

GUARDIANSHIP CAPACITY QUESTIONNAIRE

There is no need to complete this questionnaire if the respondent is in a coma, persistent vegetative state, or is not responsive.

The questionnaire is designed to help all parties in an incompetency proceeding gather information that will assist the Clerk of Court in determining what if any rights, powers and privileges the respondent can retain under guardianship or limited guardianship. The form may also assist the parties in determining whether alternatives to guardianship such as a representative payee for government benefits, a power of attorney, or a special needs trust might solve a problem thereby avoiding the need for incompetency hearing.

This form can be used by the petitioner, the respondent, or any other person who has information that is useful to the court such as family or friends of the respondent or staff of a facility who knows the respondent well. It should be used by the Guardian Ad Litem to both gather the respondent's answers if the respondent cannot fill it out for him/herself and for the GAL's own opinion.

Name Of Respondent		Date Of Birth	
Address		Telephone No.	
Nature Of Impairment		County Of Residence	
Is there a representative payee for governmental benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Payee	Are there any Powers of Attorney in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> General/Durable <input type="checkbox"/> Health Care If Yes, Who has the POA? If Recorded, What County(ies)?		Are there any trusts in place? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Trustee and location of trust
Name And Address Of Person Completing This Form		Telephone No.	Has Known Respondent (years/months)
		Relationship to the Respondent	

A. LANGUAGE AND COMMUNICATION	B. NUTRITION
<ol style="list-style-type: none"> 1. Does the person understand and participate in social conversation in his/her primary language (including such topics as sports, family, activities)? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the person communicate independently with acquaintances in the community? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Can the person understand and respond to verbal communications? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Can the person read and write? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Can the person understand various signs (e.g. keep out, stop, men, women, poison)? <input type="checkbox"/> Yes <input type="checkbox"/> No 	<ol style="list-style-type: none"> 1. Does the person make reasonable decisions regarding eating (e.g. when, where, and what to eat)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> With assistance 2. Is the person able to eat and drink independently? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> With assistance 3. Is the person able to prepare food that requires cooking and mixing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> With assistance 4. Is the person able to prepare food that does not-require cooking and mixing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> With assistance 5. Does the person know which foods, if any, he or she is unable to tolerate? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> With assistance 6. If the person has a health condition such as diabetes, is he or she able to follow a prescribed diet? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> With assistance

C. PERSONAL HYGIENE	E. PERSONAL SAFETY Cont.
<p>1. Does the person bathe and maintain personal hygiene? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>2. Does the person brush teeth daily and maintain adequate dental care? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>3. Does the person control toilet functions during the day? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>4. When toileting, does the person use proper hygiene? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>5. Is the person able to fully and properly dress and undress himself or herself? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>6. Does the person wear clothing appropriate to the weather and/or occasion? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p>	<p>4. Can the person be left alone for periods up to 24 hours without being at risk? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>5. Can the person use a telephone to contact help in an emergency? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>6. In what areas, if any, might the person be especially vulnerable and need protection?</p>
	F. RESIDENTIAL
	<p>1. Can the person make and communicate choices in regard to residence and roommates? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>2. Is the person able to maintain shelter that is safe/adequately heated and ventilated? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>3. Can the person evacuate the premises in the case of fire or other danger? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p>
D. HEALTH CARE	G. EMPLOYMENT
<p>1. Can the person make and communicate choices in regard to medical treatment? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>2. Can the person make and communicate choices in regard to caregivers and assistants? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>3. Does the person know whom to notify of symptoms of illness? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>4. Is the person able to take care of minor health problems such as colds, cuts, etc.? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>5. Is the person able to follow proper instructions in taking prescribed medicine? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>6. Can the person communicate medication problems or needs? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>7. Does the person understand the consequences of not accepting medical treatment? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>8. Can the person reach emergency health care (e.g. calling an ambulance)? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p>	<p>1. Can the person make and communicate choices in regard to employment? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>2. Does the person express knowledge of or demonstrate skills required at job sites (neatness, punctuality, getting along with others)? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>3. Is the person able to use several approaches to finding a job (e.g. going to an employment agency, responding to ads, and using contacts)? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>With assistance</p> <p>4. Does the person have a job? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>5. Does the person interact appropriately with co-workers and authority figures? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>
E. PERSONAL SAFETY	H. INDEPENDENT LIVING
<p>1. Can the person identify physical or sexual abuse and protect him or herself from personal harm by others? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>2. Can the person identify neglect and know what to do if neglected? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>3. Does the person avoid common environmental dangers, such as oncoming traffic, sharp objects, a hot stove, and poisonous products? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p>1. Can the person initiate and follow a daily schedule of activities (e.g. when to get up, what to do, and when to go to bed)? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>2. Does the person acquire and retain new skills and readily apply them? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>3. Can the person utilize familiar community resources (e.g. post office, stores, bus, bank)? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>4. Can the person avoid common dangers when traveling in the community? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>5. Can the person identify his or her address and return home or seek assistance if lost or stranded? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p>AOC-SP-208, Side Two, New 6/04 © 2004 Administrative Office of the Courts</p>	

Name Of Respondent

H. INDEPENDENT LIVING cont.

ADDITIONAL COMMENTS

6. Does the person establish and maintain personal relationships with friends, relatives, co-workers?
Yes No
7. Can the person determine his or her degree of participation in religious activities?
Yes No
8. Does the person make and communicate choices in regard to leisure activities?
Yes No
9. Can the person drive a car?
Yes No
10. Does the person exercise reasonably good judgment most of the time?
Yes No

I. CIVIL

1. Does the person know whom to contact if he or she is being exploited or treated unfairly (e.g. police, DSS, Arc, lawyer, etc.)
Yes No
2. Does the person understand how to obtain legal counsel or advocacy services?
Yes No
3. Is the person able to communicate wishes regarding legal documents or services?
Yes No
4. Does the person understand the consequences of being charged and convicted of a crime?
Yes No
5. Does the person demonstrate a willingness to vote?
Yes No

J. FINANCIAL

1. Can the person make and communicate decisions to manage a budget?
Yes No With assistance
2. Does the person know the source and amounts of monetary benefits he or she receives on a weekly, monthly or annual basis?
Yes No With assistance
3. Does the person identify and make change for \$1, \$5, and \$20?
Yes No
4. Can the person adequately maintain a bank account?
Yes No With assistance
5. Can the person protect and spend small amounts of money?
Yes No With assistance
6. Does the person understand the concept of a debt?
Yes No With assistance
7. Can the person identify and resist financial exploitation?
Yes No