



COUNTY OF GLENN  
OFFICE OF  
**PUBLIC ADMINISTRATOR — PUBLIC GUARDIAN**

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**REFERRAL PACKET**

**REQUEST FOR INVESTIGATION**

**OF**

**A PUBLIC PROBATE CONSERVATORSHIP**

REFERRAL PACKET  
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A PUBLIC PROBATE CONSERVATORSHIP

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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.

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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