686 E Mill Street, San Bernardino, CA 92415-0647 | Phone: (909) 798-8500 | Fax: (909) 798-8575
www.SBCounty.gov

SAN BERNARDINO COUNTY

Aging and Adult Services
Public Guardian
Office of the Public Guardian

Sharon Nevins, LCSW, MA-PPM
Director-Public Guardian

Thank you for contacting the Office of the Public Guardian-Conservator regarding obtaining the services from our office. For the Public Guardian to consider an individual for a possible probate conservatorship, you must complete the forms included in the referral packet. Please return the completed forms, along with a Capacity Declaration (GC 335) to the following:

Office of the Public Guardian-Conservator
ATTN: Probate Investigations Unit
686 East Mill Street
San Bernardino CA 92415-0646

It is critical for you to provide the requested information to conduct a thorough investigation. An investigation for a probate conservatorship can take up to sixty (60) days to complete.

If you have any questions, please do not hesitate to contact the Office of the Public Guardian at 909-798-8500.

Thank you for your time!

Sincerely,

Public Guardian
County of San Bernardino

By: _____
PAUL GRAY
Chief Deputy Public Guardian

SAN BERNARDINO COUNTY PUBLIC GUARDIAN OFFICE

Before filling out the application for an investigation for public probate conservatorship, please read the following information:

LEGAL CRITERIA: Inability to properly provide for food, clothing, shelter, or physical health (conservatorship of the person) and/or substantial inability to manage financial resources, or resist fraud, or undue influence (conservatorship of the estate). The individual's incapacity must be measured and confirmed by the attending physician.

GUIDING MANDATES: A conservatorship is not an emergency response instrument. It may require as much as 8-12 weeks from the beginning of an investigation, to an actual court date. Additionally, legislation contemplates that a public probate conservatorship be the last resort and that all alternatives to such conservatorship be explored first. A public probate conservatorship may not be appropriate as a preventative measure. Generally an individual must meet the legal criteria at the time the referral is made.

I. FACTORS WHICH GENERALLY FAVOR A PUBLIC PROBATE CONSERVATORSHIP

A. The inability to think logically or exercise sound judgment. This is important when considering if the individual can provide for his/her own care and well being.

   1. Examples:
      a. If multiple physical treatments are necessary and the individual lacks the ability to perceive: basic concepts of self care, diagnosis, options or treatment available; and is unable to give informed consent.
      b. Severe memory loss resulting in the individual's being unable to discern whether his/her needs are being met such as payment for housing, meals, clothing, medications, etc.
      c. Inability to choose an appropriate responsible individual to act on his/her behalf.

B. A primary physical diagnosis which might also affect mental functioning such as stroke, Alzheimer's disease, etc. **OR** a primary physical disabling disease with a secondary mental impairment which does not require mental health treatment.

C. No family members are able to provide care or act a conservator.

II. FACTORS WHICH GENERALLY DISCOURAGE A PUBLIC PROBATE CONSERVATORSHIP:

A. The individual has the ability to provide for and choose his/her own services (e.g. a person is in a nursing home, is alert and able to execute a power of attorney).

B. A second party (e.g. friend family member, facility) is providing for all of the individual's needs.

C. The individual has a primary diagnosis of mental illness or alcoholism which requires placement in a locked treatment facility.

D. The individual presents a continual resistance to assistance (e.g. able to physically resist initial placement, willing and able to walk out of treatment or placement, able to articulate and justify reasons he/she objects to a conservatorship).

E. Conservatorship is desired simply to facilitate medical consent or to pay bills.

F. The individual is 'on the streets.' The Public Guardian cannot adequately conduct an investigation unless the individual is in some type of placement such as a hospital, home, facility, etc.

REFERRAL FOR INVESTIGATION FOR PUBLIC PROBATE CONSERVATORSHIP

INSTRUCTIONS

I. FACE SHEET (Page 1)

1. Please fill our all personal information as completely as possible.

2. Relatives and Interested Parties – This should include names of any persons who have personal or professional connections to the proposed conservatee.

