



HEALTH AUTHORITY DESIGNATE INFORMATION PACKAGE COVER SHEET FOR CERTIFICATE OF INCAPABILITY AGA PART 2.1

The purpose of this cover sheet is to provide the health authority designate with contact information and with a list of all the necessary documents for review in considering whether to issue a Certificate of Incapability or for review for Acceptance of Determination of Capability.

1. ABOUT THE ADULT

Form section 1 containing fields for Last Name, First Name, Middle Name, Maiden Name, Alias, Gender, Date of Birth, Personal Health Number, Current Location, Address of Current Location, and Name of Hospital or Facility.

2. PURPOSE OF REVIEW AND REQUIRED DOCUMENTS

Form section 2 containing checkboxes for 'Whether to issue a Certificate of Incapability' and 'Acceptance of Determination of Capability', with radio buttons for 'Second Assessment' or 'Reassessment'.

Table with 3 columns: Documents Attached, Yes, No. Rows include PGT Summary of Investigation, Medical Component of Assessment, Functional Component of Assessment, Form 1 with Details of Assessment attached, Health Authority Designate Checklist, and Previous Assessment(s) Medical/Functional Forms with Form 1 and Details Attached.

3. URGENCY: IMPORTANT DATES

Table with 3 columns: Specify Commitment, Date (YYYY / MM / DD), Comments. Rows include PGT Protective Measures Expire, Pending Eviction, Pending Foreclosure, and Other - Specify.

4. KEY CONTACTS FOR NOTIFICATION

Table with 4 columns: Name, Relationship, Mailing Address/Contact Information, Telephone. Row description: Spouse and/or Near Relative(s) (adult children, parents, adult siblings, grandparents or any other adult related by birth or adoption).

**5. KEY CONTACTS FOR NOTIFICATIONS: SPECIAL INSTRUCTIONS**

Have any previous notifications to the adult been waived due to serious physical or mental harm or significant damage or loss to the adult's property?  
Please explain.

Please list any spouse or near relatives who were purposefully **not** notified throughout the process, and the reason(s).

If known, what is the best way for HAD to notify the adult?

**6. ADULT'S INVOLVED CLINICAL, AND AGENCY/OTHER SUPPORTS**

Name and Role	Agency	Mailing Address/Contact Information	Telephone
1) Health Authority Staff Involved in Consultation with PGT			
2) Family Physician			
3) Medical Component of Assessment – Physician			
4) Functional Component of Assessment QHCP			
5) Form 1 – Report of Assessment of Incapability QHCP Other			
6) Other Community Supports			

**7. COVER SHEET AND HAD PACKAGE INFORMATION**

Cover Sheet and HAD Package Initiated By		Date (YYYY / MM / DD)
Position	Agency	
Address		
Phone	Fax	Email