County of San Diego Public Guardian
Request for Conservatorship Investigation

Print Form

Name:	AKA's:		
Home Address:			
Telehone Number:			
Current Address:			
Date Admitted:	Telephone:	Contact Person:	
Birth Date:	SSN	Birth Place:	
Marital Status:	Spouse/Last Spouse:	Place of Death:	

Military Information for Proposed Conservatee/Spouse

Name:	Claim/ Serial #:	Branch/ Rank:	Dates of Service:

Please provide copies of any supporting documents (i.e. Bank Statements, Income Statements)

Monthly Income:

SSA:	SSI:	VA:
Civil Service:	Military Pension:	Pension:
Annuity Payments:	Other:	Amount:
Trust Yes/No	POA/DPOA:	

Total Monthly Expenses:

Mortgage Payment Amount:	Insurance Premium:	Utilities
Care Bills	Other Expenses	

Assets: Check all that apply

☐ House	☐ Automobile(s)	☐ Mobile Home	☐ Jewelry	☐ Furniture	☐ Life Insurance Policy	☐ Bonds
☐ Oil Leases	☐ Notes Receivable	Who:				
☐ Stock(s)/Securities	Company/Broker:					
☐ Bank Account(s)						
Name:			Balance:			
Account #:						
Name:			Balance:			
Account #						
Name:			Balance:			
Account #:						
☐ Rental(s)	☐ Other	List:				

Please provide copies of any supporting documents

Assessment (Please mark only htose areas that assistance is needed):

☐ Walking	☐ Cooking	☐ Personal Care	☐ Shopping	☐ Housekeeping	☐ Transferring	☐ Laundry	☐ Eating
☐ Paying Bills	☐ Resist Undue Influence	Other Needs:					

Other information (check all that apply):

☐ Uses Walker/ Cane	☐ Incontinent	☐ Smokes	☐ Wanders	☐ Has animal(s)	☐ Uses hearing aids	☐ Homeless	☐ Under LPS
Care Provider Name:				Phone Number			
Other Information:							

List below the Names, Addresses and Telephone Numbers of relatives and friends of the Proposed Conservatee:	
Name:	Relationship:
Address	Telephone #
Name:	Relationship:
Address	Telephone #
Name:	Relationship:
Address	Telephone #
List below the Names, Addresses and Telephone Numbers of other key contact persons:	
Name:	Relationship:
Address	Telephone #
Name:	Relationship:
Address	Telephone #
Name:	Relationship:
Address	Telephone #

Please list diagnosis and other ailments:		
Please list all medications that are currently prescribed:		
Doctor's Name	Phone:	Medical Insurance:

Please give the concerns as to why a conservatorship by the Public Guardian is needed:
How long have you been acquainted with the person this referral is regarding?

Date Completed:	Name & Title:

Agency Name & Relationship:	Agency Telephone
Agency Address:	

AFFIDAVIT IN SUPPORT OF REQUEST FOR INVESTIGATION

PLEASE NOTE: THIS AFFIDAVIT MUST BE COMPLETED IN FULL AND WILL BE USED OR ATTACHED TO THE PUBLIC GUARDIAN'S CONFIDENTIAL SUPPLEMENTAL INFORMATION FORM SUBMITTED TO THE COURT. USE ADDITIONAL PAGES, IF NECESSARY.

1) ESTATE REFERRALS: STATE BELOW THE SPECIFIC INDICATIONS OF THE PROPOSED CONSERVATEE'S SUBSTANTIAL INABILITY TO MANAGE HIS/HER OWN FINANCIAL RESOURCES OR RESIST FRAUD OR UNDUE INFLUENCE. ALSO, PLEASE DESCRIBE ANY VARIATIONS FROM PRIOR SPENDING PATTERNS.:

2) PERSON REFERRALS: STATE BELOW THE SPECIFIC FACTS SUPPORTING YOUR ALLEGATION THAT THE PROPOSED CONSERVATEE IS UNABLE TO PROVIDE PROPERLY FOR HIS/HER OWN NEEDS FOR PHYSICAL HEALTH, FOOD, CLOTHING AND SHELTER. PLEASE PROVIDE SPECIFIC EXAMPLES FROM THE PROPOSED CONSERVATEE'S DAILY LIFE SHOWING SIGNIFICANT HEALTH PATTERNS.