II. INCOME AND ASSETS (Page 2)

1. Please give as much detailed information as possible regarding finances of the proposed conservatee.

2. Item 2 refers to Supplemental Security Income (SSI) which is administered by Social Security Administration.

III. DESCRIPTION OF CURRENT PROBLEMS AND LEVEL OF FUNCTIONING (Pages 3, 4, and 5)

1. It is important that the referring party fully describe all known problems and circumstances associated with the proposed conservatee's incapacity, precipitating events, needs not being met, and level of care needed. Please be specific and use examples.

2. Be sure to sign the bottom of page 5.

IV. CAPACITY DECLARATION – CONSERVATORSHIP (Judicial Form GC-355)

1. California Law requires that the court find deficits in mental functioning of the proposed conservatee before specific powers (i.e. authority to give medical consent, contract, execute a trust or make a conveyance) can be granted to the conservator.

2. **This declaration must be filled out and signed by the attending physician.**

IMPORTANT – The document requiring physician input is necessary to satisfy legal requirements. If it is not filled out completely and singed by the physician, then the referral packet may be returned to the referring party.

County of San Bernardino
Public Guardian – Conservator
686 East Mill Street
San Bernardino, CA 92415

REFERRAL FOR AN INVESTIGATION FOR PROBATE CONSERVATORSHIP

Name _____ AKA's _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow
Spouse's Name/Address _____

_____

Date of Birth _____ Birth Place _____

Height (Approx) _____ Weight (approx) _____

Currently: ☐ Hospital ☐ Nursing Home ☐ Board & Care ☐ Home ☐ Other

Address & Phone: _____

_____

Social Security # _____ Medi-Cal # _____

Medicare # _____ Citizen: ☐ Yes ☐ No Alien# _____

Veteran's Status: ☐ Yes ☐ No Service # _____ Dates of Service: _____

RELATIVES AND INTERESTED PARTIES

Name	Relationship	Address	Phone	Age

Physician's Name and Address _____

_____

Prescription Medications (Please do not list 'over the counter' medication)

_____

_____

INCOME AND ASSETS

1. SOCIAL SECURITY ☐ Yes ☐ No Amount: _____
2. SSI ☐ Yes ☐ No Amount: _____ VA ☐ Yes ☐ No Amount: _____
3. WAGES ☐ Yes ☐ No Employer: _____ Amount: _____
4. OTHER INCOME/ASSETS: _____
5. CHECKING ACCOUNT ☐ Yes ☐ No Balance: _____
   Bank/Branch/Account #: _____
   Direct Deposits: _____
6. SAVINGS ACCOUNT ☐ Yes ☐ No Balance: _____
   Bank/Branch/Account #: _____
   Bank/Branch/Account #: _____
   Direct Deposits: _____
   Type of Account (Trust, etc.): _____
7. SAFETY DEPOSIT BOX ☐ Yes ☐ No Location: _____
8. STOCK/BONDS/SECURITIES ☐ Yes ☐ No Type/Location: _____
9. PENSION ☐ Yes ☐ No Annuities ☐ Yes ☐ No
   Name & address of company: _____
10. REAL PROPERTY Address: _____ Value: _____
11. MOBILE HOME Address: _____ Value: _____
12. VEHICLES Location: _____ Description & Value: _____
13. PERSONAL PROPERTY ☐ Yes ☐ No
    Description & Location: _____
14. INSURANCE POLICIES ☐ Yes ☐ No Type: _____ Company: _____
15. BURIAL PLANS ☐ Yes ☐ No Pre-Paid ☐ Arrangements: _____
16. BURIAL PLOT/CRYPT ☐ Yes ☐ No Pre-Paid ☐ Location: _____
17. WILL ☐ Yes ☐ No Location: _____
18. POWER OF ATTORNEY OR TRUST ☐ Yes ☐ No Name: _____

List any additional information Below

ASSESSMENT OF SOCIAL/MEDICAL NEEDS

It is important for our evaluation to include the following information. All referrals must address each area and be complete, if known. Skilled nursing facilities and hospital staff should be able to address all areas.

