



Office of the Public Guardian

Sharon Nevins
Director
Public Guardian
TDD – 909.252.4703

Thank you for contacting the Office of the Public Guardian regarding obtaining the services from our office. In order 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 address:

Office of the Public Guardian
ATTN: Probate Investigations Unit
222 West Brookside Avenue
Redlands, CA 92373-4606

It is critical for you to provide the requested information to conduct a thorough investigation. An investigation for a probate conservatorship may 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



GLEND A JACKSON
Chief Public Guardian

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REFERRAL FOR INVESTIGATION FOR PUBLIC PROBATE CONSERVATORSHIP

INSTRUCTIONS

I. FACE SHEET (Page 1)

1. Please fill out 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 signed by the physician, then the referral packet may be returned to the referring party.

County of San Bernardino
Public Guardian – Conservator
222 West Brookside Ave.
Redlands, Ca 92373-4606

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

<u>Name</u>	<u>Relationship</u>	<u>Address</u>	<u>Phone</u>	<u>Age</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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). _____

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

17. _____

18. (Optional) Pertinent personal history. _____

Continue to next page.

CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (Name):	CASE NUMBER:
<input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE	

6. EVALUATION OF (PROPOSED) CONSERVATEE'S MENTAL FUNCTIONS

Note to practitioner: This form is *not* a rating scale. It is intended to assist you in recording your *impressions* of the (proposed) conservatee's mental abilities. Where appropriate, you may refer to scores on standardized rating instruments.

(Instructions for items 6A–6C): Check the appropriate designation as follows: **a** = no apparent impairment; **b** = moderate impairment; **c** = major impairment; **d** = so impaired as to be incapable of being assessed; **e** = I have no opinion.)

A. Alertness and attention

- (1) Levels of arousal (lethargic, responds only to vigorous and persistent stimulation, stupor)
 - a b c d e
- (2) Orientation (types of orientation impaired)
 - a b c d e Person
 - a b c d e Time (day, date, month, season, year)
 - a b c d e Place (address, town, state)
 - a b c d e Situation ("Why am I here?")
- (3) Ability to attend and concentrate (give detailed answers from memory, mental ability required to thread a needle)
 - a b c d e

B. Information processing. Ability to:

- (1) Remember (ability to remember a question before answering; to recall names, relatives, past presidents, and events of the past 24 hours)
 - i. Short-term memory a b c d e
 - ii. Long-term memory a b c d e
 - iii. Immediate recall a b c d e
- (2) Understand and communicate either verbally or otherwise (deficits reflected by inability to comprehend questions, follow instructions, use words correctly, or name objects; use of nonsense words)
 - a b c d e
- (3) Recognize familiar objects and persons (deficits reflected by inability to recognize familiar faces, objects, etc.)
 - a b c d e
- (4) Understand and appreciate quantities (deficits reflected by inability to perform simple calculations)
 - a b c d e
- (5) Reason using abstract concepts. (deficits reflected by inability to grasp abstract aspects of his or her situation or to interpret idiomatic expressions or proverbs)
 - a b c d e
- (6) Plan, organize, and carry out actions (assuming physical ability) in one's own rational self-interest (deficits reflected by inability to break complex tasks down into simple steps and carry them out)
 - a b c d e
- (7) Reason logically.
 - a b c d e

C. Thought disorders

- (1) Severely disorganized thinking (rambling thoughts; nonsensical, incoherent, or nonlinear thinking)
 - a b c d e
- (2) Hallucinations (auditory, visual, olfactory)
 - a b c d e
- (3) Delusions (demonstrably false belief maintained without or against reason or evidence)
 - a b c d e
- (4) Uncontrollable or intrusive thoughts (unwanted compulsive thoughts, compulsive behavior).
 - a b c d e

(Continued on next page)

CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (Name):	CASE NUMBER:
<input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE	

6. (continued)

D. **Ability to modulate mood and affect.** The (proposed) conservatee has does NOT have a pervasive and persistent or recurrent emotional state that appears inappropriate in degree to his or her circumstances. (If so, complete remainder of item 6D.) I have no opinion.

