BRITISH COLUMBIA | Ministry of Health

ASSESSMENT OF FINANCIAL INCAPABILITY FUNCTIONAL COMPONENT AGA PART 2.1

This form assists the qualified health care provider (QHCP) in completing the AGA Report of Assessment of Incapability (Form 1) and Details of Assessment attachment, and is submitted to the health authority designate (HAD) along with all collateral information as part of the package for making a determination regarding the issuing of a Certificate of Incapability; this form is not attached to the AGA Report of Assessment of Incapability or Details of Assessment.

The information on this form is collected under the authority of the Adult Guardianship Act and Statutory Property Guardianship Regulation. Information collected may be used for the purpose of authorizing the Public Guardian and Trustee (PGT) to act as Statutory Property Guardian under Part 2.1 of the Adult Guardianship Act. If you have any questions about the collection and use of this information, please contact the PGT.

PART ONE: OVERVIEW

Adult's Last Name	Adult's First Name	Date of Birth (YYYY / MM / DD)	Personal Health Number (PHN)

Type of Assessment under the Certificate of Incapability Process

☐ Initial Assessment ☐ Second Assessment ☐ Reassessment

Reason for Assessment / Presenting Problem Relating to Concerns About Financial Management (including any concerns about vulnerability to abuse, time sensitivities, e.g. PGT protective measures in place.)

Past Medical / Psychiatric History

Current Medical / Psychiatric Diagnosis and Prognosis from Medical Component of Assessment

Attached ☐ Yes ☐ No

Date of Most Recent Medical / Psychiatric Exam (YYYY / MM / DD)

Additional Comments

PART ONE: OVERVIEW continued

Birthplace	Education
Spirituality	Occupation

Languages

Living Situation

☐ Alone ☐ Spouse ☐ Family ☐ Other (specify)

☐ Home ☐ Group ☐ Assisted Living ☐ Care Facility ☐ Other (specify)

Living Conditions (describe the adult's living environment including any safety issues or other concerns)

Involved Health and Social Service Professionals (list if not included in PGT summary of investigation) (List QHCPs on page 3)

Name	Title	Phone Number

Community Supports (e.g. relatives, friends, spiritual affiliation, community group membership, etc.)

Name of Contact	Relationship	Phone Number

PART TWO: COLLATERAL SOURCES AND PREVIOUS COLLATERAL TEST RESULTS

The purpose of this section is to record the contact information for any person (family, friends, neighbours, service providers, support people, etc.) specific to this assessment of incapability that you as QHCP have contacted to obtain information about the adult's ability to manage their financial affairs. The detailed information should be recorded in the summary of observations/findings and in the work table found in Part Four of this form. Collateral information is information collected by the QHCP in addition to that provided in the PGT Summary of Investigation to compare for consistency with information provided by the adult.

Name	Relationship / Role	Frequency of Contact With Adult	Phone Number

Assessment Tools and Results from Collateral Sources
(Mini Mental State Examination (MMSE), Montreal Cognitive Assessment (MOCA), Geriatric Depression Scale (GDS), InterRAI Assessment Instrument (RAI), Other - repeat full information for each tool used)

Tool	Date (YYYY / MM / DD)	Conducted By
Result(s) / Comments		
Tool	Date (YYYY / MM / DD)	Conducted By
Result(s) / Comments		
Tool	Date (YYYY / MM / DD)	Conducted By
Result(s) / Comments		

Assessment Without Adult

Was either component of the assessment completed solely on the basis of observational or collateral information?

