El Paso County Statutory Probate Court
500 East San Antonio, 8th Floor, Rm. 803
El Paso, Texas 79901
(915) 546-2161
Fax (915) 875-8527

GUARDIANSHIP REFERRAL

Date of Referral: _____

Attn: Probate Court Investigator

I request an investigation into the need for guardianship on the following individual:

Name: _____

Address: _____

Phone No.: _____

Social Security No.: _____

Date of Birth: _____

This person has the following relatives (indicate by asterisk (*) person/s who have expressed a willingness to serve as a surrogate decision-maker or to be appointed as a legal guardian.

Spouse (please list name even if deceased): _____
Address and Phone No.: _____
_____

Children:

1. _____ Address/Phone No.: _____
2. _____ Address/Phone No.: _____
3. _____ Address/Phone No.: _____
4. _____ Address/Phone No.: _____
5. _____ Address/Phone No.: _____

Siblings:

1. _____ Address/Phone No.: _____
2. _____ Address/Phone No.: _____
3. _____ Address/Phone No.: _____

Next of Kin:

1. _____ Address/Phone No.: _____
2. _____ Address/Phone No.: _____
3. _____ Address/Phone No.: _____

Friends/Neighbors:

1. _____ Address/Phone No.: _____
2. _____ Address/Phone No.: _____
3. _____ Address/Phone No.: _____

The person ☐ **does** ☐ **does not** have a guardian in the State of Texas.
The person ☐ **has** ☐ **has not** executed a Durable Power of Attorney.
The person ☐ **has** ☐ **has not** executed a Living Will.
The person ☐ **has** ☐ **has not** executed a DNR.

The person ☐ **is** ☐ **is not** a resident of El Paso County. If not, the person is a resident of _____.

If the person **has** executed a **Power of Attorney** please provide the following information:

Name of agent: _____
Address: _____
Phone No.: _____

The nature and degree of the person's incapacity is as follows: (Copy of Physician's Certificate of Medical Examination is attached).

_____

_____

_____

_____

I am aware of the following facts that indicate that the person needs a guardian:

_____

_____

_____

The person has the following assets and income:

Home located at: _____
Approximate Value: $_____

Bank Accounts: (Please list name of Banking Institution and balance on account/s)

_____ $_____
_____ $_____
_____ $_____

Stocks/Bonds:

_____ $_____
_____ $_____

Other Assets:

_____ $_____
_____ $_____

Monthly Income and Sources: (i.e., Social Security/SSI/Retirement/V.A.)

_____ $_____
_____ $_____
_____ $_____

The person ☐ **is** ☐ **is not** involved with other community agencies (i.e., Adult Protective Services, Mental Health Authority, Hospice, etc.)

Please List Agencies and Contact Person:

1. _____
2. _____
3. _____
4. _____

I ☐ **have** ☐ **have not** made attempts to contact family members and the results are as follows:

_____

_____

_____

I ☐ **do believe** ☐ **do not believe** that the person is in imminent danger, has a serious impairment, and that there is a possibility that his/her estate will be subject to damage or dissipation unless immediate action is taken (please provide an explanation below):

_____

_____

_____

_____

This information is true and correct to the best of my knowledge; I am aware that this information might be included in the Application for Guardianship filed with the Probate Court.

Date: _____, _____.

_____ _____

(Please print your name) *(Signature)*

Address: _____

_____

_____

Phone No.: _____

Health Care Provider's Certificate of Medical Examination

Revision September 2023

In the Matter of the Guardianship of

_____,

an Alleged Incapacitated Person

For Court Use Only
Court Assigned:_____

To the Physician, Psychologist, or Advanced Practice Registered Nurse

This form is to enable the Court to determine whether the individual identified above is incapacitated according to the legal definition (on page 3), and whether that person should have a guardian appointed.

1. General Information

Examining Health Care Provider's Name _____ Phone: (_____)_____
Office Address _____
_____

Select one: ☐ I am a physician currently licensed to practice in the State of Texas;
☐ I am a psychologist currently licensed in the State of Texas or certified by HHSC; or
☐ I am an advanced practice registered nurse acting under a physician's delegation authority and supervision in accordance with Chapter 157, Occupations Code.

☐ YES ☐ NO I have experience examining individuals with the physical or mental condition resulting in the Proposed Ward's incapacity; or

☐ YES ☐ NO I have an established patient-provider relationship with the Proposed Ward

Proposed Ward's Name _____
Date of Birth _____ Age_____ Gender ☐ M ☐ F
Proposed Ward's Current Residence: _____
_____

I last examined the Proposed Ward on _____, 20_____ at:
☐ a Medical facility ☐ the Proposed Ward's residence ☐ Other: _____

☐ YES ☐ NO The Proposed Ward is under my continuing treatment.
☐ YES ☐ NO Before the examination, I informed the Proposed Ward that communications with me would not be privileged.
☐ YES ☐ NO A mini-mental status exam was given. If "YES," please attach a copy.