1. Is individual in a coma or has a terminal condition? _____

   (Life-sustaining devices used) _____

2. Orientation to person, place, time (be specific). _____

   _____

3. Individual's knowledge of medical condition and medication. _____

   _____

4. If individual is in pain, to what degree? _____

   _____

5. Social and communication abilities. _____

   _____

6. Ability to follow instructions. _____

   _____

7. Ability to make needs known. _____

   _____

8. Grooming and eating abilities. _____

   _____

9. Bladder/bowel control and frequency. _____

   _____

10. Mobility and aides used. _____

    _____

11. Ability to transfer from bed to wheelchair (If applicable). _____

    _____

12. Ability to cooperate with treatment and/or assistance (specify). _____

    _____

    _____

    _____

ASSESSMENT OF SOCIAL/MEDICAL NEEDS, continued

13. Who secured current placement? _____

_____

14. Monthly expenses and amounts (if known). _____

_____

15. Where is the income mailed? _____

_____

16. Prior address (if currently in acute hospital). _____

_____

17. Does individual have any past or current history of violence, verbal, or physical aggression or acting out behaviors? If yes, please describe in detail.

_____

_____

_____

18. (Optional) Pertinent personal history. _____

_____

_____

Continue to next page.

Please check all areas of need that are not currently being met. Describe precipitating event(s) that led to this referral, and level of care required.

1. NEEDS NOT BEING MET:

☐ Food ☐ Clothing ☐ Shelter ☐ Health ☐ Finances

2. EVENTS LEADING UP TO THIS REFERRAL AND HOW NEEDS ARE NOT BEING MET:

3. LEVEL OF CARE NEEDED:

Signature of Referring Party

Date

Agency and Title

Printed Name

Phone Number

CONFIDENTIAL

GC-335

ATTORNEY OR PARTY WITHOUT ATTORNEY	STATE BAR NUMBER: SBN 193560	FOR COURT USE ONLY FILE IN CONFIDENTIAL FOLDER
NAME: THOMAS DALE BUNTON FIRM NAME: County Counsel for San Bernardino County STREET ADDRESS: 385 North Arrowhead Avneue, 4th Floor CITY: San Bernardino STATE: CA ZIP CODE: 92415 TELEPHONE NO.: (909)798-8500 FAX NO.: EMAIL ADDRESS: ATTORNEY FOR (*name*): The Office of the Public Guardian of San Bernardino County		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN BERNARDINO STREET ADDRESS: 17780 Arrow Blouevard MAILING ADDRESS: 17780 Arrow Boulevard CITY AND ZIP CODE: Fontana, California 92335 BRANCH NAME: Fontana District		
CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF (*name*): ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE		CASE NUMBER:
CONFIDENTIAL CAPACITY ASSESSMENT AND DECLARATION—PROBATE CONSERVATORSHIP		HEARING DATE: TIME: DEPT. or ROOM:

This form is intended to record the results of a capacity assessment of the person named in item 2, to describe the assessing clinician's conclusions about the person's mental functioning and capacity, and to submit the results and conclusions under oath to the court. The petitioner completes items 1 and 2 to give instructions to the clinician. The clinician completes the remainder of the form.

PETITIONER'S INSTRUCTIONS TO CLINICIAN

1. **Assessments requested.** In addition to completing Parts I and II (pages 2–4), please complete the following items in Part III (pages 5–6) to assess the person's ability to perform the action or capacity to make the decision indicated *(check all that apply):*
   a. ☐ Item 20: Give or withhold informed consent to medical treatment specified in the petition. (Prob. Code, §§ 811, 813, 2357.)
   b. ☐ Item 21: Give or withhold informed consent to medical treatment generally. (*Id.*, §§ 811, 1880–1891, 2355.)
   c. ☐ Item 22: Give or withhold informed consent to placement in a secured-perimeter (locked) residential care facility for the elderly. (*Id.*, §§ 811, 2356.5.)
   d. ☐ Item 23: Give or withhold informed consent to administration of medication appropriate for care and treatment of major neurocognitive disorders (e.g., dementia). (*Id.*, §§ 811, 813, 2356.5.)

