BRITISH COLUMBIA | Ministry of Health

HEALTH AUTHORITY DESIGNATE NOTICE OF INTENTION TO ISSUE A CERTIFICATE OF INCAPABILITY

AGA PART 2.1

TO: _____

Name of Recipient (adult, spouse or near relative)

_____

Address, Postal Code

RE: _____ _____

Name of Adult (Last Name, First Name) *Date of Birth (Month/Day/Year e.g., Apr 3, 1982)*

REASONS

This is my notice that I intend to issue a certificate of incapability for the adult listed above. My reasons for this decision are considering all of the following:

- The adult needs to make decisions about their financial affairs
- The adult is incapable of making these decisions
- The adult needs and will benefit from the assistance and protection of the Public Guardian and Trustee
- The needs of the adult would not be sufficiently met by alternative means of assistance
- The adult has not granted power over their financial affairs to an attorney under an enduring power of attorney, or their attorney is not complying with their duties under the *Power of Attorney Act*

If a certificate of incapability is issued, the Public Guardian and Trustee of BC will become statutory property guardian for the adult and may make decisions respecting his/her financial affairs.

OPPORTUNITY TO RESPOND

If you wish to respond to this notice, for example, by correcting or providing information to be taken into consideration before a final decision to issue a certificate of incapability is made, please send a response to or contact me on or before the response date listed below.

_____

Response Date (Month/Day/Year e.g., Apr 3, 1982)

Signature of Health Authority Designate	Name of Health Authority Designate	
	Address	
Date Signed (Month/Day/Year e.g., Apr 3, 1982)	Phone	Fax

Save Print Clear Form