Medical Component: ☐ Yes ☐ No If Yes, state reason: _____

Functional Component: ☐ Yes ☐ No If Yes, state reason: _____

PART THREE: FUNCTIONAL COMPONENT INTERVIEWS AND DETAILED CLINCIAL IMPRESSION

Date(s) and Location(s) of Interview(s)

Communication Aides

Name of Support Person in Attendance	Phone Number

Name of Interpreter	Phone Number

Other Qualified Health Care Professionals Involved in the Functional Component

Name	Role	Phone Number

Notifications

Section 6 of the Statutory Property Guardianship Regulation requires that before conducting the medical or functional component of the assessment that the adult be advised of all of the following (see the only exceptions below):

- ☐ that the adult is being assessed to determine whether the adult is incapable of managing that adult's financial affairs;
- ☐ that the assessment may be used to determine whether the adult will have or continue to have, a statutory property guardian;
- ☐ that the adult can refuse to be assessed, in which case the assessment may be conducted using observational information and information gathered from other sources;
- ☐ that the adult may have a person of his or her choosing present during all or part of the assessment unless, in the opinion of the qualified health care provider, the person's presence would disrupt or in any way adversely affect the assessment process;
- ☐ that if the assessment is completed, the adult may have a copy of the assessment report from the person who completes the report (Note: this refers to Form 1 in the Regulation + a summary of the assessment. This does not refer to this form).
- ☐ that the adult may ask questions of, and raise concerns with, the qualified health care provider with respect to the assessment and the results of the assessment.

EXCEPTIONS – If you did not advise the adult of all of the above, was it because:

- ☐ you have reason to believe it may result in serious physical or mental harm to the adult, OR
- ☐ you have reason to believe it may result in significant damage or loss to the adult's property.

Functioning (describe the adult's functional ability)

Mobility	
ADLs (Activities of Daily Living) [1]	
IADLs (Instrumental Activities of Daily Living) [2]	

PART THREE: FUNCTIONAL COMPONENT INTERVIEWS AND DETAILED CLINCIAL IMPRESSION continued	
Assessment Information	**Adult's Report / Collateral Details / Notes / Concerns**
Income (employment, benefits, business, pension, other) Please identify your source of income	
Regular Bills Can they explain the meaning and purpose of bills: Please identify the amounts owed on your bills Please explain how to question the amount on a bill Please explain the consequences of unpaid bills	
Debts Please identify all debts held	
Assets Please identify all of your valuables	
Business and Investments Please identify any business and investment holdings	
Obligations to Dependents Please identify your responsibilities to your dependents	
Assistance in Managing Finances Please describe any assistance you receive with managing your finances (family, accountant, lawyer, trustee, other)	
POA, Representation Agreement, Trusteeship, or Committee Which of these do you have in place (if any)?	
Will/Estate Planning Do you have a will or have you done any other type of estate planning for what happens to your assets when you die?	

PART THREE: FUNCTIONAL COMPONENT INTERVIEWS AND DETAILED CLINCIAL IMPRESSION continued	
Taxes Do you know who does your taxes?	
Bank Account(s) What are some of the ways you spent money during this month?	
Credit Card Do you have a credit card? How do you make payments?	
Mode of Transportation for Banking How do you do your banking/get to your bank?	
Use of Cheques How do you manage your finances? (daily/ weekly/monthly)?	
Use of Debit Card How do you manage your finances? (daily/ weekly/monthly)?	
Ever Run Out of Money for Food/Shelter How do you pay for food, rent/mortgage (cash, cheque, debit, credit card)?	
Carry Money in their Wallet How do you pay for things (cash, cheque, debit, credit card)?	
Do Any People in the Adult's Life Ask for Money Does anyone in your life regularly ask you for money? (if so who)	

PART THREE: FUNCTIONAL COMPONENT INTERVIEWS AND DETAILED CLINCIAL IMPRESSION continued

Assessment Tools Used and Results by QHCP during this assessment to evaluate the adult's financial decision making incapability
(Mini Mental State Examination (MMSE), Montreal Cognitive Assessment (MOCA), Geriatric Depression Scale (GDS), InterRAI Assessment Instrument (RAI), Other - repeat full information for each tool used)

Tool	Date (YYYY / MM / DD)	Conducted By
Result(s) / Comments		

Tool	Date (YYYY / MM / DD)	Conducted By
Result(s) / Comments		

Tool	Date (YYYY / MM / DD)	Conducted By
Result(s) / Comments		

Financial Functional Tests / Screen(s) Used and Results by QHCP during this assessment to evaluate the the adult's financial decision making ability
(e.g. writing a cheque, interpreting a bill, calculating and making change)

Test	Date (YYYY / MM / DD)	Conducted By
Result(s) / Comments		

Use this space to record details such as: Is there evidence of problems with managing finances? Are there historical changes in the adult's pattern of financial management? Is there risk taking in managing finances and if so steps are being taken to mitigate risk? Does the adult realize that the financial issues discussed apply to them?

