# Financial Incapability and Referral to the Public Trustee

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VGH/UBCH Joint Staff M+M Rounds

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# Financial Capacity Assessment

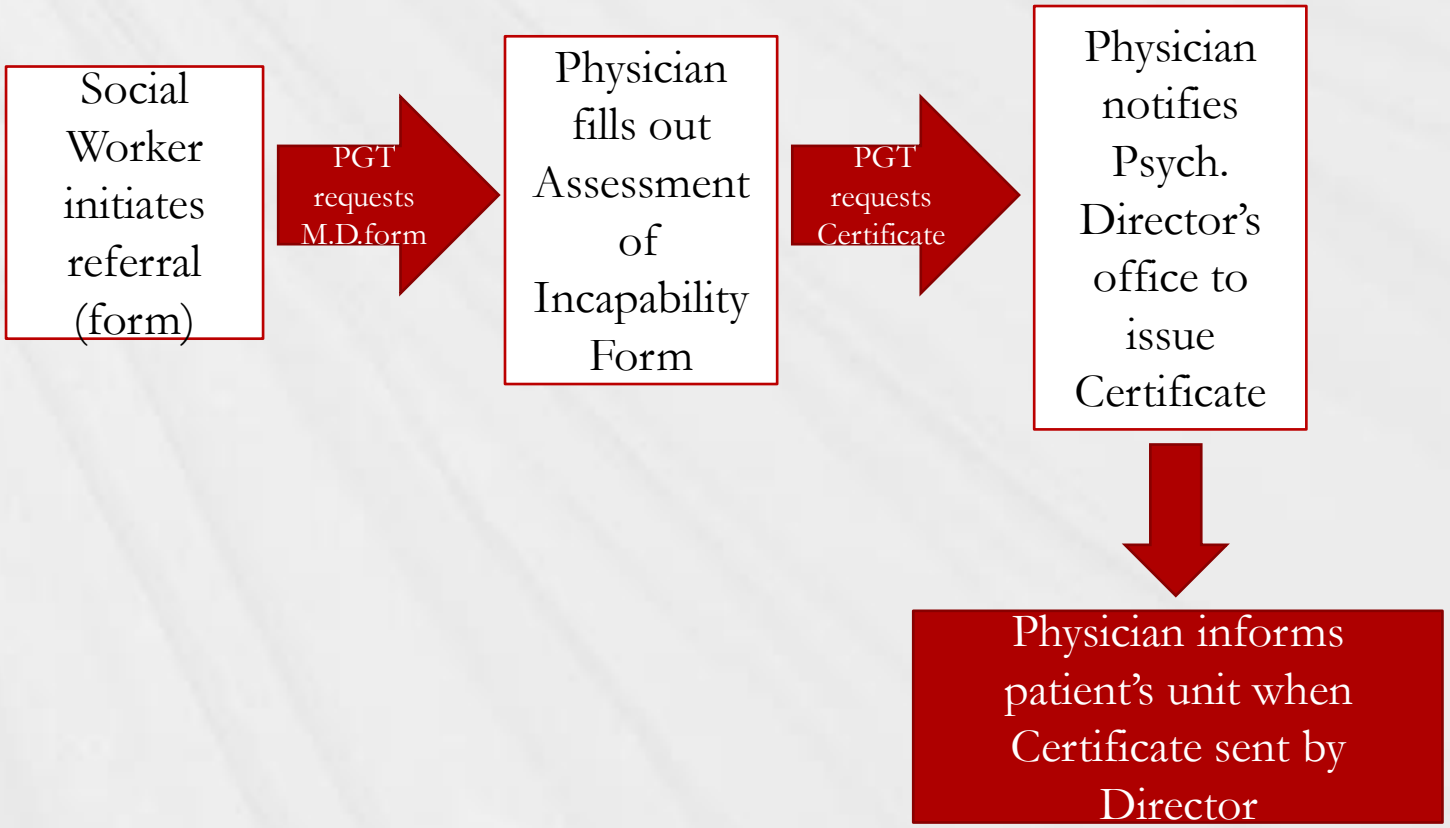
- Domains
  - Cognitive
  - Functional
  - Judgement

# Financial Management

- Once deemed INCAPABLE:
  - Activation of POA (general or bank)
  - Activation of Representation Agreement
  - Public Trustee Referral
  - Income Security Programs Pension Trusteeship
    - Designated individual ("trustee") such as next-of-kin
    - St. James Community Services Society (if no one else)
  - Committeeship for Finances--Private
  - Do Nothing

# Steps to Refer to Public Guardian and Trustee (PGT) for Finances

- This process only applies to Joint A+A VH psychiatric staff
- PGT should inform Physician and/or Director of Psychiatry **in writing** when requesting AI form or Certificate



PUBLIC GUARDIAN AND TRUSTEE OF BRITISH COLUMBIA

# PHYSICIAN OPINION OF INCAPABILITY UNDER THE *PATIENTS PROPERTY ACT*

The information on this form is collected under the authority of the *Public Guardian and Trustee Act*. Information collected may be used fo the purpose of authorizing the Public Guardian and Trustee to act as Committee of Estate through Certificate or Court Order under the *Patients Property Act*. If you have any questions about the collection and use of this information, please contact Assessment and Investigation Services (AIS).

