Filing a Conservatorship Action in Chester County

A. **Summons and Petition for Appointment of Conservator** (Form #540GC---only financial decisions)

B. **Notice of Right to Counsel** (Form #524GC)

C. Examiner's Report & Affidavit Regarding Capacity
   a. (Form #539GC--- will need 2 – from different examiners)

D. Applicant's Credit Report.

E. **Applicant's Criminal Background Check**
   (which is a SLED check for S.C residents or a check the state of residence for out-of-state residents)

F. Filing of $150.00.

Chester County Probate Court
1476 J A Cochran Bypass
P O Box 580
Chester, SC 29706
803-385-2604

STATE OF SOUTH CAROLINA

COUNTY OF **CHESTER**

IN THE MATTER OF:

____

☐ Decedent ☐ Alleged Incapacitated Individual

▲ PROBATE COURT USE ONLY ▲

IN THE PROBATE COURT
CASE NUMBER:____________________

Petitioner(s),

vs.

__________________________________,
Respondent(s).*

SUMMONS

*For Guardianship/Conservatorship matters, you must include the alleged incapacitated individual as a Respondent.

TO THE RESPONDENT(S) LISTED ABOVE:

YOU ARE HEREBY SUMMONED and required to Answer the Petition in this action, a copy of which is herewith served upon you, and to serve a copy of your Answer upon the Petitioner(s) listed above at the following address(es):

Please Type or Print.

(Name of Petitioner/Attorney for Petitioner)

(Street Address or Mailing Address)

(City, State, and Zip Code)

Your Answer must be served on the Petitioner at the above address within **thirty (30) days** after the service of this Summons and Petition upon you, exclusive of the day of such service; and if you fail to answer the Petition within that time, judgment by default will be rendered against you for the relief demanded in the Petition.

____
Signature of Petitioner(s)/Attorney for Petitioner(s)

Date: ____________

Case Number: ______________________

INSTRUCTION SHEET FOR FORM #540GC
PETITION FOR FINDING OF INCAPACITY, PROTECTIVE PROCEEDING,
APPOINTMENT OF CONSERVATOR FOR AN ADULT

This petition is intended to be used when a petitioner is seeking the appointment of a Conservator for an alleged incapacitated individual (A.I.I.). It can also be used when a petitioner seeks to have an A.I.I. found to be incapacitated for one of the other reasons stated below. The following actions may be requested with the filing of the attached petition:

- **FINDING OF INCAPACITY**
    - The petitioner may be seeking to have the A.I.I. found to be an incapacitated individual for the purpose of a protective proceeding or the appointment of a Conservator. The court makes this determination, based in part a physician's examination and report and other relevant evidence. Generally, if there is no finding of incapacity, the court will not be able to proceed with any other action regarding the person who is alleged to be incapacitated.

- **If authority is needed to manage financial affairs, please read below for available options and check the appropriate box(es) in the Petition:**
    - **PROTECTIVE ORDER** - Can be used to establish incapacity, allow for appointment of a special Conservator, establish a special needs trust, or to have a durable power of attorney for business and/or financial affairs ratified by the Court.
    - **APPOINTMENT OF SPECIAL CONSERVATOR** - Can be used to request appointment of an individual or professional fiduciary to complete specific tasks within a specific period of time.
    - **APPOINTMENT OF CONSERVATOR (including appointment on an EMERGENCY or TEMPORARY basis; see *Forms #512GC and #513GC*)** - Can be used to request permanent appointment of an individual or professional fiduciary and, if needed, appointment of a Conservator on an emergency or temporary basis before the permanent appointment can be made.
    - **APPOINTMENT OF SUCCESSOR CONSERVATOR** - Can be used to request appointment of a successor to the permanent Conservator.

