., and on the ____ day of _____, 20____, I served the same by delivering a true copy thereof personally to _____

_____ FEES

_____ Sheriff

Service and return, 1st name, \$ _____

_____ Deputy Sheriff/Process Server

Additional names, at \$ _____

Miles traveled, at \$ _____

_____ Name

_____ \$ _____

_____ Title

Total \$ _____

CASE NO. _____

47 6. (Complete if applicable) Petitioner requests a waiver of the 24 hour notice
48 requirement because:

49
50 a.) Immediate and irreparable physical harm to the Adult or others will result
51 from the 24 hour delay. Explain: _____
52 _____
53 _____
54 _____

55
56 And

57
58 b.) Reasonable attempts have been made to notify the above listed individuals,
59 if any, if their whereabouts are known. Explain: _____
60 _____
61 _____
62 _____

63
64 7. The Adult has not consented and there is no person authorized by law or court
65 order available or willing to give consent to the emergency protective services.

66
67 WHEREFORE, the Petitioner requests the Court to authorize the implementation of the
68 proposed emergency protective services and for such other relief as may be equitable.

69
70
71 _____ County Department of Job and Family Services

72
73
74
75
76 _____
77 Attorney

By: _____

78
79
80 Address

_____ Title

81
82
83 _____

Address

84
85
86 Phone Number (including area code)

87
88
89 Registration No.

Phone Number (including area code)

90
91
92 E-mail

_____ E-mail

CASE NO. _____

49 The State of Ohio, _____ County Probate Court

50
51 I hereby certify that I caused a copy of the within notice to be mailed, by certified
52 mail, to the last known address of

53 _____
54
55 at _____

56 _____
57
58 at _____

59 _____
60
61 _____, Probate Judge

62 _____, Probate Judge
63
64 By: _____
65 Deputy Clerk

66
67
68
69

RETURN

70 _____ County, Ohio
71
72

73 _____ ++ _____,
74

75 Received this notice on the _____ day of _____, 20____, at _____
76 o'clock _____.M., and on the _____ day of _____, _____, I served the
77 same by delivering a true copy thereof personally to _____
78 _____

79
80
81

82 _____ FEES _____ Sheriff
83 _____

84 Service and return, 1st name, \$ _____ Deputy Sheriff/Process Server
85 _____

86 _____ Additional names, at \$ _____
87 _____ Miles traveled, at \$ _____
88 _____ Name

89 _____ \$ _____
90
91 Total \$ _____ Title
92 _____

1 PROBATE COURT OF _____ COUNTY, OHIO
2 _____, JUDGE
3

4 IN THE MATTER OF _____, AN ADULT

5
6 CASE NO. _____
7

8
9 **NOTICE OF HEARING ON PETITION FOR TEMPORARY RESTRAINING ORDER
10 TO PREVENT INTERFERENCE WITH THE PROVISION OF SERVICES**

11 [R.C. ~~5401.68~~ 5101.69]
12

13 TO: _____
14 (Name of Person interfering with the provision of services)

15 _____
16 (Address)
17

18
19 The above captioned Adult has consented to the provision of adult protective services
20 pursuant to Chapter 5101. of the Revised Code.
21

22 You hereby notified that a Petition for Temporary Restraining Order to Prevent
23 Interference with the Provision of Services was filed with this Court pursuant to R.C.
24 ~~5401.68~~ 5101.69. It is alleged in the Petition that you are interfering with the provision of
25 protective services for the Adult, and that a temporary restraining order should be issued
26 against you to prevent your interference. A copy of the Petition is attached hereto.
27

28 The Petition for Temporary Restraining Order to Prevent Interference with the Provision
29 of Services shall be heard in the _____ County Probate Court,
30 _____, Ohio
31 located at _____ on the ____ day of _____, 20
32 ____ at _____ o'clock ____ M. You or any interested person is
33 permitted to attend this hearing and give testimony or present other evidence as to why
34 the petition for restraining order should or should not be granted.
35

36
37 Witness my signature and the seal of the Court
38 This ____ day of _____, 20 ____.
39