   Note to petitioner: Provide a copy of the petition to the clinician who will be assessing the person named in item 2 for the clinician's reference. Do ***not*** attach *Confidential Supplemental Information* (form GC-312).

2. **Person to be assessed**
   a. Name:
   b. Address:
      Telephone number: Email address:
   c. Date of birth:
   d. Highest level of education completed *(grade or degree):*
   e. Marital or partnership status: ☐ single ☐ married/partnered ☐ dissolved ☐ widowed
   f. Preferred language: ☐ speaks ☐ reads ☐ writes

TO THE CLINICIAN: Provide your contact and license information below.

3. a. Name:
   b. Office address:
      Telephone number: Email address:

4. a. ☐ I am a California-licensed physician. License no:
   b. ☐ I am a California-licensed psychologist practicing within the scope of my license. License no:
      ☐ I have at least two years' experience diagnosing major neurocognitive disorders (including dementia).
   c. I have been practicing as a licensed physician or psychologist for years.

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(name):* ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

Information about the assessment

5. a. The person named in item 2 ☐ is ☐ is ***not*** a patient under my continuing care and treatment.
   b. I have known this person for *(specify length of time in months or years):*

6. a. Date of the examination on which this assessment is based or, if based on multiple examinations, the date I most recently examined the person:
   b. Time spent in most recent examination:

7. My responses to the questions and prompts on this form are based on *(check all that apply):*
   a. ☐ My examination of this person for the purpose of assessing the person's abilities and capacities.
   b. ☐ Multiple examinations of this person for purposes of general health care and medical treatment.
   c. ☐ Administration of standardized examinations or tools that measure the person's mental functioning. All tests administered and dates of administration are listed ☐ below ☐ in Attachment 7c.
   d. ☐ My review of the person's medical records.
   e. ☐ Discussions with other practitioners responsible for providing health care to the person. These discussions are described ☐ below ☐ in Attachment 7e.
   f. ☐ Discussions with team members or other professionals who participated in the person's assessment. These discussions are described ☐ below ☐ in Attachment 7f.
   g. ☐ Discussions with the person's family or friends; names and relationships are given ☐ below ☐ in Attachment 7g.
   h. ☐ Other sources of information, which are described ☐ below ☐ in Attachment 7h.

REPORT OF ASSESSMENT

If a question or prompt does not apply to an ability or capacity checked in item 1 or your assessment does not address a question or prompt, please check the appropriate box in that item or, if there is no box, leave the item blank. Secure or destroy your copy of the petition. Do not send it to the court.

PART I. GENERAL PHYSICAL AND MENTAL HEALTH This part describes the general state of the physical and mental health of the person named in item 2. ☐ Information focused on the effect of the person's health on their mental function is given in items 16–18.

8. **Physical health**
   a. Overall physical health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know
   b. Overall physical health is likely to: ☐ Improve ☐ Remain stable ☐ Deteriorate ☐ I don't know
      ☐ The person should be reevaluated in weeks.
   c. Chronic conditions that require ongoing care and treatment are listed ☐ below ☐ in Attachment 8c.

9. **Mental health**
   a. Overall mental health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know
   b. Overall mental health is likely to: ☐ Improve ☐ Remain stable ☐ Deteriorate ☐ I don't know
      ☐ The person should be reevaluated in weeks.
   c. All known diagnosed mental health disorders (current *Diagnostic and Statistical Manual of Mental Disorders*) are listed ☐ below ☐ in Attachment 9c.

