COUNTY OF GLENN
OFFICE OF
PUBLIC ADMINISTRATOR — PUBLIC GUARDIAN
~~421 WEST SYCAMORE STREET~~ P.O. BOX 366
WILLOWS, CALIFORNIA 95988
(530) 934-6453 · FAX (530) 934-6482

REFERRAL PACKET

REQUEST FOR INVESTIGATION

OF

A PUBLIC PROBATE CONSERVATORSHIP

REFERRAL PACKET
REQUEST FOR INVESTIGATION OF
A PUBLIC PROBATE CONSERVATORSHIP

CONTENTS

BEFORE FILLING OUT THE APPLICATION FOR INVESTIGATION OF A PUBLIC PROBATE CONSERVATORSHIP, PLEASE READ THE FOLLOWING INFORMATION:

LEGAL CRITERIA: An individual who is unable to properly provide for his/her food, clothing, shelter or physical health (conservatorship of the person) and/or substantially unable to manage financial resources or resist fraud or undue influence (conservatorship of the estate). The individual's capacity must be measured and confirmed by the attending physician.

GUIDING MANDATES: (1) A conservatorship is not an emergency response instrument. It requires approximately 6 - 8 weeks from the beginning of an investigation to an actual court date. Additionally, legislation decrees that a conservatorship be the "last resort" and "all alternatives to a conservatorship first be explored"; and (2) A conservatorship is not a preventative measure. The individual must meet the criteria at the time the referral is made.

I. FACTORS WHICH GENERALLY FAVOR A 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.

Examples:

1. 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;

2. Severe memory loss resulting in the individual's being unable to discern whether his/her needs have been met (e.g. payment for housing, meals, clothing, medications, etc.); and

3. Inability to choose a responsible individual to act on his/her behalf.

B. A primary physical diagnosis (which might also affect mental functioning, e.g., stroke, Alzheimers' Disease, etc.) OR a primary physically disabling disease with a secondary mental impairment which does not require mental health treatment.

C. No family member or friend able to provide care or act as conservator.

II. FACTORS WHICH GENERALLY DISCOURAGE A 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. Continual resistance or ability to resist 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 provide medical consent or to pay bills;

F. Individual is "on the streets." The Public Guardian cannot conduct an investigation unless the individual is in some type of placement (e.g., hospital, home, facility, etc.).

GLENN COUNTY PUBLIC GUARDIAN'S OFFICE
REFERRAL FOR INVESTIGATION OF A PROBATE CONSERVATORSHIP
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INSTRUCTIONS

A. PERSONAL DATA

1. 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.

B. INCOME/EXPENSES & ESTATE PLANNING

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

2. In Items 18 and 19, please indicate whether or not these have been pre-paid.

C. MEDICAL INFORMATION

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. Be specific and use examples.

DECLARATION OF INCAPACITY

1. The 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.

   The Declaration of Incapacity is a legal requirement and must be filled out and signed by the attending physician. IMPORTANT: If the Declaration of Incapacity is not filled out completely and signed by the physician, the referral packet will be returned to the referring party.

PUBLIC GUARDIAN, COUNTY OF GLENN
P.O. BOX 366
WILLOWS, CA 95988
(530) 934-6453

REFERRAL FOR INVESTIGATION OF PROBATE CONSERVATORSHIP

A. PERSONAL DATA

1. **NAME:**_____ **AKA'S**_____

2. **MARTIAL STATUS (S M D W) SPOUSE'S NAME/ADDRESS**_____

_____

3. **BIRTHDATE**_____ **BIRTHPLACE**_____

4. **HEIGHT** (approx.) feet _____ inches_____ **WEIGHT** (approx.)_____

5. **CURRENT ADDRESS/PHONE:**_____

   hospital__ nursing home__ board/care__ home___other_____

6. **SOCIAL SECURITY #**_____ **MEDI-CAL #**_____

7. **MEDICARE #**_____ **CITIZEN:** yes__ no__ Alien #_____

8. **VETERANS STATUS:** yes__ no__ Branch_____ Service #_____

   Dates of Service_____

9. **RELATIVES AND INTERESTED PARTIES:**

Name	Relationship	Address	Phone	Age

10. **PERTINENT PERSONAL HISTORY;**_____

10. **PERTINENT PERSONAL HISTORY;**_____

_____

_____

_____

_____

_____

B. INCOME/EXPENSES & ESTATE PLANNING

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 and address of Company_____
10. **WHERE IS THE INCOME MAILED?**_____