- **RIGHTS AND POWERS OF THE ALLEGED INCAPACITATED INDIVIDUAL**
    - S.C. Code Ann. § 62-5-403(B)(7) requires the petitioner to indicate in the petition what rights the Court is being asked to remove from the A.I.I. For protective proceedings, those rights are stated in S.C. Code Ann. § 62-5-407(B). The burden of proof will be on the petitioner to show why certain rights should be removed. Rights not asked to be removed or not stated as being removed in the court order will be retained.
    - If the A.I.I. is found to be incapacitated based on mental illness, "mental deficiency," "mental defect," or an impairment other than **solely** a physical impairment or disability, the court is required to report the name of the incapacitated individual to the S.C State Law Enforcement Division (SLED), pursuant to S.C. Code Ann. § 23-31-1020. **He or she will not be allowed to purchase, possess, or have access to firearms or ammunition, pursuant to S.C. Code Ann. § 23-31-1040(A).**

STATE OF SOUTH CAROLINA

COUNTY OF CHESTER

IN THE MATTER OF:

___________________________,
an alleged incapacitated individual.

▲ PROBATE COURT USE ONLY ▲

IN THE PROBATE COURT
CASE NUMBER ________________________

,
Petitioner(s),

vs.

,
Respondent(s).*

PETITION FOR (check all that apply):
☐ FINDING OF INCAPACITY
☐ PROTECTIVE ORDER
☐ APPOINTMENT OF:
  ☐ CONSERVATOR
  ☐ SPECIAL CONSERVATOR
  ☐ SUCCESSOR CONSERVATOR

*You must include the alleged incapacitated individual (A.I.I.) as a Respondent.

1. Petitioner(s):

   Relationship to the A.I.I., if any, or your interest in this proceeding:

2. **Information about A.I.I.**

   Name: Age:
   Date of Birth:
   Last 4 digits of Social Security Number: XXX-XX-
   Address:
   City/State/Zip:
   Preferred Telephone: Secondary Telephone:
   Email:

   The address provided for the A.I.I. is his/her: Home ☐; a Facility ☐; Other ☐ (please specify)

3. **Existing legal documents and/or legal appointments relating to the A.I.I.**

   To my knowledge, the A.I.I:
   ☐ Does have ☐ Does not have a Will
   ☐ Does have ☐ Does not have a general Durable Power of Attorney (POA)
   ☐ Does have ☐ Does not have a Health Care POA
   ☐ Does have ☐ Does not have a Living Will
   ☐ Does have ☐ Does not have a Guardian
   ☐ Does have ☐ Does not have a Conservator or Trustee

   If the A.I.I. does have any of the above-named documents, copies must be provided with this Petition or an explanation provided as to why the document is not available.

4. **Jurisdiction:**

   ☐ The A.I.I. has been physically present in South Carolina for the six (6) month period immediately preceding the filing of this petition or for at least six (6) consecutive months ending within the six (6) month period immediately preceding the filing of this petition.

If the A.I.I. has not been physically present in South Carolina for the period of time described above, explain what connections the A.I.I. has to South Carolina. Please refer to S.C. Code Ann. §§ 62-5-700 through 62-5-711.

5. **Venue** (*check all that apply*):

Venue for this proceeding is proper in this county because the A.I.I.:

- ☐ resides in this county and has resided in this county for more than six (6) months;
- ☐ resides in this county (*this is his/her county of residence*);
- ☐ is physically present in this county at this time;
- ☐ does not reside in this state but owns real or personal property in this county; or
- ☐ does not reside in this state but has the right to take legal action in this county (a copy of the pleadings will be required).

If the A.I.I. has not resided in this county for the six (6) months preceding this action, state the address where the A.I.I. did reside or is currently residing:

6. **Information about family of the A.I.I.** – You must provide information about the spouse and any children of the A.I.I.; if there is no spouse or adult children, then list his/her parents. If no parents are living, then list the closest adult relative(s).

