

SUPERIOR COURT OF CALIFORNIA
COUNTY OF TULARE

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PROBATE CONSERVATORSHIP

| Forms included in this packet: | | |
|---------------------------------|---------|--|
| PETITIONER COMPLETES | GC-312 | Confidential Supplemental Information |
| | GC-314 | Confidential Conservator Screening Form |
| | GC-355 | Confidential Conservatorship Care Plan - Part 1 |
| | GC-356 | Confidential Conservatorship Care Plan - Part 2 (Medical Information) |
| | PRO-006 | Confidential Conservatorship Questionnaire |
| CLINICIAN COMPLETES | GC-335 | Confidential Capacity Assessment and Declaration |
| | GC-335A | Everyday Activities Attachment to Confidential Capacity Assessment and Declaration |
| | GC-325 | Confidential Declaration on Medical Ability to Attend Hearing |

What is a probate conservatorship?

A probate conservatorship is a court case where a judge appoints a responsible person or organization (the "conservator") to care for an adult (the "conservatee") who cannot care for themselves. The conservator is responsible for caring for the conservatee's daily activities, health care, and living arrangements. The person who asks the court for a probate conservatorship case is called the Petitioner, and may be the spouse, domestic partner, relative, or friend of the proposed conservatee, or may be an interested state or local agency (or employee of the agency). To learn more, visit: <https://selfhelp.courts.ca.gov/conservatorships>.

How does the Petitioner start the probate conservatorship process?

The Petitioner completes the first five forms in this packet, which cover information about the proposed conservator, conservatee, and the conservatee's relatives. These forms also discuss the reasons that a conservatorship is necessary, and why alternatives to a conservatorship are not available. The conservatee's clinician completes the three remaining forms, which include a capacity assessment and whether the proposed conservatee is able to attend court hearings. Once all forms are complete, take them to the Tulare County Superior Court's Self-Help Resource Center (SHRC), where staff will assist with completing the remaining forms for filing with the Clerk of Court.

About the Self-Help Resource Center (SHRC):

SHRC staff can provide guidance on how to complete forms, how to properly serve notice on necessary parties, and can answer procedural questions about the conservatorship process. However, SHRC staff **CANNOT** provide legal advice or represent you in court. SHRC offices are located at:

- County Civic Center: 221 S. Mooney Blvd., Room 203, Visalia CA 93291
- South County Justice Center: 300 E. Olive Ave., Porterville, CA 93257

SHRC hours are Monday through Thursday from 8 a.m. to 4 p.m., and Fridays from 8 a.m. to 12 noon. Litigants are assisted on a first-come, first-served basis; appointments are not available. SHRC staff can be reached at (559) 737-5500 and selfhelp@tularecourts.ca.gov.

CONFIDENTIAL (DO NOT ATTACH TO PETITION)

GC-312

| | |
|--|---------------------------|
| <div style="display: flex; justify-content: space-between;"><div>ATTORNEY OR PARTY WITHOUT ATTORNEY:</div><div>STATE BAR NUMBER:</div></div> <div style="display: flex; justify-content: space-between;"><div>NAME:</div><div></div></div> <div style="display: flex; justify-content: space-between;"><div>FIRM NAME:</div><div></div></div> <div style="display: flex; justify-content: space-between;"><div>STREET ADDRESS:</div><div></div></div> <div style="display: flex; justify-content: space-between;"><div>CITY:</div><div>STATE:</div><div>ZIP CODE:</div></div> <div style="display: flex; justify-content: space-between;"><div>TELEPHONE NO.:</div><div>FAX NO.:</div></div> <div style="display: flex; justify-content: space-between;"><div>EMAIL ADDRESS:</div><div></div></div> <div style="display: flex; justify-content: space-between;"><div>ATTORNEY FOR (name):</div><div></div></div> | FOR COURT USE ONLY |
| SUPERIOR COURT OF CALIFORNIA, COUNTY OF <div style="display: flex; justify-content: space-between;"><div>STREET ADDRESS:</div><div></div></div> <div style="display: flex; justify-content: space-between;"><div>MAILING ADDRESS:</div><div></div></div> <div style="display: flex; justify-content: space-between;"><div>CITY AND ZIP CODE:</div><div></div></div> <div style="display: flex; justify-content: space-between;"><div>BRANCH NAME:</div><div></div></div> | |
| CONSERVATORSHIP OF (name): | |
| PROPOSED CONSERVATEE | |
| CONFIDENTIAL SUPPLEMENTAL INFORMATION <input type="checkbox"/> Limited Conservatorship of the <input type="checkbox"/> Person <input type="checkbox"/> Estate | CASE NUMBER: |
| 1. a. Proposed conservatee (name): | HEARING DATE: |
| b. Date of birth: | DEPT.: TIME: |
| c. Age: | |
| d. Social security number: | |

2. I, the person completing this form, am the (check each that applies) ☐ petitioner ☐ proposed conservator in this proceeding.