2. Evaluation of the Proposed Ward's Physical Condition *(required to be completed by physician or APRN only, not psychologist)*

Physical Diagnosis: _____
a. Severity: ☐ Mild ☐ Moderate ☐ Severe
b. Prognosis: _____
c. Treatment/Medical History: _____

3. Evaluation of the Proposed Ward's Mental Functioning

Mental Diagnosis: _____
a. Severity: ☐ Mild ☐ Moderate ☐ Severe
b. Prognosis: _____
c. Treatment/Medical History: _____

If the mental diagnosis includes dementia, answer the following:

☐ YES ☐ NO ---- It would be in the Proposed Ward's best interest to be placed in a secured facility for the elderly or a secured nursing facility that specializes in the care and treatment of people with dementia.
☐ YES ☐ NO ---- It would be in the Proposed Ward's best interest to be administered medications appropriate for the care and treatment of dementia.
☐ YES ☐ NO ---- The Proposed Ward currently has sufficient capacity to give informed consent to the administration of dementia medications.

d. Possibility for Improvement:

☐ YES ☐ NO ---- Is improvement in the Proposed Ward's physical condition and mental functioning possible?

If "YES," after what period should the Proposed Ward be reevaluated to determine whether a guardianship continues to be necessary? _____

4. Cognitive Deficits

a. The Proposed Ward is oriented to the following (check all that apply):

☐ Person ☐ Time ☐ Place ☐ Situation

b. The Proposed Ward has a deficit in the following areas (check all areas in which Proposed Ward has a deficit):

☐--- Short-term memory
☐--- Long-term memory
☐--- Immediate recall
☐--- Understanding and communicating (verbally or otherwise)
☐--- Recognizing familiar objects and persons
☐--- Solve problems
☐--- Reasoning logically
☐--- Grasping abstract aspects of his or her situation
☐--- Interpreting idiomatic expressions or proverbs
☐--- Breaking down complex tasks down into simple steps and carrying them out

c. ☐ YES ☐ NO -- The Proposed Ward's periods of impairment from the deficits indicated above (if any) vary substantially in frequency, severity, or duration.

5. Ability to Make Responsible Decisions

Is the Proposed Ward able to initiate and make responsible decisions concerning himself or herself regarding the following:

☐ YES ☐ NO ---- Make complex business, managerial, and financial decisions
☐ YES ☐ NO ---- Manage a personal bank account
If "YES," should amount deposited in any such bank account be limited? ☐ YES ☐ NO
☐ YES ☐ NO ---- Safely operate a motor vehicle
☐ YES ☐ NO ---- Vote in a public election
☐ YES ☐ NO ---- Make decisions regarding marriage
☐ YES ☐ NO ---- Determine the Proposed Ward's own residence
☐ YES ☐ NO ---- Administer own medications on a daily basis
☐ YES ☐ NO ---- Attend to basic activities of daily living (ADLs) (e.g., bathing, grooming, dressing, walking, toileting) without supports and services
☐ YES ☐ NO ---- Attend to basic activities of daily living (ADLs) (e.g., bathing, grooming, dressing, walking, toileting) with supports and services
☐ YES ☐ NO ---- Attend to instrumental activities of daily living (e.g., shopping, cooking, traveling, cleaning)
☐ YES ☐ NO ---- Consent to medical and dental treatment at this point going forward
☐ YES ☐ NO ---- Consent to psychological and psychiatric treatment at this point going forward

6. Developmental Disability

☐ YES ☐ NO ---- Does the Proposed Ward have developmental disability?
If "NO," skip to number 7 below.
If "YES," answer the following question and look at the next page.

Is the disability a result of the following? (Check all that apply)

☐ YES ☐ NO ---- Intellectual Disability?
☐ YES ☐ NO ---- Autism?
☐ YES ☐ NO ---- Static Encephalopathy?
☐ YES ☐ NO ---- Cerebral Palsy?
☐ YES ☐ NO ---- Down Syndrome?
☐ YES ☐ NO ---- Other? Please explain _____

Answer the questions in the "Determination of Intellectual Disability" box below only if both of the following are true:

(1) The basis of a proposed ward's alleged incapacity is intellectual disability. **and**

(2) **You are making a "Determination of Intellectual Disability" in accordance with rules of the executive commissioner of the Health and Human Services Commission governing examinations of that kind**.

If you are not making such a determination, please skip to number 7 below.

DETERMINATION OF INTELLECTUAL DISABILITY

Among other requirements, a Determination of Intellectual Disability must be based on an interview with the Proposed Ward and on a professional assessment that includes the following:

1) a measure of the Proposed Ward's intellectual functioning;
2) a determination of the Proposed Ward's adaptive behavior level; and
3) evidence of origination during the Proposed Ward's developmental period.