**Spouse:
Address:
City/State/Zip:
Preferred Telephone: Secondary Telephone: _
Email:

**If deceased, a certified death certificate is required.

Children of A.I.I.:

Name	Address	Year of Birth

(***IF REQUIRED***) Living Parents of A.I.I.:

Name	Address

(***IF REQUIRED***) Closest Living Adult Relative(s) of A.I.I. – use additional paper if needed:
Adult Relative:
Address:
City/State/Zip:
Preferred Telephone: Secondary Telephone:
Email:

7. Information about <u>any other</u> interested parties such as a Guardian, Conservator, trustee, representative payee, agent under a general durable power of attorney, or a health care agent under a health care power of attorney.

Name	Address	Relationship to A.I.I.

8. **Rights and Powers of the A.I.I.** *(See S.C. Code Ann. § 62-5-407(B))*

(*If you are the A.I.I. in this matter, you should be prepared to defend the assertion that any of the following rights should be removed; however, the burden is on the Petitioner to show why.*)

Do you believe the A.I.I. should **<u>retain</u>** the following rights to:

a.	Buy, sell, or transfer real property?	☐ YES	☐ NO
b.	Buy, sell, or transfer personal property?	☐ YES	☐ NO
c.	Make, modify, or terminate contracts?	☐ YES	☐ NO
d.	Make significant purchases?	☐ YES	☐ NO
e.	Transact business of any type?	☐ YES	☐ NO
f.	Bring or defend a lawsuit?	☐ YES	☐ NO
g.	Create a will?	☐ YES	☐ NO
h.	Create a trust?	☐ YES	☐ NO
i.	Pay his or her bills?	☐ YES	☐ NO
j.	Make gifts?	☐ YES	☐ NO
k.	Vote?	☐ YES	☐ NO

If you answered NO to any of the above-listed rights, please explain:

9. Any other rights and powers not specifically stated here that the Court should address:

10. Please note any of the rights in Question 8 you believe should be given to the Conservator (*vested in the Conservator*) to exercise on behalf of the incapacitated person. (*Some rights, such as voting, cannot be given to a Conservator.*):

11. **AUTHORITY TO MANAGE FINANCIAL AFFAIRS OF THE A.I.I.**

a. Why do you believe the A.I.I. needs a Conservator or protective order? Provide a brief description of the nature and extent of the alleged incapacity. (*See S.C. Code Ann. § 62-5-403(B)(6)*).

b. Is there a less restrictive alternative? If so, please explain.

c. In what ways is the alleged incapacitated individual able to provide for health, education, maintenance, and support for himself/herself and his or her dependents?

d. Is any type of emergency or temporary proceeding needed to protect the funds, assets, or business affairs of the A.I.I.? (*If seeking emergency or temporary relief, use Forms #512GC and #513GC.*) ☐ No. ☐ Yes. If yes, please explain:

e. Has the A.I.I. been rated incapable of handling his estate and monies after examination by the VA? (*See S.C. Code Ann. § 62-5-403(B)(9)*).
☐ No. ☐ Yes. If yes, please explain:

f. The following is a list of the real and personal property owned by the A.I.I., business affairs of the A.I.I., funds available to the A.I.I., or legal action necessary for the benefit of the A.I.I. and an estimate of the value: (*An Inventory & Appraisement, Form #550GC, shall be filed with the Court within thirty (30) days of the date of appointment.*)

Description	Value

g. I request the appointment of (*if someone other than Petitioner*):
Name:
Address:
City/State/Zip:
Preferred Telephone: Secondary Telephone:
Email:

h. **Priority for the requested appointee** (*either the Petitioner or person named in 11g., above*) is:

☐ Previously appointed Conservator, Guardian of property, or Guardian of assets appointed by a court of another county or state;
☐ Individual nominated by the A.I.I., who is deemed mentally capable of making such choice;
☐ Spouse of A.I.I.;
☐ Adult Child of A.I.I.;
☐ Adult sibling of A.I.I. (*specify relationship*): ;
☐ Closest adult relative (*specify relationship*): ;
☐ Person with whom the A.I.I. resides (*specify relationship*): ;
☐ Nominee of any of the above (*specify who made nomination*): ; or
☐ Other (*specify*):

i. Does the proposed Conservator plan on receiving any fees for serving as Conservator?
☐ No. ☐ Yes.