    _____

11. **REAL PROPERTY**: (Address & value)_____

_____

12. **MOBILE HOME**: (Address & value)_____

_____

13. **VEHICLES**: (Description/value/location)_____

_____

14. **PERSONAL PROPERTY**: yes___ no___ DESCRIPTION & LOCATION_____

_____

15. **INSURANCE POLICIES**: yes___ no___ COMPANY & TYPE_____

_____

16. **MONTHLY EXPENSES & AMOUNTS (IF KNOWN)**:_____

_____

17. **BURIAL PLANS**: yes___ no___ ARRANGEMENTS:_____

_____

18. **BURIAL PLOT OR CRYPT**: yes___ no___ LOCATION:_____

_____

19. **WILL** yes___ no___ LOCATION:_____

20. **DURABLE POWER OF ATTORNEY FOR FINANCIAL MANAGEMENT:** yes___ no___

FINANCIAL AGENT:_____

ADDRESS/PHONE #:_____

21. **ATTORNEY'S NAME, ADDRESS & PHONE**_____

_____

C. MEDICAL INFORMATION

IT IS IMPORTANT FOR OUR EVALUATION TO INCLUDE THE FOLLOWING INFORMATION. ALL REFERRALS MUST ADDRESS EACH AREA AND BE COMPLETE. SKILLED NURSING FACILITIES AND HOSPITAL STAFF SHOULD BE ABLE TO ADDRESS ALL AREAS.

1. **PHYSICIAN'S NAME & ADDRESS:**_____

_____

2. **DIAGNOSIS/ES:**_____

_____

3. **DURABLE POWER OF ATTORNEY FOR HEALTH CARE:** yes___ no___

HEALTH CARE AGENT:_____

ADDRESS/PHONE #:_____

4. **PRESCRIPTION MEDICATIONS** (do not list "over the counter" meds)_____

_____

_____

5. **IS INDIVIDUAL IN A COMA OR HAVE A TERMINAL CONDITION?**_____

6. **LIFE-SUSTAINING DEVICES USED:**_____

7. **ORIENTATION TO PERSON, PLACE, AND TIME (Be specific):**_____

_____

8. **INDIVIDUAL'S KNOWLEDGE OF MEDICAL CONDITION AND MEDICATION:**_____

_____

9. **IF INDIVIDUAL IS IN PAIN, TO WHAT DEGREE?**_____

_____

10. **SOCIAL & COMMUNICATION ABILITIES:**_____

_____

11. **ABILITY TO MAKE NEEDS KNOWN:**_____

_____

12. **ABILITY TO FOLLOW INSTRUCTIONS:**_____

_____

13. **GROOMING & EATING ABILITIES:**_____

_____

14. **BLADDER & BOWEL CONTROL & FREQUENCY:**_____

_____

15. MOBILITY & AIDES USED: _____

_____

16. ABILITY TO TRANSFER FROM BED TO WHEELCHAIR (IF APPROPRIATE): _____

_____

17. ABILITY TO COOPERATE WITH TREATMENT AND/OR ASSISTANCE (Be specific):

_____

_____

18. WHO SECURED CURRENT PLACEMENT? _____

_____

19. PRIOR ADDRESS (IF CURRENTLY IN ACUTE HOSPITAL): _____

_____

20. DOES INDIVIDUAL HAVE ANY PAST OR CURRENT HISTORY OF VIOLENCE, VERBAL OR PHYSICAL AGGRESSION OR ACTING OUT BEHAVIORS? IF SO, DESCRIBE IN DETAIL. _____

_____

_____

21. PERTINENT PERSONAL HISTORY: _____

_____

_____

_____

_____

_____

22. CHECK ALL AREAS OF NEED THAT ARE NOT CURRENTLY BEING MET.

Food___ Clothing___ Shelter___ Health___ Finances___

23. DESCRIBE THE PRECIPITATING EVENT(S) THAT LED TO THIS REFERRAL.

_____

_____

_____

24. **LEVEL OF CARE NEEDED:** _____

_____

_____

_____

25. **SERVICES PROVIDED TO REFEREE BY ALL AGENCIES, FAMILY, FRIENDS, ETC, WITHIN PAST YEAR TO MAINTAIN WITHOUT CONSERVATORSHIP:**

_____

Service provider/address

_____

Contact person/Phone #

_____

Service provided

_____

Dates of service

_____

Service provider/address

_____

Contact person/Phone #

_____

Service provided

_____

Dates of service

_____

Service provider/address

_____

Contact person/Phone #

_____

Service provided

_____

Dates of service

_____

Service provider/address

_____

Contact person/Phone #

_____

Service provided

Dates of service

Service provider/address

Contact person/Phone #

Service provided

Dates of service

Service provider/address

Contact person/Phone #

Service provided

Dates of service

26.DATE REFEREE FIRST KNOWN TO REFERRING AGENCY:

DATE

PRINTED NAME OF REFERRING PARTY **PRINTED TITLE**

SIGNATURE OF REFERRING PARTY **PRINTED NAME OF AGENCY**

MAILING ADDRESS AND PHONE NUMBER OF REFERRING PARTY

GC-335

ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, State Bar number, and address)*:	FOR COURT USE ONLY
TELEPHONE NO.: FAX NO. *(Optional)*: E-MAIL ADDRESS *(Optional)*: ATTORNEY FOR *(Name)*:	
SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name)*: ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	
CAPACITY DECLARATION—CONSERVATORSHIP	CASE NUMBER

TO PHYSICIAN, PSYCHOLOGIST, OR RELIGIOUS HEALING PRACTITIONER

The purpose of this form is to enable the court to determine whether the (proposed) conservatee *(check all that apply)*:

A. ☐ is able to attend a court hearing to determine whether a conservator should be appointed to care for him or her. The court hearing is set for *(date)*: ☐. *(Complete item 5, sign, and file page 1 of this form.)*

B. ☐ has the capacity to give informed consent to medical treatment. *(Complete items 6 through 8, sign page 3, and file pages 1 through 3 of this form.)*

C. ☐ has dementia and, if so, (1) whether he or she needs to be placed in a secured-perimeter residential care facility for the elderly, and (2) whether he or she needs or would benefit from dementia medications. *(Complete items 6 and 8 of this form and form GC-335A; sign and attach form GC-335A. File pages 1 through 3 of this form and form GC-335A.)*

(If more than one item is checked above, sign the last applicable page of this form or form GC-335A if item C is checked. File page 1 through the last applicable page of this form; also file form GC-335A if item C is checked.)

COMPLETE ITEMS 1–4 OF THIS FORM IN ALL CASES.

GENERAL INFORMATION

1. *(Name)*:
2. *(Office address and telephone number)*:

3. I am
   a. ☐ a California licensed ☐ physician ☐ psychologist acting within the scope of my licensure ☐ with at least two years' experience in diagnosing dementia.
   b. ☐ an accredited practitioner of a religion whose tenets and practices call for reliance on prayer alone for healing, which religion is adhered to by the (proposed) conservatee. The (proposed) conservatee is under my treatment. *(Religious practitioner may make the determination under item 5 ONLY.)*
4. (Proposed) conservatee *(name)*:
   a. I last saw the (proposed) conservatee on *(date)*:
   b. The (proposed) conservatee ☐ is ☐ is NOT a patient under my continuing treatment.

ABILITY TO ATTEND COURT HEARING

5. A court hearing on the petition for appointment of a conservator is set for the date indicated in item A above. *(Complete a or b.)*
   a. ☐ The proposed conservatee is able to attend the court hearing.
   b. ☐ Because of medical inability, the proposed conservatee is NOT able to attend the court hearing *(check all items below that apply)*
      (1) ☐ on the date set *(see date in box in item A above)*.
      (2) ☐ for the foreseeable future.
      (3) ☐ until *(date)*:
      (4) **Supporting facts** *(State facts in the space below or check this box ☐ and state the facts in Attachment 5)*:

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)

Form Adopted for Mandatory Use
Judicial Council of California
GC-335 [Rev. January 1, 2004]

Probate Code, §§ 811, 813, 1801, 1825, 1881, 1910, 2356.5

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

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 ☐ PERSON ☐ ESTATE OF *(Name)*: ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

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 ☐	b ☐	c ☐	Euphoria	a ☐	b ☐	c ☐	Helplessness	a ☐	b ☐	c ☐
Anxiety	a ☐	b ☐	c ☐	Depression	a ☐	b ☐	c ☐	Apathy	a ☐	b ☐	c ☐
Fear	a ☐	b ☐	c ☐	Hopelessness	a ☐	b ☐	c ☐	Indifference	a ☐	b ☐	c ☐
Panic	a ☐	b ☐	c ☐	Despair	a ☐	b ☐	c ☐				

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 ☐ PERSON ☐ ESTATE OF *(Name)*: ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

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)

Form Adopted for Mandatory Use
Judicial Council of California
GC–335A [New January 1, 2004]

DEMENTIA ATTACHMENT TO CAPACITY DECLARATION—CONSERVATORSHIP

Probate Code, § 2356.5

REPRESENTATIVE PAYEE PROGRAM POLICY

1. The Glenn County Representative Payee Program has been established to assist those persons who don't qualify for conservatorship, but have over a period of time consistently demonstrated they have a need for assistance in their budgeting.

