PROBATE COURT / GUARDIANSHIP REFERRAL FORM

TEXAS ESTATES CODE SECTION 1102.003 INFORMATION LETTER
COURT'S INITIATION OF GUARDIANSHIP PROCEEDINGS

Date:_____

Person Allegedly Requiring A Guardian (Proposed Ward)

Name:_____

Date of Birth:_____ Social Security: XXX-XX_____**(last 4 digits only)**

Address_____

_____

Phone:_____Fax:_____Cell:_____

Type of Residence: Please check type, if facility, provide the name.

_____Facility (Name:_____)

_____Private Residence _____Other

1. State why you believe the person requires a guardian. What new event(s) precipitated this referral? What least restrictive alternatives to guardianship have been attempted?
   Please include a description of any incidences you have witnessed and dates on which they occurred. If necessary, please continue on back of this page or attach additional pages.

   _____
   _____
   _____
   _____
   _____

2. The nature and degree of the person's incapacity is as follows:

   _____
   _____
   _____
   _____
   _____

Please answer the following to the best of your knowledge by circling the appropriate response:

3. This person **does/does not** have a guardian in Texas.
4. This person **is/is not** a resident of Denton County.
5. This person **has/has not** executed a power of attorney. If yes, provide the following:

   Name:_____

   Relationship to Proposed Ward:_____

   Address:_____

   Phone:_____Cell:_____

6. Please list all known family members of the proposed ward:

Name/Address	***Phone/Work/Cell***	***Relationship***

1. Please list all known friends, clergy, third parties affiliated with the proposed ward:

Name/Address	***Phone/Work/Cell***	***Relationship***

2. Describe any property of the person and provided its estimated value:

	Assets	***Value***
Real Property		
Bank Accounts		
Automobiles		
Stocks & Bonds		
Other		

9. Identify the source and amount of any monthly income:

Source	***Income***

10. Is this person in imminent danger of serious impairment to his/her physical health or safety unless immediate action is taken? **No/Yes** If yes, please explain:

_____

_____

_____

_____

_____

11. Is this person in imminent danger of having his/her estate seriously damaged or dissipated unless immediate action is taken? **No/Yes** If yes, please explain:

_____

_____

_____

_____

_____

12. Have you contacted the Texas Department of Family and Protective Services APS Division? **No/Yes** If yes, please provide the following:

    Name and number of case worker: _____

    Date contact made: _____

    Complaint number: _____

13. Please give any other information that you think may be relevant or helpful to the Court in its investigation of this matter. (This can include, and not limited to the names of physicians, financial managers and caregivers.)

    _____

    _____

    _____

14. The referring party will also need to submit the attached Physician's Certificate of Medical Examination form along with the 1102.003 Information Letter. An Information Letter that is received without a Physician's Certificate of Medical Examination (CME) may cause a delay in the Court having the ability to take any further action.

REFERRAL SOURCE (Person completing and submitting this section 1102.003 Information Letter to the Court) Please note that this is **not** an Application for Guardianship. If you or a family member are seeking guardianship please retain an attorney to file an application.

Name:_____

Title or relationship to the proposed ward:_____

Address:_____

Phone:_____Fax:_____Cell:_____

E-mail Address:_____

This information is true and correct to the best of my knowledge.

_____

Signature Date

RETURN THIS FORM, THE ATTACHED CME AND ANY RELATED DOCUMENTS TO:

Court Investigator
Denton County Probate Court
1450 E. McKinney
Denton, Texas 76209-4524
(940) 349-2148
FAX: (940) 349-2141

Physician's Certificate of Medical Examination

Revision September 2015

In the Matter of the Guardianship of
_____,
an Alleged Incapacitated Person

For Court Use Only
Court Assigned:_____

To the Physician

This form is to enable the Court to determine whether the individual identified above is incapacitated according to the legal definition (on page 3), and whether that person should have a guardian appointed.

1. General Information

Physician's Name _____ Phone: (_____)_____
Office Address _____
_____

☐ YES ☐ NO I am a physician currently licensed to practice in the State of Texas.

Proposed Ward's Name _____
Date of Birth _____ Age_____ Gender ☐ M ☐ F
Proposed Ward's Current Residence: _____

I last examined the Proposed Ward on _____, 20_____ at:
☐ a Medical facility ☐ the Proposed Ward's residence ☐ Other: _____

☐ YES ☐ NO The Proposed Ward is under my continuing treatment.
☐ YES ☐ NO Before the examination, I informed the Proposed Ward that communications with me would not be privileged.
☐ YES ☐ NO A mini-mental status exam was given. If "YES," please attach a copy.