If yes, indicate the hourly rate or desired compensation amount: $

Occupation of proposed Conservator:

Case Number: ________________________

VERIFICATION

The Petitioner, being sworn, states: That the facts set forth in the foregoing Petition are true to the best of the Petitioner's knowledge, information, and belief.

SWORN to before me this ________ day of ________, 20 ____.

____
Print Name:
Notary Public for:
(State)
My Commission Expires:
(Date)

Applicant/Petitioner
Signature: ______________________
Print Name: ______________________
Address: ______________________
____
Preferred Telephone: ______________________
Secondary Telephone: ______________________
Email: ______________________

SWORN to before me this ________ day of ________, 20 ____.

____
Print Name:
Notary Public for:
(State)
My Commission Expires:
(Date)

Co-Applicant/Petitioner
Signature: ______________________
Print Name: ______________________
Address: ______________________
____
Preferred Telephone: ______________________
Secondary Telephone: ______________________
Email: ______________________

<u>This section is to be signed by the individual(s) nominated to serve in one of the roles listed below.</u>

QUALIFICATION AND STATEMENT OF ACCEPTANCE

I agree to serve as appointed and to perform the duties and discharge the trust of the office of (*check the applicable choices*): ☐Conservator, ☐Special Conservator, ☐Successor Conservator for (*Name of A.I.I.*) .

Executed this day of , 20 .

Signature: ______________________
Printed Name:

Signature: ______________________
Printed Name:

STATE OF SOUTH CAROLINA)

COUNTY OF CHESTER)

IN THE MATTER OF:)

PROBATE COURT USE ONLY

____________________________,)

IN THE PROBATE COURT
CASE NUMBER ___________________

an alleged incapacitated individual.)

EXAMINER REPORT AND AFFIDAVIT REGARDING CAPACITY

Please answer the following questions concerning the alleged incapacitated individual (hereinafter, "patient") and provide explanations or additional comments and details at the end of this form or on an attached sheet of paper.

1. Patient's name:

2. Have you treated the patient previously? Yes☐ No☐

   If yes, how long?

3.
   a) Date(s) and place(s) of all examination(s) within previous ninety (90) days:

   b) Date(s) and place(s) of all examination(s) relied upon in making this report:

4. Please provide a diagnosis and assessment of the patient's mental and physical condition, including whether he/she is taking any medications that may affect his/her actions:

   Are additional tests or assessments, such as lab tests, neuroimaging/MRI, neuropsychological testing, or other tests needed in order to give a more definitive diagnosis? If so, what further tests or examinations are needed?

5. Please specify which diagnoses and/or condition(s) are progressive, permanent, or temporary.

   Progressive:

   Permanent:

   Temporary:

6. Please describe the nature and extent of any incapacity, including specific impairments:

7. Please describe the nature and extent of the patient's abilities, including those that would allow him/her to accomplish certain tasks with reasonably available "supports and assistance"[1]:

8. Does the patient have the capacity to retain the following rights (If you cannot attest to yes or no, please explain what additional test/s can be done to achieve that information):