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF (name): ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

PART II. MENTAL FUNCTIONING This part documents the existence and extent of any deficits found by my assessment of the mental functioning of the person described in item 2. Deficits are indicated in items 10–14 as follows:

a = no deficit; **b** = mild deficit; **c** = moderate deficit; **d** = major deficit or no function; **e** = not applicable or not assessed

10. **Alertness and attention** (ability to recognize and react to a stimulus)
    a. Level of arousal or consciousness (deficit may be shown by lethargy, lack of response without constant stimulation, or stupor) ☐ a ☐ b ☐ c ☐ d ☐ e
    b. Orientation to:
       (1) Time (When? Year, month, day, hour) ☐ a ☐ b ☐ c ☐ d ☐ e
       (2) Place (Where? State, city, address) ☐ a ☐ b ☐ c ☐ d ☐ e
       (3) Person (Who? Name, relationship) ☐ a ☐ b ☐ c ☐ d ☐ e
       (4) Situation (What? How? Why?) ☐ a ☐ b ☐ c ☐ d ☐ e
    c. Ability to attend to and concentrate on tasks (ability to attend to a stimulus; concentrate on a stimulus over brief time periods) ☐ a ☐ b ☐ c ☐ d ☐ e

    Notes:

11. **Information processing**
    a. Memory
       (1) Immediate recall ☐ a ☐ b ☐ c ☐ d ☐ e
       (2) Short-term memory and learning (the ability to encode, store, and retrieve information) ☐ a ☐ b ☐ c ☐ d ☐ e
       (3) Long-term memory (ability to remember information from the past) ☐ a ☐ b ☐ c ☐ d ☐ e
    b. Understanding (the ability to receive and accurately process information given in written, spoken, visual, or other media) ☐ a ☐ b ☐ c ☐ d ☐ e
    c. Communication (the ability to express oneself and indicate preferences in speech, writing, signs, pictures, etc.) ☐ a ☐ b ☐ c ☐ d ☐ e
    d. Visual-spatial reasoning (recognition of familiar objects; spatial perception, problem solving, and design) ☐ a ☐ b ☐ c ☐ d ☐ e
    e. Quantitative reasoning (the ability to understand basic quantities and make simple calculations) ☐ a ☐ b ☐ c ☐ d ☐ e
    f. Verbal reasoning (the ability to compare options, to reason using abstract concepts, and to reason logically about outcomes) ☐ a ☐ b ☐ c ☐ d ☐ e
    g. Executive functioning (the ability to plan, organize, and carry out actions (assuming physical ability) in one's own rational self-interest) ☐ a ☐ b ☐ c ☐ d ☐ e

    Notes:

12. **Thought processes**
    a. Organization of thinking (deficit may be demonstrated by severely disorganized, nonsensical, or incoherent thinking) ☐ a ☐ b ☐ c ☐ d ☐ e
    b. Correspondence of thoughts to reality (deficit may be demonstrated by hallucinations or delusions) ☐ a ☐ b ☐ c ☐ d ☐ e
    c. Control of thoughts (deficit may be demonstrated by uncontrollable, repetitive, or intrusive thoughts) ☐ a ☐ b ☐ c ☐ d ☐ e

    Notes:

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF (name): ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

a = no deficit; **b** = mild deficit; **c** = moderate deficit; **d** = major deficit or no function; **e** = not applicable or not assessed

13. **Ability to modulate mood and affect** (deficit may be demonstrated by pervasive and persistent or recurrent mood or affect inappropriate in kind or degree to the circumstances) ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    Notes:

14. **Ability to accept and cooperate with appropriate care or assistance** (deficit may be demonstrated by inability to acknowledge illness or disorder, acting without regard for consequences, or inability or refusal to accept appropriate care)
    ☐ **a** ☐ **b** ☐ **c** ☐ **d** ☐ **e**
    Notes:

15. **Variation** (some or all of the deficits noted above vary in frequency, severity, or duration):
    ☐ Yes ☐ No ☐ I don't know Variation of deficits is described ☐ below ☐ in Attachment 15.

Possible Temporary or Reversible Causes of Mental Function Deficits

16. **Medications**
    a. Is the person currently taking any medication—prescription or nonprescription—that may impair the person's mental functioning?
    ☐ Yes ☐ No ☐ I don't know ☐ Not applicable
    If *yes,* each of those medications, with dosage and treatment indications, is listed ☐ below ☐ in Attachment 16a.