2. Referrals usually received from Social Security, Social Services and Mental Health.

3. Preference is given to prior conservatees in order to keep them off of conservatorship.

4. Upon receipt of referral, investigation will be conducted to see if referral is appropriate.

5. Attempts will be made by the Glenn County Representative Payee to locate a competent, willing, and able family member or friend to act as Representative Payee and acceptable to Social Security.

6. Upon approval for the Program by the Glenn County Representative Payee:

    a. Client Income and Expense Summary/Financial Statement will be completed.
    b. Representative Payee Agreement will be signed by client and Payee.

7. If the client has a need for a change to the approved budget, the "Request/ Authorization for Change to Budget" must be complete and submitted by the 25th of the month to be effected the following month.

REPRESENTATIVE PAYEE PROGRAM REFERRAL REQUIREMENTS

In order to process a referral to the Glenn County Representative Payee Program, the following information is required from the referring agency:

1. Proposed client's:

    a. Name
    b. Physical address
    c. Mailing address if different
    d. Social Security Number
    e. Medi-Cal Number
    f. Date of Birth
    g. Diagnoses
    h. Physician's name
    i. Psychiatrist's name
    j. Social Worker's name
    k. Mental Health Counselor's name
    l. Marital status

2. Copies of proposed client's:

    a. Social Security card
    b. Medi-Cal card
    c. Birth Certificate

3. Names, addresses, and phone numbers of all known family members and/or friends;

4. How long has proposed client been known to referring agency?

5. How has proposed client demonstrated inability to handle his own financial affairs?

6. Name of referring agency; and

7. Signature of referring person.

REPRESENTATIVE PAYEE REFERRAL

PROPOSED CLIENT: _____
SS #: _____
Medi-Cal #: _____
Medicare #: _____
VA #: _____
Date of Birth: _____
Marital Status: _____
If married, spouse's address: _____
_____
Driver's License/I.D.#: _____
Address: _____
_____
_____
Phone #: _____

REFERRAL: The proposed client was referred by:

___ Social Security
___ Mental Health Services
___ Other_____

CONTACTS: (Social Worker, Case Manager, family, friends)

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Current Diagnoses:

_____
_____

Finances:

The proposed client presently receives:

$_____ SSI per month $_____Other

$_____ SS per month

Assets: _____ Vehicle
_____ Home
_____ Other_____

Debts: _____
_____
_____
_____

Please bring in copies of Social Security card, Medicare/Medi-Cal cards, birth certificate, current bills.

_____ _____
Signature / Referring Agency Date

SOCIAL SECURITY ADMINISTRATION | TOE 250 | Form Approved OMB No. 0960-0024

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U. S C § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). *Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd Baltimore, MD 21235-6401.*

In replying, use this address
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Including Area Code)
( ) -

DATE

SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER
- -

Privacy Act Statement

Sections 205(a) and 205(j), of the Social Security Act, as amended, authorize us to collect this information. The information is needed to make a determination regarding whether or not the named individual should be paid benefits directly or whether benefits should be paid to a representative payee. The information you furnish on this form is voluntary. However, failure to provide all or part of the information could prevent an accurate and timely decision on the proper payee for benefit receipt purposes.

We rarely use the information you supply for any purpose other than for making a determination on a claim. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to: (1) to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veteran Affairs), (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, state, and local level; and (4) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded and administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Record Notices 60-0089 and 60-0222. The notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER - -	PATIENT'S DATE OF BIRTH	

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. Please Note: This determination affects how benefits are paid and has no bearing on disability determinations; SSA will NOT pay for this information. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER - -	PATIENT'S DATE OF BIRTH	

1 Date you last examined the patient _____

2 Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest?

By capable we mean that the patient:

- Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
- Is able, in spite of physical impairments, to manage funds or direct others how to manage them

☐ Yes	☐ No	☐ Unsure
If "Yes", please omit question 3, but be sure to sign and date the form.	If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.	If "unsure", please explain.

3 Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

☐ Yes ☐ No

If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER (Please print.)	TITLE
ADDRESS (Number and street, City, State, and ZIP Code)	TELEPHONE NUMBER *(Include Area Code)* ( ) -

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PHYSICIAN/ MEDICAL OFFICER	DATE