You may use a previous assessment, social history, or relevant record from a school district, another physician, a psychologist, an authorized provider, a public agency, or a private agency if you determine that the previous assessment, social history, or record is valid.

1. Check the appropriate statement below. If neither statement is true, skip to number 7 below.
   - ☐ **I examined the proposed ward in accordance with rules of the executive commissioner of the Health and Human Services Commission governing Intellectual Disability examinations**, and my written findings and recommendations include a determination of an intellectual disability.
   - ☐ **I am updating or endorsing in writing a prior determination of an intellectual disability** for the proposed ward made in accordance with rules of the executive commissioner of the Health and Human Services Commission by a physician or psychologist licensed in this state or an authorized provider certified by the Health and Human Services Commission to perform the examination.
2. What is your assessment of the Proposed Ward's level of intellectual functioning and adaptive behavior?
   ☐ Mild (IQ of 50-55 to approx. 70) ☐ Moderate (IQ of 35-40 to 50-55)
   ☐ Severe (IQ of 20-25 to 35-40) ☐ Profound (IQ below 20-25)
3. ☐ Yes ☐ No ---- Is there evidence that the intellectual disability originated during the Proposed Ward's developmental period?

Note to attorneys: *If the above box is filled out because a determination of intellectual disability has been made in accordance with rules of the executive commissioner of the Health and Human Services Commission governing examinations of that kind, a Court may grant a guardianship application if (1) the examination is made not earlier than 24 months before the date of the hearing or (2) a prior determination of an intellectual disability was updated or endorsed in writing not earlier than 24 months before the hearing date. If a physician's or NPRN's diagnosis of intellectual disability is not made in accordance with rules of the executive commissioner — and the above box is not filled out — the court may grant a guardianship application only if the Physician's Certificate of Medical Examination is based on an examination the physician performed within 120 days of the date the application for guardianship was filed. See Texas Estates Code § 1101.104(a)(1).*

7. Definition of Incapacity

For purposes of this certificate of medical examination, the following definition of incapacity applies:

An "**Incapacitated Person**" is an adult who, because of a physical or mental condition, is substantially unable to: (a) provide food, clothing, or shelter for himself or herself; (b) care for the person's own physical health; or (c) manage the person's own financial affairs. Texas Estates Code § 1002.017.

8. Evaluation of Capacity

☐ YES ☐ NO ---- Based upon my last examination and observations of the Proposed Ward, it is my opinion that the Proposed Ward is incapacitated **according to the legal definition in section 1002.017 of the Texas Estates Code, set out in the box above.**

If you indicated that the Proposed Ward is incapacitated, indicate the level of incapacity:

☐ **Total** ---------- The Proposed Ward is totally without capacity (1) to care for himself or herself and (2) to manage his or her property.

☐ **Partial** ---------- The Proposed Ward lacks the capacity to do some, but not all, of the tasks necessary to care for himself or herself or to manage his or her property.

Evaluation of Capacity (continued)

If you indicated the Proposed Ward's incapacity is partial, what specific powers or duties of the guardian should be limited if the Proposed Ward receives supports and services? _____

_____

_____

If you answered "NO" to all of the questions regarding decision-making in Section 5 (on page 2) and yet still believe the Proposed Ward is **partially** incapacitated, please explain: _____

_____

_____

If you answered "YES" to any of the questions regarding decision-making in Section 5 (on page 2) and yet still believe the Proposed Ward is **totally** incapacitated, please explain: _____

_____

_____

9. Ability to Attend Court Hearing

☐ YES ☐ NO ---- The Proposed Ward would be able to attend, understand, and participate in the hearing.

☐ YES ☐ NO ---- Because of the Proposed Ward's incapacities, I recommend that the Proposed Ward not appear at a Court hearing.

☐ YES ☐ NO ---- Does any current medication taken by the Proposed Ward affect the demeanor of the Proposed Ward or his or her ability to participate fully in a court proceeding?

10. What is the least restrictive placement that you consider is appropriate for the Proposed Ward:

☐ ---------- Nursing home level of care ☐--- Assisted Living Facility

☐ ---------- Group Home ☐--- Memory care unit

☐ ---------- Own Home or with family ☐--- Other _____

11. Additional Information of Benefit to the Court: If you have additional information concerning the Proposed Ward that you believe the Court should be aware of or other concerns about the Proposed Ward that are not included above, please explain on an additional page.

_____ _____

Physician/Psychologist/Advanced Practice Registered Nurse's Signature — Date

_____ _____

Physician/Psychologist/Advanced Practice Registered Nurse's Name Printed — License Number

If the examination was conducted by an Advanced Practicing Registered Nurse, the supervising physician shall sign below:

_____ _____

Supervising Physician's Signature — Date

_____ _____

Supervising Physician's Name Printed — License Number