Name	Dosage/Schedule	Indications

    b. An explanation of the nature and severity of the impairment that each listed medication can cause is given
    ☐ below ☐ in Attachment 16b ☐ No medications listed.

17. **Reversible causes** Have temporary or reversible causes of mental impairment been considered, assessed, diagnosed, or treated?
    ☐ Yes ☐ No ☐ I don't know All causes considered are discussed ☐ below ☐ in Attachment 17.

18. **Physical or emotional factors** Are there physical or emotional factors (e.g., hearing, vision, or speech impairment; bereavement; or others) present that could diminish the person's capabilities and that could improve with time, treatment, or assistive devices?
    ☐ Yes ☐ No ☐ I don't know
    ☐ Applicable physical or emotional factors are described ☐ below ☐ in Attachment 18.

Effect on Ability to Perform Everyday Activities

19. In my professional opinion, the mental function deficits, if any, identified in items 10–14 ☐ will ☐ will not significantly impair the person's ability to perform some or all activities of daily living (e.g., eating, cooking, toileting, bathing, dressing) or instrumental activities of daily living (e.g., shopping, scheduling appointments, paying bills, using a credit card or checks, taking medication). More details about specific activities and reasons for my opinion are given *(check all that apply):*
    ☐ below ☐ in Attachment 19 ☐ in the attached *Everyday Activities Attachment* (form GC-335A).

    ☐ I do not have enough information to form an opinion on this issue.

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF (name): ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

PART III. CAPACITY TO GIVE OR WITHHOLD INFORMED CONSENT This part documents my professional conclusions about each issue checked in item 1. The conclusions are based on my assessment of the level of the person's mental functions described in Part II.

20. ☐ **Capacity to give or withhold informed consent to medical treatment specified in the petition** (Probate Code, § 2357.)

The following medical treatment has been recommended for the person *(describe):*

Based on my assessment of the person's applicable mental functions and abilities, it is my professional opinion that:

a. ☐ The person ***has*** the capacity to give or withhold informed consent to the recommended medical treatment because the person can do ***all*** of the following: (1) respond knowingly and intelligently to questions about the treatment; (2) participate in the treatment decision by means of a rational thought process; and (3) understand (A) the nature and seriousness of the diagnosed disorder, (B) the nature of the recommended treatment, (C) the probable degree and duration of and benefits and risks of the recommended treatment, (D) the consequences of lack of treatment, and (E) the nature, risks, and benefits of any reasonable alternatives to the recommended treatment.

b. ☐ The person ***lacks*** the capacity to give or withhold informed consent to the recommended medical treatment because the person ***cannot do at least one*** of the following: (1) respond knowingly and intelligently to questions about the treatment, (2) participate in the treatment decision by means of a rational thought process, or (3) understand at least one of the following: (A) the nature and seriousness of the diagnosed disorder, (B) the nature of the recommended treatment, (C) the probable degree and duration of and benefits and risks of the recommended treatment, (D) the consequences of lack of treatment, or (E) the nature, risks, and benefits of any reasonable alternatives to the recommended treatment.
☐ These conclusions are further explained ☐ below ☐ in Attachment 20b.

c. ☐ I do not have enough information to form an opinion on this issue.

21. ☐ **Capacity to give or withhold informed consent to medical treatment generally** (Probate Code, §§ 811, 1881.)

Based on my assessment of the person's applicable mental functions and abilities, it is my professional opinion that:

a. ☐ The person ***has*** the capacity to give or withhold informed consent to medical treatment because the person can do ***all*** of the following: (1) respond knowingly and intelligently to questions about at least some forms of medical treatment; (2) participate in at least some treatment decisions by means of a rational thought process; and (3) understand (A) the nature and seriousness of some diagnosed disorders, (B) the nature of some recommended treatments, (C) the probable degree and duration of and benefits and risks of at least some forms of treatment, (D) the consequences of lack of at least some forms of treatment, and (E) the nature, risks, and benefits of any reasonable alternatives to at least some forms of treatment.

b. ☐ The person ***lacks*** the capacity to give or withhold informed consent to any form of medical treatment because ***either*** (1) the person is unable to respond knowingly and intelligently to questions about their medical treatment ***or*** (2) the person is unable to participate in treatment decisions by means of a rational thought process, which means the person cannot understand at least one of the following: (A) the nature and seriousness of any illness, disorder, or defect that they have or may develop; (B) the nature of any medical treatment that is or may be recommended by their health-care providers; (C) the probable degree and duration of any benefits and risks of any medical intervention that is or may be recommended by the person's health-care providers and the consequences of lack of treatment; or (D) the nature, risks, and benefits of any reasonable alternatives.