2. Evaluation of the Proposed Ward's Physical Condition

Physical Diagnosis: _____
a. Severity: ☐ Mild ☐ Moderate ☐ Severe
b. Prognosis: _____
c. Treatment/Medical History: _____

3. Evaluation of the Proposed Ward's Mental Functioning

Mental Diagnosis: _____
a. Severity: ☐ Mild ☐ Moderate ☐ Severe
b. Prognosis: _____
c. Treatment/Medical History: _____

If the mental diagnosis includes dementia, answer the following:
☐ YES ☐ NO-----It would be in the Proposed Ward's best interest to be placed in a secured facility for the elderly or a secured nursing facility that specializes in the care and treatment of people with dementia.
☐ YES ☐ NO-----It would be in the Proposed Ward's best interest to be administered medications appropriate for the care and treatment of dementia.
☐ YES ☐ NO-----The Proposed Ward currently has sufficient capacity to give informed consent to the administration of dementia medications.

d. Possibility for Improvement:
☐ YES ☐ NO-----Is **improvement in the Proposed Ward's physical condition and mental functioning possible?**
If "YES," after what period should the Proposed Ward be reevaluated to determine whether a guardianship continues to be necessary? _____

4. Cognitive Deficits

a. The Proposed Ward is oriented to the following (check all that apply):
☐ Person ☐ Time ☐ Place ☐ Situation

b. The Proposed Ward has a deficit in the following areas (check all areas in which Proposed Ward has a deficit):
☐ ---Short-term memory
☐ ---Long-term memory
☐ ---Immediate recall
☐ ---Understanding and communicating (verbally or otherwise)
☐ ---Recognizing familiar objects and persons
☐ ---Solve problems
☐ ---Reasoning logically
☐ ---Grasping abstract aspects of his or her situation
☐ ---Interpreting idiomatic expressions or proverbs
☐ ---Breaking down complex tasks down into simple steps and carrying them out

c. ☐ YES ☐ NO --The Proposed Ward's periods of impairment from the deficits indicated above (if any) vary substantially in frequency, severity, or duration.

5. Ability to Make Responsible Decisions

Is the Proposed Ward able to initiate and make responsible decisions concerning himself or herself regarding the following:

☐ YES ☐ NO-----Make complex business, managerial, and financial decisions
☐ YES ☐ NO-----Manage a personal bank account
If "YES," should amount deposited in any such bank account be limited? ☐ YES ☐ NO
☐ YES ☐ NO-----Safely operate a motor vehicle
☐ YES ☐ NO-----Vote in a public election
☐ YES ☐ NO-----Make decisions regarding marriage
☐ YES ☐ NO-----Determine the Proposed Ward's own residence
☐ YES ☐ NO-----Administer own medications on a daily basis
☐ YES ☐ NO-----Attend to basic activities of daily living (ADLs) (e.g., bathing, grooming, dressing, walking, toileting) without supports and services
☐ YES ☐ NO-----Attend to basic activities of daily living (ADLs) (e.g., bathing, grooming, dressing, walking, toileting) with supports and services
☐ YES ☐ NO-----Attend to instrumental activities of daily living (e.g., shopping, cooking, traveling, cleaning)
☐ YES ☐ NO-----Consent to medical and dental treatment at this point going forward
☐ YES ☐ NO-----Consent to psychological and psychiatric treatment at this point going forward

6. Developmental Disability

☐ YES ☐ NO-----Does the Proposed Ward have developmental disability?
If "NO," skip to number 7 below.
If "YES," answer the following question and look at the next page.

Is the disability a result of the following? (Check all that apply)

☐ YES ☐ NO-----Intellectual Disability?
☐ YES ☐ NO-----Autism?
☐ YES ☐ NO-----Static Encephalopathy?
☐ YES ☐ NO-----Cerebral Palsy?
☐ YES ☐ NO-----Down Syndrome?
☐ YES ☐ NO-----Other? Please explain _____

Answer the questions in the "Determination of Intellectual Disability" box below only if both of the following are true:

(1) The basis of a proposed ward's alleged incapacity is intellectual disability.
And

(2) **You are making a "Determination of Intellectual Disability" <u>in accordance with rules of the executive commissioner of the Health and Human Services Commission governing examinations of that kind</u>**.

If you are not making such a determination, please skip to number 7 below.

<u>"DETERMINATION OF INTELLECTUAL DISABILITY"</u>

Among other requirements, a Determination of Intellectual Disability must be based on an interview with the Proposed Ward and on a professional assessment that includes the following:

1) a measure of the Proposed Ward's intellectual functioning;
2) a determination of the Proposed Ward's adaptive behavior level; and
3) evidence of origination during the Proposed Ward's developmental period.