3) ABILITY TO GIVE INFORMED MEDICAL CONSENT: IF YOU ARE REQUESTING A DETERMINATION THAT THERE IS NO FORM OF MEDICAL TREATMENT FOR WHICH THE PROPOSED CONSERVATEE HAS THE CAPACITY TO GIVE AN INFORMED CONSENT, STATE BELOW WHY YOU ALLEGE THAT THE PROPOSED CONSERVATEE IS UNABLE TO UNDERSTAND THE FOLLOWING ITEMS:

a) NATURE AND SERIOUSNESS OF ANY ILLNESS, DISORDER, OR DEFECT THAT HE/SHE HAS OR MAY DEVELOP

b) NATURE OF ANY MEDICAL TREATMENT THAT IS BEING OR MAY BE RECOMMENDED BY HEALTH CARE PROVIDERS:

c) PROBABLE DEGREE AND DURATION OF ANY BENEFITS/RISKS OF ANY MEDICAL INTERVENTION AND THE RISKS OF LACK OF TREATMENT:

4) CAPACITY:DESCRIBE ANY DEFICITS THE PROPOSED CONSERVATEE MAY HAVE IN THE FOLLOWING MENTAL FUNCTIONS:

a) LEVEL OF CONSCIOUSNESS:

b) ORIENTATION AS TO TIME, PERSON, PLACE OR SITUATION:

c) ABILITY TO ATTEND AND CONCENTRATE:

d) SHORT AND LONG TERM MEMORY:

e) ABILITY TO UNDERSTAND OR COMMUNICATE WITH OTHERS, VERBALLY OTHERWISE:

f) RECOGNITION OF FAMILIAR OBJECTS AND FAMILIAR PERSONS:

g) ABILITY TO UNDERSTAND AND APPRECIATE QUANTITIES:

h) ABILITY TO REASON USING ABSTRACT CONCEPTS:

i) ABILITY TO PLAN, ORGANIZE, AND CARRY OUT ACTIONS IN ONE'S OWN RATIONAL SELF INTEREST:

j) ABILITY TO REASON LOGICALLY:

k) ABILITY TO MODULATE MOOD AND AFFECT:

5) DESCRIBE THE FREQUENCY, SEVERITY AND DURATION OF THE PERIODS OF IMPAIRMENT (IF ANY) OF THE FOLLOWING:

a) SEVERELY DISORGANIZED THINKING:

b) HALLUCINATIONS:

c) DELUSIONS:

d) UNCONTROLLABLE, REPETITIVE OR INTRUSIVE THOUGHTS:

6) STATE BELOW THE REASON(S) THE ALTERNATIVES TO CONSERVATORSHIP ARE UNSUITABLE OR UNAVAILABLE TO THE PROPOSED CONSERVATEE:

a) VOLUNTARY ACCEPTANCE OF INFORMAL OR FORMAL ASSISTANCE:

b) SPECIFIC POWER OF ATTORNEY:

c) GENERAL POWER OF ATTORNEY:

d) DURABLE POWER OF ATTORNEY FOR HEALTH CARE:

e) TRUST:

f) OTHER ALTERNATIVES CONSIDERED (SPECIFY AND GIVE REASON EACH IS UNSUITABLE OR UNAVAILABLE:

g) HOMEMAKER SERVICES:

h) WAS A REP. PAYEE REFERRAL MADE?:

i) WAS LPS CONSERVATORSHIP MADE?

7) STATE BELOW WHETHER SERVICES DESCRIBED WERE PROVIDED TO THE PROPOSED CONSERVATEE WITHIN THE LAST YEAR. IF YOU HAVE NO KNOWLEDGE IF THE STATE SERVICES WERE PROVIDED, PLEASE STATE.

a) HEALTH SERVICES	☐ WERE PROVIDED	☐ WERE NOT PROVIDED	EXPLAIN
b) SOCIAL SERVICES	☐ WERE PROVIDED	☐ WERE NOT PROVIDED	EXPLAIN
c) ESTATE MANAGEMENT SERVICES	☐ WERE PROVIDED	☐ WERE NOT PROVIDED	EXPLAIN

STATE BELOW THE PROPOSED CONSERVATEE'S ABILITY TO LIVE IN OR RETURN TO THEIR RESIDENCE HOME:

I DECLARE UNDER THE PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

EXECUTED AT,		CALIFORNIA ON		NAME:	