The person's lack of capacity to give or withhold informed consent is linked to one or more mental function deficits described in Part II.

☐ These conclusions are further explained ☐ below ☐ in Attachment 21b.

c. ☐ I do not have enough information to form an opinion on this issue.

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF (name): ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

22. ☐ **Capacity to give or withhold informed consent to placement in a secured-perimeter residential facility for persons with major neurocognitive disorders** (Probate Code, § 2356.5.)
    a. ☐ The person has a major neurocognitive disorder (such as dementia) as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.* See Part I of this form for more information.
    b. ☐ The person needs or would benefit from placement in a restricted and secure environment for the reasons (for example, wandering, violence, or rejecting care) explained ☐ below ☐ in Attachment 22b.

    c. Based on my assessment of the person's relevant mental functions and abilities, it is my professional opinion that:
        (1) ☐ The person ***has*** the capacity to give or withhold informed consent to this placement.
        (2) ☐ The person ***lacks*** the capacity to give or withhold informed consent to this placement. The mental function deficit or deficits described in Part II significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of giving consent to placement in a restricted, secured-perimeter residential facility.
        ☐ These conclusions are further explained ☐ below ☐ in Attachment 22c.

    d. The proposed placement in a locked or secured-perimeter facility ☐ is ☐ is ***not*** the least restrictive environment appropriate to the person's needs.
    e. ☐ I do not have enough information to form an opinion on this issue.

23. ☐ **Capacity to give or withhold informed consent to administration of medication for treatment of major neurocognitive disorders** (Probate Code, § 2356.5.)
    a. ☐ The person has a major neurocognitive disorder (such as dementia) as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.* See Part I of this form for more information.
    b. ☐ The person needs or would benefit from appropriate medications for the care and treatment of major neurocognitive disorders (including dementia). Any medications and the need or potential benefit of each are described ☐ below ☐ in Attachment 23b.

    c. Based on my assessment of the person's relevant mental functions and abilities, it is my professional opinion that:
        (1) ☐ The person ***has*** the capacity to give or withhold informed consent to the administration of medications appropriate for the care and treatment of major neurocognitive disorders (including dementia).
        (2) ☐ The person ***lacks*** the capacity to give or withhold informed consent to the administration of medications appropriate to the care and treatment of major neurocognitive disorders (including dementia). The mental function deficit or deficits described in Part III significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of giving consent to the administration of medications for the care and treatment of major neurocognitive disorders (including dementia).
        ☐ These conclusions are further explained ☐ below ☐ in Attachment 23c.

    d. ☐ I do not have enough information to form an opinion on this issue.

24. ☐ Other information regarding my assessment of the person's mental functions, any deficits in those functions, and any resulting significant impairments to the person's ability to understand and appreciate the consequences of acts or decisions is given in Attachment 24.

25. Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT NAME)

(SIGNATURE OF DECLARANT)

CONFIDENTIAL

GC-335A

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(name):* ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

EVERYDAY ACTIVITIES ATTACHMENT TO CONFIDENTIAL CAPACITY ASSESSMENT AND DECLARATION—PROBATE CONSERVATORSHIP (FORM GC-335)

This form is for optional use in a probate conservatorship proceeding, in conjunction with *Confidential Clinical Assessment and Declaration—Probate Conservatorship* (form GC-335), to indicate the ability of the person described in item 1 to perform activities of daily living and instrumental activities of daily living.