**Directions to the Physician:**

This assessment is to be performed by a general practitioner or psychiatrist. It is designed to obtain informatio on whether there is a mental disability that affects the adult's ability to make decisions. If you need more spac for answers, attach additional sheets and/or a copy of your assessment report. Upon completion you may sen a copy to the adult, as well as AIS at the PGT.

## 1. Adult's Personal Information

Name of the adult being assessed:

Last Name First Name Initial

| | |
|---|---|
| Date of Birth:<br>Month Day Year | For approximately how long have you been treating the adult? |
| When did you last examine the adult?<br>Date: | Where did the last examination take place?<br>Place: |
| Do you anticipate seeing the adult again?<br>☐ Yes<br>☐ No | If Yes, when will you next see the adult? |

## 2. Mental Status

Mental status evaluation to be based on a direct examination of the adult:

Was the Folstein's Mini Mental Status Examination given?
☐ Yes Adult's Score ____/3 0
☐ No

If a MMS was not conducted, what other tests or questions were asked of the adult regarding ability to manage financial and legal affairs (and/or person if applicable) and what responses did the adult give. Attach additional sheets if needed.

Was the adult able to follow simple directions / instructions:
☐ Yes
☐ No

Was the adult oriented to time and place?
- ☐ Yes
- ☐ No

How would you describe the adult's short term memory?

### 3. Mental Health Status (adapted from the LTC1)

| Attitude | Self-Direction | Affect | Thought Content |
|---|---|---|---|
| ☐ Cooperative | ☐ Independent | ☐ Appropriate | ☐ Normal |
| ☐ Indifferent | ☐ Needs motivation | ☐ Anxious | ☐ Delusions |
| ☐ Resistive | ☐ Needs direction | ☐ Euphoric | ☐ Persecutory |
| ☐ Demanding | ☐ Dependent | ☐ Labile | ☐ Guilt |
| ☐ Suspicious | | ☐ Angry | ☐ Obsessions |
| ☐ Hostile | | ☐ History of mood swings | ☐ Phobias |
| | | ☐ Blunted | ☐ Preoccupation |
| | | ☐ Depressed | ☐ Other |
| | | ☐ Inappropriate | ☐ Not able to assess |
| | | ☐ Other | |

| Perceptions | Cognition | Insight | Judgement | Other |
|---|---|---|---|---|
| ☐ Normal | ☐ Normal | ☐ Good | ☐ Good | ☐ |
| ☐ Hallucinations | ☐ Impairment | ☐ Partial | ☐ Adequate | ☐ |
| ☐ Auditory | ☐ Mild | ☐ None | ☐ Poor | ☐ |
| ☐ Visual | ☐ Moderate | | | |
| ☐ Other | ☐ Severe | | | |

### 4. Communication Skills

Comment on responsiveness, vocabulary loss etc.:

### 5. Medical and Psychiatric Diagnoses

Medical Diagnoses:

Psychiatric History:

| Psychiatric Diagnoses: |
|---|
| Prognosis: |

**6. Functional Status**

| | | |
|---|---|---|
| Is the adult able to perform simple financial transactions? | ☐ Yes | ☐ No |
| Is the adult aware of the nature and extent of his/her finances? | ☐ Yes | ☐ No |
| Is the adult able to do his or her own banking? | ☐ Yes | ☐ No |
| Is the adult able to do his or her own shopping? | ☐ Yes | ☐ No |
| Is the adult able to carry out other activities of daily living? | ☐ Yes | ☐ No |

If no, please provide examples of activities the adult cannot carry out.

**7. Statement of Opinion of Capability to Manage Legal or Financial Affairs**

**In your opinion** (check one):

☐ The adult is **capable** of managing his or her own financial or legal affairs, **or**

☐ The adult has a mental disorder / disability that renders him / her **incapable** of making decisions regarding financial or legal affairs, **or**

☐ I am unable to provide an opinion based on available information and recommend further assessment.

| Prognosis: Is the adult's ability to manage his or her affairs likely to improve? |
|---|
| Other Comments: |

**8. Notification**

(Note: a copy of this form may be shared with the adult)

Has the adult been notified of this assessment?

☐ Yes

☐ No

If no, why not?

**If the adult has been assessed as incapable of managing financial and legal affairs, please complete the following:**

In your opinion would it be injurious to the health of the adult to serve him or her with copies of all the documents relating to the application to appoint a Committee?

