Filing a Guardianship Action in Chester County Probate Court

A. **Summons and Petition for Appointment of Guardian** (Form #530GC---only healthcare decisions)

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

C. **Examiner's Report & Affidavit Regarding Capacity** (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 from the state of residence for out-of-state residents)

F. **Filing fee 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:) _____,) an alleged incapacitated individual.)	▲ PROBATE COURT USE ONLY ▲
) ,) Petitioner(s),) vs.) ,) Respondent(s).)	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:

_____

_____

☐ Decedent ☐ Alleged Incapacitated Individual

▲ PROBATE COURT USE ONLY ▲

IN THE PROBATE COURT
CASE NUMBER _____

Petitioner(s),

vs.

SUMMONS

Respondent(s).*

*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 #530GC
PETITION FOR FINDING OF INCAPACITY, APPOINTMENT OF GUARDIAN, APPOINTMENT OF SUCCESSOR GUARDIAN

Payment of the filing fee or filing of a *Motion and Affidavit to Proceed In Forma Pauperis* (see Form SCCA405PC) is required when this petition is filed. The petition is intended to be used when a petitioner is seeking the appointment of a Guardian for an alleged incapacitated individual (A.I.I.). It can also be used when a petitioner seeks to have a Successor Guardian appointed for an incapacitated individual. 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 the appointment of a Guardian. This is determined by the Court based upon 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 make decisions regarding health care, medical treatment, medical decisions, or appropriate placement for the A.I.I., please read below for situations in which a guardianship may be needed and check the appropriate box(es) in the Petition:**
    - **APPOINTMENT OF GUARDIAN (including appointment on an EMERGENCY or TEMPORARY basis; see Forms #512GC and #513GC)** - Can be used to request appointment of an individual, including a professional Guardian, on an emergency, temporary, and/or permanent basis to be the substitute health care decision-maker for an alleged incapacitated individual.
    - **APPOINTMENT OF SUCCESSOR GUARDIAN** - Can be used to request appointment of a successor to the permanent Guardian.
    - **IF NOMINATED TO SERVE IN A WILL** – Based on the facts of the case and the filings of the parties, pursuant to S.C. Code Ann. § 62-1-100, it is within the discretion of the Court to determine whether a testamentary Guardian designation in a will executed by a parent or spouse prior to January 1, 2019, the effective date of the revisions to Article 5 of the S.C. Probate Code, will fall under the processes and procedures of the 1987 Probate Code or under the processes and procedures enacted by the 2017 amendments. *(See §62-5-301 of the 1987 Probate Code versus the changes to §62-5-301 enacted by the 2017 amendments.)*

- **RIGHTS AND POWERS OF THE ALLEGED INCAPACITATED INDIVIDUAL**
    - S.C. Code Ann. § 62-5-303(B)(7) requires that the petitioner must indicate in the petition what rights the Court is being asked to remove from the A.I.I. For guardianships those rights are stated in S.C. Code Ann. § 62-5-304A. 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 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).**

Case Number: _____

STATE OF SOUTH CAROLINA	)	
	)	
COUNTY OF **CHESTER**	)	
	)	
IN THE MATTER OF:	)	
	)	
_____,	)	▲ PROBATE COURT USE ONLY ▲
an alleged incapacitated individual.	)	
	)	
	)	IN THE PROBATE COURT
	)	CASE NUMBER _____
	)	
,	)	**PETITION FOR:**
Petitioner(s),	)	☐ FINDING OF INCAPACITY
vs.	)	☐ APPOINTMENT OF:
	)	☐ GUARDIAN
_____,	)	☐ SUCCESSOR GUARDIAN
Respondent(s).*	)	

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

1. Petitioner(s):

   Relationship to the alleged (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:
   Telephone: (Home): (Cell):
   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 SC Code §§ 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; or
- ☐ is admitted to an institution in this county pursuant to an order of a court of competent jurisdiction, but this is not the county of residence.

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 where he/she 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:
Telephone: (Home): (Cell):
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:
Telephone: (Home): (Cell):
Email:

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

Name	Address	Relationship to A.I.I.