3. ☐ **ABILITY TO PROVIDE PROPERLY FOR PERSONAL NEEDS*** The following facts and circumstances supplement and support the petition's assertions that the proposed conservatee is unable to provide properly for personal needs for physical health, food, clothing, or shelter (specify in detail, expanding on the reasons in the petition; give specific examples *from the proposed conservatee's daily life showing significant, ongoing behavior patterns*):
- a. Physical health (give examples showing the proposed conservatee's inability to move and exercise, maintain personal hygiene, make and attend routine medical appointments, take medication as prescribed, etc.):

☐ Continued in Attachment 3a.

- b. Food (give examples showing the proposed conservatee's inability to eat or drink, prepare food, shop for food, etc.):

☐ Continued in Attachment 3b.

- c. Clothing (give examples showing the proposed conservatee's inability to get dressed, do laundry, shop for clothing, etc.):

☐ Continued in Attachment 3c.

- d. Shelter (give examples showing the proposed conservatee's inability to pay rent or mortgage, pay utility bills, keep house, etc.):

☐ Continued in Attachment 3d.

* If any part of item 3 does not apply to the proposed conservatorship, skip it, check box 3 in item 10, and explain why it does not apply.

Page 1 of 4

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|--------------------------------------|--------------|
| CONSERVATORSHIP OF <i>(name):</i> | CASE NUMBER: |
| PROPOSED CONSERVATEE | |

4. ☐ **ABILITY TO MANAGE OWN FINANCIAL RESOURCES*** The following facts and circumstances supplement and support the petition's assertions that the proposed conservatee is substantially unable to manage that person's own financial resources or to resist fraud or undue influence *(specify in detail, expanding on the reasons in the petition; give specific examples from the proposed conservatee's daily life showing significant, ongoing behavior patterns):*

a. Financial resources *(give examples of the proposed conservatee's substantial inability to manage money or property):*

☐ Continued in Attachment 4a.

b. Fraud or undue influence *(give examples of the proposed conservatee's substantial inability to resist fraud or undue influence):*

☐ Continued in Attachment 4b.

* If any part of item 4 does not apply to the proposed conservatorship, skip it, check box 4 in item 10, and explain why it does not apply.

5. **RESIDENCE** *(A "residence" is the place a person would tend to describe as "home," for example, an owned or rented single-family house or an apartment in a multiunit building, or an assisted-living, board-and-care, skilled-nursing, or other long-term care facility.)*

a. The proposed conservatee's **residence** is a *(nature of residence; see above for examples):*

b. The proposed conservatee's **residence** is located at *(street address, city, state):*

c. The proposed conservatee is **currently located at** ☐ the residence in item 5b ☐ other *(street address, city, state):*

d. The proposed conservatee's **current location** is a *(nature of current location; see above for examples):*

e. **Ability to live in residence** The proposed conservatee is

(1) ☐ **living** in the residence, and

(a) ☐ is able to continue living there unless circumstances change.

(b) ☐ will need to be moved after a conservator is appointed *(give specific reasons in item 5f).*

(c) ☐ other *(specify and give reasons in item 5f).*

(2) ☐ **not living** in the residence, and

(a) ☐ will be able to return home by _____ *(explain in item 5f).*

(b) ☐ will not return to live there *(give specific reasons in item 5f).*

(c) ☐ other *(specify and give reasons in item 5f).*

f. Specific reasons supporting the determination in item 5e about the proposed conservatee's ability to live in the residence:

☐ Continued in Attachment 5f.

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| CONSERVATORSHIP OF <i>(name):</i> | CASE NUMBER: |
| PROPOSED CONSERVATEE | |

6. **ALTERNATIVES TO CONSERVATORSHIP** I have considered the following alternatives to conservatorship. For each alternative, below, either (1) I have attempted that alternative for the length of time and in the manner described and have determined for the reasons explained below that it is unsuitable or does not meet the proposed conservatee's needs; or (2) I have not attempted that alternative and have determined for the reasons explained below that it is unsuitable or does not meet the proposed conservatee's needs and therefore should not be attempted.

a. A supported decisionmaking agreement, as defined in Welfare and Institutions Code section 21001

☐ Continued in Attachment 6a.

b. Designation of a health care surrogate under Probate Code section 4711

☐ Continued in Attachment 6b.

c. An advance health care directive under Probate Code section 4600 et seq.