40
41 _____
42 Probate Judge
43

44
45 By: _____
46 Deputy Clerk
47

48
49 The State of Ohio, _____ County Probate Court

CASE NO. _____

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I hereby certify that I caused a copy of the within notice to be mailed, by certified mail, to the last known address of

at _____

at _____

_____, Probate Judge

By: _____
Deputy Clerk

RETURN

_____ County, Ohio

Received this notice on the _____ day of _____, 20____, at _____ o'clock _____.M., and on the _____ day of _____, 20____, I served the same by delivering a true copy thereof personally to _____

FEES	
Service and return, 1 st name,	\$ _____
_____ Additional names, at	\$ _____
_____ Miles traveled, at	\$ _____
_____	\$ _____
Total	\$ _____

_____ Sheriff
 _____ Deputy Sheriff/Process Server
 _____ Name
 _____ Title

CASE NO. _____

38

39

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41

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46

Guardian's Printed Name

Guardian's Signature

Street

Telephone Number (include area code)

City

State

Zip Code

1 **PROBATE COURT OF _____ COUNTY, OHIO**

2
3 **_____, JUDGE**

4
5 **ESTATE OF _____, DECEASED**

6
7 **CASE NO. _____**

8
9 **APPLICATION TO RELEASE MEDICAL RECORDS AND MEDICAL**
10 **BILLING RECORDS**

11 **[R.C. 2113.032]**

12
13 Now comes _____ the _____ of the
14 (Applicant's Name) (Relationship)

15
16 above named decedent who died on _____ and resided at _____
17 _____ whose last four (4) digits of his/her social
18 security number are _____, and hereby requests authority to obtain information regarding
19 decedent's medical records and medical billing records for the purpose of evaluating a potential
20 wrongful death, personal injury, or survivorship action on behalf of the decedent.

21
22 **Applicant states the following:**

23
24 Applicant is an individual who is eligible to be appointed as a personal representative of the above-
25 named decedent's estate under Ohio law; or

26
27 Applicant is named as executor in the above-named decedent's will, and Applicant has filed a copy
28 of decedent's will with this Application.

29
30 Applicant has attached Form 1.0 – Surviving Spouse, Children, Next of Kin, Legatees and Devisees.

31
32 Applicant acknowledges that an order shall not be issued until ten days following the probate court's
33 transmission of a copy of this application to those persons listed on the Form 1.0 who have not filed a
34 signed Waiver of Notice/Consent.

35
36
37 _____
38 Signature

39
40 _____
41 Typed or Printed Name

42
43 _____
44 Address

45
46 _____
47 _____
48 _____
49 _____
50 Phone Number

1 **PROBATE COURT OF _____ COUNTY, OHIO**

2
3 **_____, JUDGE**

4
5 **ESTATE OF _____, DECEASED**

6
7 **CASE NO. _____**

8
9 **NOTICE OF APPLICATION TO RELEASE MEDICAL RECORDS AND**
10 **MEDICAL BILLING RECORDS**

11 **[R.C. 2113.032]**

12
13 To the following persons:

14
15 _____
16 Name

15 _____
16 Address

17
18 _____
19 Name

17 _____
18 Address

20
21 _____
22 Name

20 _____
21 Address

23
24 _____
25 Name

23 _____
24 Address

26
27 _____
28 Name

26 _____
27 Address

29
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31
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35
36
37 _____ has filed an application in this Court, seeking the
38 release of the decedent's medical records and medical billing records for use in evaluating a potential
39 wrongful death, personal injury, or survivorship action on behalf of the decedent.

40
41 You are one of the above-named decedent's next of kin and are therefore entitled to notice of the
42 pending Application to Release Medical Records and Medical Billing Records. The Court shall issue an
43 order not earlier than ten (10) days of the transmission of this Notice.

44
45 The Application to Release Medical Records and Medical Billing Records shall be heard before the
46 _____ County Probate Court, located at _____, Ohio
47 _____ on the _____ day of _____, 20_____ at _____
48 o'clock _____ M.

1 **PROBATE COURT OF _____ COUNTY, OHIO**

2
3 **_____, JUDGE**

4
5 **ESTATE OF _____, DECEASED**

6
7 **CASE NO. _____**

8
9 **WAIVER OF NOTICE / CONSENT**

10 **[R.C. 2113.032]**

11
12 Application of _____ for release of medical records and medical billing
13 records of the above-named decedent.

14
15 The undersigned, being the next of kin of the above-named decedent, hereby waive notice and consent
16 to the release of medical records and medical billing records of the above-named decedent.

17
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