BRITISH COLUMBIA | Ministry of Health

DETAILS OF ASSESSMENT
AGA PART 2.1

TO:

Name of Adult	Date (YYYY / MM / DD)
Address	

Purpose of Assessement

- ☐ Assessment under Section 32 of the *Adult Guardianship Act*
- ☐ Second Assessment under Section 33 of the *Adult Guardianship Act*
- ☐ Reassessment under Section 34 of the *Adult Guardianship Act*

I was asked to conduct an assessment due to the following difficulties you are having with managing your financial affairs:

As a result of these concerns, you were assessed to determine whether you are incapable of managing your financial affairs. The assessment included a medical component and a functional component.

I am writing to give you the results of this assessment. I am required to complete the attached assessment report (Form 1) and provide you with the following additional details:

- The factors that were considered in making my determination
- The conclusions that were reached on the basis of those factors
- A summary of any information gathered if the assessment was conducted without your participation
- Any other matter I believe is relevant.

The purpose of this letter is to provide you with a summary of the additional details listed above.

MEDICAL COMPONENT OF THE ASSESSMENT

Doctor Who Conducted the Medical Component of the Assessment	Date of Assessment (YYYY / MM / DD)

The doctor named above considered whether you have any diagnoses and prognoses that may contribute to your incapability to manage your financial affairs and whether your ability to manage your financial affairs is likely to improve. The doctor concluded that:

FUNCTIONAL COMPONENT OF THE ASSESSMENT

Qualified Health Care Provider(s) Who Conducted the Functional Component of the Assessment	Date of Assessment (YYYY / MM / DD)

The Qualified Health Care Provider(s) named above conducted the functional component of the assessment. As part of this process, information was obtained about how you are managing your financial affairs. The following is a summary of the clinical impression of your ability to manage your financial affairs and the information considered.

ADDITIONAL RELEVANT INFORMATION ***(attach a separate sheet if needed)***

In making the determination on page 4, the following information and factors were considered.

DETERMINATION

Based on the assessment information I obtained and reviewed, I considered whether any of the following criteria apply to your situation. The law says that if **any** of the following apply to your situation, I am required to determine that you are incapable of managing your financial affairs. It is my determination that those ticked apply to your situation:

- ☐ You cannot understand the nature of your financial affairs, including the approximate value of your business and property and the obligations you owe to your dependents
- ☐ You cannot understand the decisions that need to be made or actions that must be taken to reasonably manage your financial affairs
- ☐ You cannot understand the risks and benefits of making or not making particular decisions or taking or not taking particular actions
- ☐ You cannot understand that the information referred to above applies to you
- ☐ You cannot demonstrate that you are able to implement or direct others to implement the decisions necessary to manage your financial affairs

I have determined that you are:

- ☐ Capable of managing your financial affairs
- ☐ Incapable of managing your financial affairs

I will be providing this information to the person or people listed below.

Depending on the purpose of the assessment (initial, second or reassessment), the information will be used to:

- ☐ Consider whether or not to issue or continue with an existing certificate of incapability resulting in the Public Guardian and Trustee of BC being your statutory property guardian to manage your financial affairs
- ☐ Consider whether or not to accept the determination of capability resulting in the Public Guardian and Trustee of BC transfering the control of your finances back to you.

Name of Health Authority Designate Receiving Information		
Name of Regional Consultant at the Public Guardian and Trustee Receiving Information		
If you have any questions or concerns please contact me.		
Signature of Qualified Health Care Provider	Name of Qualified Health Care Provider	
	Address	
Date Signed (YYYY / MM / DD)	Phone	Fax

- ☐ cc: Regional Consultant at the Public Guardian and Trustee of BC
- ☐ cc: Spouse and/or Near Relatives
- ☐ cc: _____