☐ Continued in Attachment 6c.

d. A power of attorney (general or limited, durable or nondurable) under Probate Code section 4000 et seq.

☐ Continued in Attachment 6d.

e. A trust, as defined in Probate Code section 82

☐ Continued in Attachment 6e.

f. Other alternatives considered or attempted

☐ Continued in Attachment 6f.

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|--------------------------------------|--------------|
| CONSERVATORSHIP OF <i>(name):</i> | CASE NUMBER: |
| PROPOSED CONSERVATEE | |

7. HEALTH OR SOCIAL SERVICES PROVIDED *(complete all that apply):*

- a. ☐ In the year immediately before the petition was filed, the proposed conservatee received the following **health services**, for example, doctor's visits, medical testing, hospitalizations, surgeries, administration of medication, wound care, or therapy. *(describe the services and the circumstances in which they were provided; if none were provided, state "none"):*

☐ Continued in Attachment 7a.

- b. ☐ In the year immediately before the petition was filed, the proposed conservatee received the following **social services**, for example, companionship, assistance with personal hygiene, housekeeping, shopping, cooking, or assistance managing finances. *(describe the services and the circumstances in which they were provided; if none were provided, state "none"):*

☐ Continued in Attachment 7b.

- c. ☐ I do not know, and cannot reasonably find out, what, if any, ☐ health services ☐ social services were provided to the proposed conservatee in the year immediately before the petition was filed.

8. KNOWLEDGE AND PREFERENCES The proposed conservatee *(check all that apply)*

- ☐ knows about ☐ does not know about the proposed conservatorship. ☐ I don't know.
☐ agrees with ☐ does not agree with the proposed conservatorship. ☐ I don't know. ☐ Not applicable.

9. SOURCE OF INFORMATION The facts, circumstances, and conclusions stated on this form are based, *(check all that apply)*

- a. in item 3, on ☐ my own personal knowledge ☐ an affidavit (declaration) by another person, attached as Attachment 3.
 b. in item 4, on ☐ my own personal knowledge ☐ an affidavit (declaration) by another person, attached as Attachment 4.
 c. in item 5, on ☐ my own personal knowledge ☐ an affidavit (declaration) by another person, attached as Attachment 5.
 d. in item 6, on ☐ my own personal knowledge ☐ an affidavit (declaration) by another person, attached as Attachment 6.
 e. in item 7, on ☐ my own personal knowledge ☐ an affidavit (declaration) by another person, attached as Attachment 7.
 f. in item 8, on ☐ my own personal knowledge ☐ an affidavit (declaration) by another person, attached as Attachment 8.

10. ITEMS THAT DO NOT APPLY The following items on this form, or parts of those items, do not apply to the proposed conservatorship. *(for each item checked, explain why that item or part of an item does not apply):* ☐ 3 ☐ 4

☐ Continued on Attachment 10.

11. Number of pages attached: _____

DECLARATION

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

| | | |
|----------------------|--|-------------|
| _____ | | _____ |
| (TYPE OR PRINT NAME) | | (SIGNATURE) |

CONFIDENTIAL (DO NOT ATTACH TO PETITION)

GC-314

| | | |
|---|------------------------------|--------------|
| ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address): TELEPHONE NO.: _____ FAX NO. (Optional): _____ E-MAIL ADDRESS (Optional): _____ ATTORNEY FOR (Name): _____ | FOR COURT USE ONLY | |
| SUPERIOR COURT OF CALIFORNIA, COUNTY OF _____ STREET ADDRESS: _____ MAILING ADDRESS: _____ CITY AND ZIP CODE: _____ BRANCH NAME: _____ | | |
| CONSERVATORSHIP OF _____ (Name): _____ PROPOSED CONSERVATEE | CASE NUMBER: _____ | |
| CONFIDENTIAL CONSERVATOR SCREENING FORM Conservatorship of <input type="checkbox"/> Person <input type="checkbox"/> Estate <input type="checkbox"/> Limited Conservatorship | HEARING DATE AND TIME: _____ | DEPT.: _____ |

The proposed conservator must complete and sign this form. The person requesting appointment of a conservator must submit the completed and signed form to the court with the conservatorship petition. This form must remain confidential.

How This Form Will Be Used

This form is **confidential** and will not be a part of the public file in this case. Each proposed conservator must complete and sign a separate copy of this form under rule 7.1050 of the California Rules of Court. The information provided in this form will be used by the court and by the persons and agencies designated by the court to assist the court in determining whether to appoint the proposed conservator as conservator. The proposed conservator **must** respond to each item.