As a physician, you may use a previous assessment, social history, or relevant record from a school district, another physician, a psychologist, an authorized provider, a public agency, or a private agency if you determine that the previous assessment, social history, or record is valid.

1. Check the appropriate statement below. If neither statement is true, skip to number 7 below.
   - ☐ **I examined the proposed ward in accordance with rules of the executive commissioner of the Health and Human Services Commission governing Intellectual Disability examinations**, and my written findings and recommendations include a determination of an intellectual disability.
   - ☐ **I am updating or endorsing in writing a prior determination of an intellectual disability** for the proposed ward made in accordance with rules of the executive commissioner of the Health and Human Services Commission by a physician or psychologist licensed in this state or an authorized provider certified by the Department of Aging and Disability Services to perform the examination.
2. What is your assessment of the Proposed Ward's level of intellectual functioning and adaptive behavior?
   ☐ Mild (IQ of 50-55 to approx. 70) ☐ Moderate (IQ of 35-40 to 50-55)
   ☐ Severe (IQ of 20-25 to 35-40) ☐ Profound (IQ below 20-25)
3. ☐ Yes ☐ No---- Is there evidence that the intellectual disability originated during the Proposed Ward's developmental period?

Note to attorneys: *If the above box is filled out because a determination of intellectual disability has been made in accordance with rules of the executive commissioner of the Health and Human Services Commission governing examinations of that kind, a Court may grant a guardianship application if (1) the examination is made not earlier than 24 months before the date of the hearing or (2) a prior determination of an intellectual disability was updated or endorsed in writing not earlier than 24 months before the hearing date. If a physician's diagnosis of intellectual disability is <u>not</u> made in accordance with rules of the executive commissioner — and the above box is not filled out — the court may grant a guardianship application only if the Physician's Certificate of Medical Examination is based on an examination the physician performed within 120 days of the date the application for guardianship was filed. See Texas Estates Code § 1101.104(1).*

7. <u>Definition of Incapacity</u>

For purposes of this certificate of medical examination, the following definition of incapacity applies:

An "**Incapacitated Person**" is an adult who, because of a physical or mental condition, is substantially unable to: (a) provide food, clothing, or shelter for himself or herself; (b) care for the person's own physical health; or (c) manage the person's own financial affairs. Texas Estates Code § 1002.017.

8. <u>Evaluation of Capacity</u>

☐ YES ☐ NO-----Based upon my last examination and observations of the Proposed Ward, it is my opinion that the Proposed Ward is incapacitated **according to the legal definition in section 1002.017 of the Texas Estates Code, set out in the box above.**

If you indicated that the Proposed Ward is incapacitated, indicate the level of incapacity:

☐ **Total** ----------The Proposed Ward is totally without capacity (1) to care for himself or herself and (2) to manage his or her property.

☐ **Partial**----------The Proposed Ward lacks the capacity to do some, but not all, of the tasks necessary to care for himself or herself or to manage his or her property.

Evaluation of Capacity (continued)

If you indicated the Proposed Ward's incapacity is partial, what specific powers or duties of the guardian should be limited if the Proposed Ward receives supports and services? _____

_____

_____

If you answered "NO" to all of the questions regarding decision-making in Section 5 (on page 2) and yet still believe the Proposed Ward is **partially** incapacitated, please explain: _____

_____

_____

If you answered "YES" to any of the questions regarding decision-making in Section 5 (on page 2) and yet still believe the Proposed Ward is **totally** incapacitated, please explain: _____

_____

_____

9. Ability to Attend Court Hearing

☐ YES ☐ NO -----The Proposed Ward would be able to attend, understand, and participate in the hearing.

☐ YES ☐ NO -----Because of the Proposed Ward's incapacities, I recommend that the Proposed Ward not appear at a Court hearing.

☐ YES ☐ NO -----Does any current medication taken by the Proposed Ward affect the demeanor of the Proposed Ward or his or her ability to participate fully in a court proceeding?

10. What is the least restrictive placement that you consider is appropriate for the Proposed Ward:

☐ ----------Nursing home level of care ☐--- Assisted Living Facility

☐ ----------Group Home ☐--- Memory care unit

☐ ----------Own Home or with family ☐--- Other _____

11. Additional Information of Benefit to the Court: If you have additional information concerning the Proposed Ward that you believe the Court should be aware of or other concerns about the Proposed Ward that are not included above, please explain on an additional page.

_____ _____

Physician's Signature Date

_____ _____

Physician's Name Printed License Number

Revised September 2015