The person whose abilities are described on this form

1. a. Name:
   b. Address:
   Telephone number: Email address:
   Date of birth:

The person who is completing this form

2. a. Name:
   b. Office address:
   Telephone number: Email address:

3. a. ☐ I am a California-licensed ☐ physician ☐ psychologist ☐ nurse practitioner ☐ physician assistant ☐ registered nurse ☐ clinical social worker ☐ occupational therapist ☐ other licensed professional *(specify profession):*
   b. My license number is:

4. *Check the box or boxes that apply to you.*
   a. ☐ I am the clinician who conducted the assessment of the person named in item 1 documented on the *Confidential Clinical Assessment and Declaration—Probate Conservatorship* (form GC-335) to which this form is attached, and I completed that form. The conclusions and opinions given in this form are based on the same assessment.
   b. ☐ I work or consult with the clinician who completed the *Confidential Clinical Assessment and Declaration—Probate Conservatorship* (form GC-335) to which this form is attached, and I participated in that clinician's assessment of the person named in item 1. The conclusions and opinions in this form are based on my participation in that assessment.
   c. ☐ The conclusions and opinions given in this form are based on the application of my knowledge, experience, and training to my personal observations of the person named in item 1, as described below.

Items 5–11 describe my conclusions about the ability of the person named in item 1 to perform activities in each of the listed categories based on information gathered as described in item 4.

Activities of Daily Living (care of self and related activities)

5. **Maintain adequate hygiene** (for example, bathing, grooming, dressing, caring for teeth, going to the toilet)
   ☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
   Comments ☐ below ☐ in Attachment 5.

Form Approved for Optional Use
Judicial Council of California
GC-335A [New January 1, 2025]

Probate Code, §§ 1800.3, 1801, 1872–1873, 2351, 2351.5, 2450
www.courts.ca.gov

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Activities of Daily Living (care of self and related activities)

6. **Prepare meals and eat for adequate nutrition**
   ☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
   Comments ☐ below ☐ in Attachment 6.

7. **Identify abuse or neglect and protect self from harm**
   ☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
   Comments ☐ below ☐ in Attachment 7.

Instrumental Activities of Daily Living

8. **Financial** *(if appropriate, note dollar limits)*
   a. Protect and spend small amounts of cash
      ☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
      Comments ☐ below ☐ in Attachment 8a.

   b. Manage and use checks; pay monthly bills
      ☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
      Comments ☐ below ☐ in Attachment 8b.

   c. Enter into a contract (including, for example, to buy, sell, or lease real property or to obtain and use a credit card)
      ☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
      Comments ☐ below ☐ in Attachment 8c.

9. **Resist fraud or undue influence** (for example, has a history of being a victim of fraud or undue influence)
   ☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
   Comments ☐ below ☐ in Attachment 9.

10. **Medical**
    a. Choose and direct caregivers
       ☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
       Comments ☐ below ☐ in Attachment 10a.

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10. b. Admit self to health-care facility
☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
Comments ☐ below ☐ in Attachment 10b.

c. Manage own medication (take proper dose as scheduled; refill or renew prescriptions as needed)
☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
Comments ☐ below ☐ in Attachment 10c.

d. Contact help if ill or in an emergency
☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
Comments ☐ below ☐ in Attachment 10d.

11. **Home and community life**

a. Maintain a reasonably safe and clean home or other living environment; arrange for home maintenance or repair
☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
Comments ☐ below ☐ in Attachment 11a.

b. Recognize and avoid common hazards (for example, a hot stove or poisons)
☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
Comments ☐ below ☐ in Attachment 11b.

c. Access transportation (for example, drive a car or use public transportation)
☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
Comments ☐ below ☐ in Attachment 11c.

d. Initiate and follow a schedule of daily activities
☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
Comments ☐ below ☐ in Attachment 11d.

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12. ☐ Other information regarding my assessment of the person's ability to perform activities of daily living or instrumental activities of daily living, including any significant impairments to that ability, is given ☐ below ☐ in Attachment 12.

13. Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

_____ (TYPE OR PRINT NAME)

_____ (SIGNATURE OF DECLARANT)