a)	Marry or divorce?	Yes ☐ No ☐ Unknown ☐
b)	Reside in a place of his/her choosing, and consent or withhold consent to any residential or custodial placement?	Yes ☐ No ☐ Unknown ☐
c)	Travel without the consent of a guardian?	Yes ☐ No ☐ Unknown ☐
d)	Give, withhold, or withdraw consent and make other informed decisions relative to medical, mental, and physical examinations, care, treatment, and therapies?	Yes ☐ No ☐ Unknown ☐
e)	Make end-of-life decisions including, but not limited to, a "do not resuscitate" order or the application of any medical procedures intended solely to sustain life, and consent or withhold consent to artificial nutrition and hydration?	Yes ☐ No ☐ Unknown ☐
f)	Consent or refuse consent to hospitalization and discharge or transfer to a residential setting, group home, or other facility for additional care and treatment?	Yes ☐ No ☐ Unknown ☐
g)	Authorize disclosures of confidential information?	Yes ☐ No ☐ Unknown ☐
h)	Operate a vehicle*?	Yes ☐ No ☐ Unknown ☐
i)	Vote?	Yes ☐ No ☐ Unknown ☐
j)	Be employed without the consent of a guardian?	Yes ☐ No ☐ Unknown ☐
k)	Consent to or refuse educational services?	Yes ☐ No ☐ Unknown ☐
l)	Participate in social, religious or political activities?	Yes ☐ No ☐ Unknown ☐
m)	Buy, sell, or transfer real or personal property or transact business of any type?	Yes ☐ No ☐ Unknown ☐
n)	Make, modify, or terminate contracts?	Yes ☐ No ☐ Unknown ☐
o)	Bring or defend any action at law or equity?	Yes ☐ No ☐ Unknown ☐
p)	Any other rights and powers? Please list.	

COMPLETE EXPLANATION(S) FOR QUESTIONS a) through p) HERE.
If more space is required, use additional sheets and attach.
(**If you answered "yes" to h), please state below whether a full driving evaluation has been conducted.*)

____

[1] As defined in S.C. Code Ann. § 62-5-101(23), "Supports and assistance" includes:
(a) systems in place for the alleged incapacitated individual to make decisions in advance or to have another person to act on his behalf, including, but not limited to, having an agent under a durable power of attorney, a health care power of attorney, a trustee under a trust, a representative payee to manage social security funds, a Declaration of Desire for Natural Death (living will), a designated health care decision maker under Section 44-66-30, or an educational representative designated under Section 59-33-310 to Section 59-33-370; and
(b) reasonable accommodations that enable the alleged incapacitated individual to act as the principal decision maker, including, but not limited to, using technology and devices; receiving assistance with communication; having additional time and focused discussion to process information; providing tailored information oriented to the comprehension level of the alleged incapacitated individual; and accessing services from community organizations and governmental agencies.

9. Would the patient benefit from:

a) Therapy or treatment? Yes ☐ No ☐
b) Medical aids or equipment? Yes ☐ No ☐
c) An operation or medical procedure(s)? Yes ☐ No ☐
d) Psychiatric treatment? Yes ☐ No ☐

10. Has the patient had in the last six months:

a) Hospitalization(s)? Yes ☐ No ☐
b) Therapy or treatment? Yes ☐ No ☐
c) Inpatient or outpatient surgery? Yes ☐ No ☐
d) Major medical test(s)? Yes ☐ No ☐
e) Psychological or psychiatric testing? Yes ☐ No ☐

11. In your opinion, does the patient have the ability to:

a) effectively manage his/her property or individual financial affairs, provide for his/her support, or for the support of his/her legal dependents? Yes ☐ No ☐

If yes, is the ability limited in any way? Please explain:

b) meet the essential requirements for his/her physical health, safety, or self-care. Yes ☐ No

If yes, is the ability limited in any way? Please explain:

12. The patient continues to perform the following activities of daily living:

13. Does the patient have:

a) A power of attorney? Yes ☐ No ☐ Unknown ☐
b) A healthcare power of attorney? Yes ☐ No ☐ Unknown ☐
c) A “living will”? Yes ☐ No ☐ Unknown ☐

14. Does the patient have any of the following coverages?

a) Health insurance? Yes ☐ No ☐ Unknown ☐
b) Medicare? Yes ☐ No ☐ Unknown ☐
c) Medicaid? Yes ☐ No ☐ Unknown ☐
d) Veteran’s health care? Yes ☐ No ☐ Unknown ☐

15. Does the patient have a primary caregiver? Yes ☐ No ☐

If yes, provide caregiver’s name, address, and relationship to the patient.