☐ Yes
☐ No

If yes, please provide an explanation.

Name of Physician (please print)

Dr. _____
Last Name First Name Initial

Signature: _____

Date: _____

Telephone Number: _____ Fax Number: _____

Return this form to:

**Greater Vancouver Region**
700-808 West Hastings St.
Vancouver, BC V6C 3L3
Tel: (604) 775-1007
Fax : (604) 660-9498

*Vancouver, North Shore, Richmond, Delta, Sunshine Coast*

**Lower Mainland Region**
700-808 West Hastings St.
Vancouver, BC V6C 3L3
Tel: (604) 775-1001
Fax: (604) 660-9479

*Burnaby, Tri-Cities, North Fraser and Fraser Valley*

**Vancouver Island Region**
1019 Wharf St., 4th floor
Victoria, BC V8W 9J2
Tel: (250) 356-8160
Fax: (250) 356-7442

*Vancouver Island, Powell River and Gulf Islands*

**Interior-North Region**
1345 St. Paul St.
Kelowna, BC V1Y 2E2
Tel: (250) 712-7576
Fax: (250) 712-7578

*Interior and Northern BC, east and north of Hope*

**Enquiry BC Toll Free Number: 1-800-663-7867**

Vancouver Health
Promoting wellness. Ensuring care.

Vancouver Acute
Department of Psychiatry
Health Centre, 4th Floor East
715 West 12th Avenue
Vancouver, BC V5Z 1M9
Tel: 604 875-4023
Fax: 604 875-4987

re:
Adult Abuse & Neglect - Response Resource

Public Guardian and Trustee
700-808 West Hastings Street
Vancouver BC V6C 3L3

**PROVINCE OF BRITISH COLUMBIA**
**CERTIFICATE OF INCAPABILITY**
*Issued Pursuant to Section 1(a) of the*
*Patients Property Act R.S.B.C. 1996, Chapter 349*

**Date** _____

**Patient Name** _____

**Date of Birth** _____

I have reviewed the assessment(s) performed on this patient and hereby declare the above-named to be incapable of managing his/her financial and legal affairs, due to mental infirmity arising from disease, age, or otherwise.

The effect of this issuance of this Certificate is that the Public Guardian and Trustee for the Province of British Columbia is the Committee of the Estate of the above-named patient, pursuant to Section 6(3) of the *Patients Property Act* R.S.B.C., 1996, Chapter 349.

_____
**Dr. Soma Ganesan**
Delegated Director for the purposes of the *Patients Property Act* for Psychiatric Units at GF Strong Centre, UBC Hospital and Vancouver General Hospital.

cc: Re:Act Response Resource A419 – 231 East 15th Street North Vancouver, BC V5L 2L7

1. Attending Psychiatrist forwards to Delegated Director
2. Delegated Director signs and returns original to originating sources – location (i.e. Unit): _____
3. Original to be forwarded to Public Guardian and Trustee, cc: Re:ACT Response Resource

Human Resources Development Canada
Income Security Programs

Développement des ressources humaines Canada
Programmes de la sécurité du revenu

OAS/CPP



# Certificate of Incapability

## Information about the Old Age Security and/or Canada Pension Plan beneficiary

Social Insurance Number ___ ___ ___

☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss — Usual First Name and Initial — Last Name

Address - No., Street, Apt., P.O. Box, R.R. and City

Province or Territory

Country - If other than Canada

Postal Code ___ ___

***Please note that, to be considered incapable of managing his/her own affairs, a person must be suffering from severe mental impairment caused by a mental or a physical illness.***

## Does the person named above have:

| | | Comments |
|---|---|---|
| 1. Good general knowledge of what is happening to his/her money or investments? | ☐ Yes ☐ No | |
| 2. Sufficient understanding of the concept of time, in order to pay bills promptly? | ☐ Yes ☐ No | |
| 3. Sufficient memory to keep track of financial transactions and decisions? | ☐ Yes ☐ No | |
| 4. Ability to balance accounts and bills? | ☐ Yes ☐ No | |
| 5. Significant impairment of judgement due to altered intellectual function? | ☐ Yes ☐ No | |

**In addition:**

6A. How long have you known this person?

6B. Please state this person's age

7. Do you consider this person capable of managing his/her own affairs? ☐ Yes ☐ No

If no, when is improvement expected? (Provide date)

8. Diagnosis of impairment

Date impairment started — Year Month Day

9. Comments

**Name and signature of professional completing this form**

First Name and Initial — Last Name

Signature

Date

Address - No., Street, Apt., P.O. Box, R.R. and City

Province or Territory

Telephone ( ) ___ - ___

Country

Postal Code ___ ___

Profession

**FOR OFFICE USE ONLY**

| Approval | Reason for disapproval | Reassessment Date | Signature | Date |
|---|---|---|---|---|
| ☐ Yes ☐ No | | | | |