Case Number: _____

8. **Rights and Powers of the A.I.I.** (*See § 62-5-304A.*)

(*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 **retain** the following rights to:

a.	Make decisions about health care and medical treatment?	☐ YES	☐ NO
b.	Choose a physician?	☐ YES	☐ NO
c.	Make end-of-life decisions?	☐ YES	☐ NO
d.	Authorize disclosure of confidential information?	☐ YES	☐ NO
e.	Choose where to live?	☐ YES	☐ NO
f.	Participate in social and religious activities?	☐ YES	☐ NO
g.	Vote?	☐ YES	☐ NO
h.	Consent to or refuse educational services?	☐ YES	☐ NO
i.	Contract for marriage?	☐ YES	☐ NO
j.	File for divorce?	☐ YES	☐ NO
k.	Travel independently?	☐ YES	☐ NO
l.	Be employed without Guardian consent?	☐ YES	☐ NO
m.	Operate a vehicle?	☐ YES	☐ NO
n.	Pay his or her bills?	☐ YES	☐ NO
o.	Enter into contracts?	☐ YES	☐ NO
p.	Bring or defend a lawsuit?	☐ YES	☐ NO
q.	Make gifts?	☐ YES	☐ NO
r.	Create a will?	☐ YES	☐ NO
s.	Create a trust?	☐ 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 Guardian (*vested in the Guardian*) to exercise on behalf of the incapacitated individual and/or for which the written consent of the Guardian should be obtained prior to exercising such right. Some rights, such as voting, cannot be given to the Guardian.

11. THE AUTHORITY TO MAKE DECISIONS ABOUT HEALTH CARE, MEDICAL TREATMENT, AND PLACEMENT FOR THE A.I.I.

    a. Why do you believe the A.I.I. needs a Guardian/Successor Guardian to provide continuing care and supervision? Provide a brief description of the nature and extent of the alleged incapacity. (*See 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 it necessary to hold any type of emergency or temporary proceeding to protect the physical person of the A.I.I., to make immediate decisions concerning health care or medical treatment, or is the appointment of a temporary Guardian necessary before a final hearing can be held on this Summons and Petition? (*If seeking emergency or temporary relief, use Form #512GC or Form #513GC*.)

☐ NO. ☐ YES. If yes, please explain:

e. Why does the A.I.I. need a Guardian to give consents or approvals that may be necessary to enable the A.I.I. to receive medical or other professional care, counsel, treatment?

f. What does the A.I.I. need for care, assistance, protection, or supervision on a daily basis?

g. Has a Guardian appointed by a will accepted such appointment?

☐ NO. ☐ YES. If yes, please explain and provide a copy of the will.

h. I request the appointment of (*if someone other than Petitioner*):

Name:
Relationship to A.
Address:
City/State/Zip:
Telephone: (Home): (Cell):
Email:

i. Priority of appointment for the proposed Guardian (*Petitioner or person named in11h., above*):

☐ A previously appointed Guardian or his/her nominee;
☐ Person nominated to serve as Guardian by the A.I.I., if the A.I.I. has sufficient mental capacity to make a reasoned choice;
☐ An agent designated in a recorded Power of Attorney whose authority includes powers relating to the care of the A.I.I. or their nominee;
☐ Spouse of the A.I.I. or person nominated as testamentary Guardian in the probated will of the spouse or their nominee;
☐ Adult child of the A.I.I. or their nominee;
☐ Parent of the A.I.I. or person nominated as testamentary Guardian in the probated will of the parent or their nominee;
☐ Closest adult relative to the A.I.I. (*specify relationship*);
☐ Person with whom the A.I.I. resides (*this does not include a health care facility, group home, homeless shelter, or prison*);
☐ Person nominated by a heath care facility caring for the A.I.I.; or
☐ Other (*specify*):

Case Number: _____

j. What does the A.I.I. own?

- ☐ Real property - Address:
- ☐ Vehicle - Make/Model/Value:
- ☐ Bank Account - Bank and current balance:
- ☐ Monthly Income – Source and amount:

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: _____

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

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:

FORM #539GC (01/2019)
62-5-303, 62-5-303D, 62-5-403, 62-5-403B, 62-5-403D, 62-5-304, 62-5-407, 62-5-407(B)

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 .

Examiner's Signature:

Print Name:

Credentials:

(*e.g.,* M.D., Ph.D., D.O., R.N.)

Address:

Telephone:

Print Name:

Notary Public for: (State)

My Commission Expires: (Date)

[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:	)	▲ 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:

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62-5-303, 62-5-303D, 62-5-403, 62-5-403B, 62-5-403D, 62-5-304, 62-5-407, 62-5-407(B)

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 .

Examiner's Signature:

Print Name:

Credentials:

(*e.g.,* M.D., Ph.D., D.O., R.N.)

Address:

Telephone:

Print Name:

Notary Public for: (State)

My Commission Expires: (Date)

[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.