16. Please identify the persons with whom you met or consulted regarding the patient’s mental or physical condition:

17. **BASED UPON MY EVALUATION OF THIS PATIENT:**

a. ☐ I DO NOT BELIEVE THIS PATIENT IS "INCAPACITATED."[2] I do not find that he/she lacks the ability to effectively receive, evaluate, and respond to information or make or communicate decisions such that a person, even with appropriate, reasonably available support and assistance cannot:

a) meet the essential requirements for his/her physical health, safety, or self-care, necessitating the need for a guardian; or
b) manage his/her property or financial affairs or provide for his/her support of for the support of his/her legal dependents, necessitating the need for a protective order.

b. ☐ I DO BELIEVE THIS PATIENT IS "INCAPACITATED" to such an extent, that he/she lacks the ability to effectively receive, evaluate, and respond to information or make or communicate decisions such that a person, even with appropriate, reasonably available support and assistance cannot:

a) meet the essential requirements for his/her physical health, safety, or self-care, necessitating the need for a guardian; or
b) manage his/her property or financial affairs or provide for his/her support of for the support of his/her legal dependents, necessitation the need for a protective order.

Use this space to provide explanations or additional comments.

SWORN to before me this ______ day of ______, 20____.

____
Print Name: ______________________
Notary Public for: ______________
(State)
My Commission Expires: ______________
(Date)

Examiner's Signature: ______________________
Print Name: ______________________
Credentials: ______________________
(*e.g.,* M.D., Ph.D., D.O., R.N.)
Address: ______________________
Telephone: ______________________

[2]As defined in S.C. Code Ann. § 62-5-101(13), "Incapacity" means the inability to effectively receive, evaluate, and respond to information or make or communicate decisions such that a person, **even with appropriate, reasonably available support and assistance cannot:**
a) meet the essential requirements for his/her physical health, safety, or self-care, necessitating the need for a guardian; or
b) manage his property or financial affairs or provide for his support of for the support of his legal dependents, necessitating the need for a protective order.

STATE OF SOUTH CAROLINA

COUNTY OF CHESTER

IN THE MATTER OF:

______________________________,
an alleged incapacitated individual.

,
Petitioner(s),

vs.

,
Respondent(s).

▲ PROBATE COURT USE ONLY ▲

IN THE PROBATE COURT
CASE NUMBER ____________________

NOTICE OF RIGHT TO COUNSEL

You, the alleged incapacitated individual, have the right to choose your own attorney to represent you in the above matter.

If a notice of appearance by your own attorney has not been received by the Court within fifteen (15) days from the filing of the proof of service in this matter, the court will appoint an attorney for you.

Executed this ____ day of ________, 2020.

Signature: ______________________________
Print Name: ______________________________
Address: ______________________________
____
Preferred Telephone: ______________________________
Secondary Telephone: ______________________________
Email: ______________________________

Attorney Signature: ______________________________
Print Name: ______________________________
Firm Name: ______________________________
Bar Number: ______________________________
Address: ______________________________
____
Telephone: ______________________________
Email: ______________________________
Attorney for: ______________________________

STATE OF SOUTH CAROLINA

COUNTY OF CHESTER

IN THE MATTER OF:

________________________,

an alleged incapacitated individual.

▲ PROBATE COURT USE ONLY ▲

IN THE PROBATE COURT
CASE NUMBER ____________________

EXAMINER REPORT AND AFFIDAVIT REGARDING CAPACITY

Please answer the following questions concerning the alleged incapacitated individual (hereinafter, "patient") and provide explanations or additional comments and details at the end of this form or on an attached sheet of paper.