PART FOUR: DETERMINATION – ASSESSMENT OF INCAPABILITY

Under Section 9 of the Statutory Property Guardianship Regulation, an adult is incapable of managing the adult's financial affairs if, in the opinion of a qualified health care provider, any of the following apply.

Test of Incapability – tick and comment on any that apply	**Details**
☐ the adult cannot understand the nature of the adult's financial affairs, including the approximate value of the adult's business and property, and the obligations owed to the adult's dependents, if any	
☐ the adult cannot understand the decisions that must be made or and actions that must be taken for the reasonable management of the adult's financial affairs	
☐ the adult cannot understand the risks and benefits of making or failing to make particular decisions or taking or failing to take particular actions respecting their financial affairs	
☐ the adult cannot understand that the information referred to above applies to the adult	
☐ the adult cannot demonstrate that he or she is able to implement, or direct others to implement, the decisions or actions referred to in b) above	
Applicable to Second and Reassement only ☐ If this functional component of assessment is for second or reassessment purposes, please indicate what has changed with respect to the adult's diagnosis/prognosis and functioning since the last functional component (if available).	

PART FOUR: DETERMINATION – ASSESSMENT OF INCAPABILITY continued

Determination

- ☐ The adult is capable of making decisions about his or her financial affairs
- ☐ The adult is incapable of making decisions about his or her financial affairs
- ☐ I am unable to provide an opinion based on available information and recommend further assessment

Assessment Report (required by Section 10(a) and (b) of the Statutory Property Guardianship Regulation)

I have:

- ☐ completed the AGA Report of Assessment of Incapability and Details of Assessment (Form 1)
- ☐ attached the Details of Assessment to the AGA Report of Assessment of Incapability and Details of Assessment (Form 1), which includes:
  a) the factors that were considered in making the determination of incapability and
  b) the conclusions that were reached on the basis of those factors
  c) a summary of the information, if any, gathered based on observational information
  d) any other matter the qualified health care provider believes to be relevant to the assessment

Adult Advised of Results

Advising the adult of the details and results of the assessment and offering a copy of the AGA Report of Assessment of Incapability (Form 1) and Details of Assessment is required by Sections 10 (c) and (d) of the Regulation unless the QHCP has reason to believe that providing the information may results in serious physical or mental harm to the adult or significant damage or loss to the adult's property.

I have:

- ☐ advised the adult of details and results of the assessment, including the determination of the adult's capability or incapability
- ☐ offered the adult a copy of the Form 1 report and the attached details

I have not advised the adult of the details of and results of the assessment because:

- ☐ I have reason to believe it may result in serious physical or mental harm to the adult OR
- ☐ I have reason to believe it may result in significant damage or loss to the adult's property

Name of Support Person Providing Notification	Date of Notification (YYYY / MM / DD)

Method of Notification

CERTIFICATION

I certify that I am a Qualified Health Care Provider under Part 2.1 of the AGA.

Position	Health Authority (if applicable)

Professional Designation

- ☐ Physician
- ☐ Registered Social Worker
- ☐ Registered Nurse
- ☐ Registered Psychiatric Nurse
- ☐ Registered Psychologist
- ☐ Registered Occupational Therapist
- ☐ Nurse Practitioner

Signature

Print Name

Date Signed (YYYY / MM / DD)

COMMENTS AND ADDITIONAL NOTES

PRINT

CLEAR FORM