(Instructions for item 6D: Check the degree of impairment of each inappropriate mood state (if any) as follows: a = mildly inappropriate; b = moderately inappropriate; c = severely inappropriate.)

Anger	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Euphoria	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Helplessness	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Anxiety	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Depression	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Apathy	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Fear	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Hopelessness	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Indifference	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Panic	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Despair	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>				

E. The (proposed) conservatee's periods of impairment from the deficits indicated in items 6A–6D

(1) do NOT vary substantially in frequency, severity, or duration.

(2) do vary substantially in frequency, severity, or duration (explain; continue on Attachment 6E if necessary):

F. (Optional) Other information regarding my evaluation of the (proposed) conservatee's mental function (e.g., diagnosis, symptomatology, and other impressions) is stated below stated in Attachment 6F.

ABILITY TO CONSENT TO MEDICAL TREATMENT

7. Based on the information above, it is my opinion that the (proposed) conservatee

a. has the capacity to give informed consent to any form of medical treatment. This opinion is limited to medical consent capacity.

b. lacks the capacity to give informed consent to any form of medical treatment because he or she is **either** (1) unable to respond knowingly and intelligently regarding medical treatment **or** (2) unable to participate in a treatment decision by means of a rational thought process, **or both**. The deficits in the mental functions described in item 6 above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of medical decisions. This opinion is limited to medical consent capacity.

(Declarant must initial here if item 7b applies: _____.)

8. 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)

CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (Name):	CASE NUMBER:
<input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE	

**ATTACHMENT TO FORM GC-335, CAPACITY DECLARATION—CONSERVATORSHIP,
ONLY FOR (PROPOSED) CONSERVATEE WITH DEMENTIA**

9. It is my opinion that the (proposed) conservatee HAS does NOT have dementia as defined in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*.
- a. **Placement of (proposed) conservatee.** (If the (proposed) conservatee requires placement in a secured-perimeter residential care facility for the elderly, please complete items 9a(1)–9a(5).)
- (1) The (proposed) conservatee needs or would benefit from placement in a restricted and secure facility because (state reasons; continue on Attachment 9a(1) if necessary):

 - (2) The (proposed) conservatee's mental function deficits, based on my assessment in item 6 of form GC-335, include (describe; continue on Attachment 9a(2) if necessary):

 - (3) The (proposed) conservatee HAS capacity to give informed consent to this placement.
 - (4) The (proposed) conservatee does NOT have capacity to give informed consent to this placement. The deficits in mental function assessed in item 6 of form GC-335 and described in item 9a(2) above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of his or her actions with regard to giving informed consent to placement in a restricted and secure environment.
 - (5) A locked or secured-perimeter facility is is NOT the least restrictive environment appropriate to the needs of the (proposed) conservatee.
- b. **Administration of dementia medications.** (If the (proposed) conservatee requires administration of psychotropic medications appropriate to the care of dementia, please complete items 9b(1)–9b(5).)
- (1) The (proposed) conservatee needs or would benefit from the following psychotropic medications appropriate to the care of dementia, for the reasons stated in item 9b(5) (list medications; continue on Attachment 9b(1) if necessary):

 - (2) The (proposed) conservatee's mental function deficits, based on my assessment in item 6 of form GC-335, include (describe; continue on Attachment 9b(2) if necessary):

 - (3) The (proposed) conservatee HAS capacity to give informed consent to the administration of psychotropic medications appropriate to the care of dementia.
 - (4) The (proposed) conservatee does NOT have the capacity to give informed consent to the administration of psychotropic medications appropriate to the care of dementia. The deficits in mental function assessed in item 6 of form GC-335 and described in item 9b(2) above significantly impair the (proposed) conservatee's ability to understand and appreciate his or her actions with regard to giving informed consent to the administration of psychotropic medications for the treatment of dementia.
 - (5) The (proposed) conservatee needs or would benefit from the administration of the psychotropic medications listed in item 9b(1) because (state reasons; continue on Attachment 9b(5) if necessary):

10. 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)