1. Patient's name:

2. Have you treated the patient previously? Yes☐ No☐

   If yes, how long?

3. a) Date(s) and place(s) of all examination(s) within previous ninety (90) days:

   b) Date(s) and place(s) of all examination(s) relied upon in making this report:

4. Please provide a diagnosis and assessment of the patient's mental and physical condition, including whether he/she is taking any medications that may affect his/her actions:

   Are additional tests or assessments, such as lab tests, neuroimaging/MRI, neuropsychological testing, or other tests needed in order to give a more definitive diagnosis? If so, what further tests or examinations are needed?

5. Please specify which diagnoses and/or condition(s) are progressive, permanent, or temporary.

   Progressive:

   Permanent:

   Temporary:

6. Please describe the nature and extent of any incapacity, including specific impairments:

7. Please describe the nature and extent of the patient's abilities, including those that would allow him/her to accomplish certain tasks with reasonably available "supports and assistance"[1]:

8. Does the patient have the capacity to retain the following rights (If you cannot attest to yes or no, please explain what additional test/s can be done to achieve that information):

a)	Marry or divorce?	Yes ☐ No ☐ Unknown ☐
b)	Reside in a place of his/her choosing, and consent or withhold consent to any residential or custodial placement?	Yes ☐ No ☐ Unknown ☐
c)	Travel without the consent of a guardian?	Yes ☐ No ☐ Unknown ☐
d)	Give, withhold, or withdraw consent and make other informed decisions relative to medical, mental, and physical examinations, care, treatment, and therapies?	Yes ☐ No ☐ Unknown ☐
e)	Make end-of-life decisions including, but not limited to, a "do not resuscitate" order or the application of any medical procedures intended solely to sustain life, and consent or withhold consent to artificial nutrition and hydration?	Yes ☐ No ☐ Unknown ☐
f)	Consent or refuse consent to hospitalization and discharge or transfer to a residential setting, group home, or other facility for additional care and treatment?	Yes ☐ No ☐ Unknown ☐
g)	Authorize disclosures of confidential information?	Yes ☐ No ☐ Unknown ☐
h)	Operate a vehicle*?	Yes ☐ No ☐ Unknown ☐
i)	Vote?	Yes ☐ No ☐ Unknown ☐
j)	Be employed without the consent of a guardian?	Yes ☐ No ☐ Unknown ☐
k)	Consent to or refuse educational services?	Yes ☐ No ☐ Unknown ☐
l)	Participate in social, religious or political activities?	Yes ☐ No ☐ Unknown ☐
m)	Buy, sell, or transfer real or personal property or transact business of any type?	Yes ☐ No ☐ Unknown ☐
n)	Make, modify, or terminate contracts?	Yes ☐ No ☐ Unknown ☐
o)	Bring or defend any action at law or equity?	Yes ☐ No ☐ Unknown ☐
p)	Any other rights and powers? Please list.	

COMPLETE EXPLANATION(S) FOR QUESTIONS a) through p) HERE.
If more space is required, use additional sheets and attach.
(*If you answered "yes" to h), please state below whether a full driving evaluation has been conducted.*)

____

[1] As defined in S.C. Code Ann. § 62-5-101(23), "Supports and assistance" includes:
(a) systems in place for the alleged incapacitated individual to make decisions in advance or to have another person to act on his behalf, including, but not limited to, having an agent under a durable power of attorney, a health care power of attorney, a trustee under a trust, a representative payee to manage social security funds, a Declaration of Desire for Natural Death (living will), a designated health care decision maker under Section 44-66-30, or an educational representative designated under Section 59-33-310 to Section 59-33-370; and
(b) reasonable accommodations that enable the alleged incapacitated individual to act as the principal decision maker, including, but not limited to, using technology and devices; receiving assistance with communication; having additional time and focused discussion to process information; providing tailored information oriented to the comprehension level of the alleged incapacitated individual; and accessing services from community organizations and governmental agencies.

9. Would the patient benefit from:

a) Therapy or treatment?	Yes ☐ No ☐
b) Medical aids or equipment?	Yes ☐ No ☐
c) An operation or medical procedure(s)?	Yes ☐ No ☐
d) Psychiatric treatment?	Yes ☐ No ☐

10. Has the patient had in the last six months:

a) Hospitalization(s)?	Yes ☐ No ☐
b) Therapy or treatment?	Yes ☐ No ☐
c) Inpatient or outpatient surgery?	Yes ☐ No ☐
d) Major medical test(s)?	Yes ☐ No ☐
e) Psychological or psychiatric testing?	Yes ☐ No ☐

11. In your opinion, does the patient have the ability to:

a) effectively manage his/her property or individual financial affairs, provide for his/her support, or for the support of his/her legal dependents? Yes ☐ No ☐

If yes, is the ability limited in any way? Please explain:

b) meet the essential requirements for his/her physical health, safety, or self-care. Yes ☐ No

If yes, is the ability limited in any way? Please explain:

12. The patient continues to perform the following activities of daily living:

13. Does the patient have:

a) A power of attorney?	Yes ☐ No ☐ Unknown ☐
b) A healthcare power of attorney?	Yes ☐ No ☐ Unknown ☐
c) A "living will"?	Yes ☐ No ☐ Unknown ☐

14. Does the patient have any of the following coverages?

a) Health insurance?	Yes ☐ No ☐ Unknown ☐
b) Medicare?	Yes ☐ No ☐ Unknown ☐
c) Medicaid?	Yes ☐ No ☐ Unknown ☐
d) Veteran's health care?	Yes ☐ No ☐ Unknown ☐

15. Does the patient have a primary caregiver? Yes ☐ No ☐

If yes, provide caregiver's name, address, and relationship to the patient.

16. Please identify the persons with whom you met or consulted regarding the patient's mental or physical condition:

17. **BASED UPON MY EVALUATION OF THIS PATIENT:**

a. ☐ I DO NOT BELIEVE THIS PATIENT IS "INCAPACITATED."[2] I do not find that he/she lacks the ability to effectively receive, evaluate, and respond to information or make or communicate decisions such that a person, even with appropriate, reasonably available support and assistance cannot:

a) meet the essential requirements for his/her physical health, safety, or self-care, necessitating the need for a guardian; or
b) manage his/her property or financial affairs or provide for his/her support of for the support of his/her legal dependents, necessitating the need for a protective order.

b. ☐ I DO BELIEVE THIS PATIENT IS "INCAPACITATED" to such an extent, that he/she lacks the ability to effectively receive, evaluate, and respond to information or make or communicate decisions such that a person, even with appropriate, reasonably available support and assistance cannot:

a) meet the essential requirements for his/her physical health, safety, or self-care, necessitating the need for a guardian; or
b) manage his/her property or financial affairs or provide for his/her support of for the support of his/her legal dependents, necessitation the need for a protective order.

Use this space to provide explanations or additional comments.

SWORN to before me this ______ day of ______, 20 ______.

____
Print Name: ______________________________
Notary Public for: ______________________________ (State)
My Commission Expires: ______________________________ (Date)

Examiner's Signature: ______________________________
Print Name: ______________________________
Credentials: ______________________________
(*e.g.,* M.D., Ph.D., D.O., R.N.)
Address: ______________________________
____
Telephone: ______________________________

[2]As defined in S.C. Code Ann. § 62-5-101(13), "Incapacity" means the inability to effectively receive, evaluate, and respond to information or make or communicate decisions such that a person, **even with appropriate, reasonably available support and assistance cannot:**
a) meet the essential requirements for his/her physical health, safety, or self-care, necessitating the need for a guardian; or
b) manage his property or financial affairs or provide for his support of for the support of his legal dependents, necessitating the need for a protective order.