1. a. **Proposed conservator (name):**
 b. Date of birth: _____
 c. Social security number: _____ d. Driver's license number: _____ State: _____
 e. Telephone numbers: Home: _____ Work: _____ Other: _____
2. a. ☐ I am related to the proposed conservatee as (specify relationship): _____
 b. ☐ I have personally known the proposed conservatee for: _____ years, _____ months.
3. ☐ I was ☐ I was not nominated as conservator of the ☐ person ☐ estate of the proposed conservatee, by ☐ the proposed conservatee. ☐ the spouse or registered domestic partner of the proposed conservatee. ☐ a parent of the proposed conservatee (If you checked "I was," provide documentation in Attachment 3.)
4. a. ☐ I am the spouse of the proposed conservatee. ☐ I have ☐ I have not filed for legal separation, dissolution of marriage, annulment, or adjudication of nullity of the marriage. (If you checked "I have," explain in Attachment 4.)
 b. ☐ I am not the spouse of the proposed conservatee.
5. a. ☐ I am the registered domestic partner of the proposed conservatee. ☐ I do not ☐ I do intend to terminate my domestic partnership with the proposed conservatee. (If you checked "I do," explain in Attachment 5.)
 b. ☐ I am a former domestic partner of the proposed conservatee. My domestic partnership with the proposed conservatee was terminated on (date): _____ . (Explain circumstances in Attachment 5.)
 c. ☐ I am neither a current nor former domestic partner of the proposed conservatee.
6. a. ☐ I do ☐ I do not owe money or have a financial obligation to the proposed conservatee. (If you checked "I do," explain in Attachment 6.)
 b. The proposed conservatee ☐ does ☐ does not owe money or have a financial obligation to me. (If you checked "does," explain in Attachment 6.)
 c. ☐ I am ☐ I am not an agent for a creditor of the proposed conservatee. (If you checked "I am," explain in Attachment 6.)

Page 1 of 2

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| CONSERVATORSHIP OF (Name): <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%; margin-top: 5px;"></div> | CASE NUMBER: <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%; margin-top: 5px;"></div> |
| PROPOSED CONSERVATEE | |

7. ☐ I have ☐ I have not filed for bankruptcy protection within the last 10 years. *(If you checked "I have," explain in Attachment 7.)*
8. ☐ I have ☐ I have not been convicted of a felony or had a felony expunged from my record. *(If you checked "I have," explain in Attachment 8.)*
9. ☐ I have ☐ I have not been charged with, arrested for, or convicted of embezzlement, theft, or any other crime involving the taking of property. *(If you checked "I have," explain in Attachment 9.)*
10. ☐ I have ☐ I have not been charged with, arrested for, or convicted of a crime involving fraud, conspiracy, or misrepresentation of information. *(If you checked "I have," explain in Attachment 10.)*
11. ☐ I have ☐ I have not been charged with, arrested for, or convicted of any form of elder abuse or neglect. *(If you checked "I have," explain in Attachment 11.)*
12. ☐ I have ☐ I have not had a restraining order or protective order filed against me in the last 10 years. *(If you checked "I have," explain in Attachment 12.)*
13. ☐ I am ☐ I am not required to register as a sex offender under California Penal Code section 290. *(If you checked "I am," explain in Attachment 13.)*
14. ☐ I have ☐ I have not previously been appointed conservator, executor, or fiduciary in another proceeding. *(If you checked "I have," explain in Attachment 14.)*
15. ☐ I have ☐ I have not been removed or resigned as a conservator, guardian, executor, or fiduciary in any other case. *(If you checked "I have," explain in Attachment 15.)*
16. ☐ I have or may have ☐ I do not have an adverse interest that the court may consider to be a risk to, or to have an effect on, my ability to faithfully perform the duties of conservator. *(If you checked "I have or may have," explain in Attachment 16.)*
17. ☐ I am ☐ I am not a private professional fiduciary, as defined in Business and Professions Code section 6501(f). *(If you checked "I am," respond to item 18. If you checked "I am not," go to item 19.)*
18. ☐ I am ☐ I am not currently licensed by the Professional Fiduciaries Bureau of the Department of Consumer Affairs. My license status and information is stated in item 1 on page 1 of the Professional Fiduciary Attachment signed by me and attached to the petition that proposes my appointment as conservator in this matter. *(Complete and sign the Professional Fiduciary Attachment and attach it to the petition, or deliver it to the petitioner for attachment, before the petition is filed. See item 3c(7) of the petition. Use form GC-210(A-PF)/GC-310(A-PF) for this attachment.)*
19. ☐ I am ☐ I am not a responsible corporate officer authorized to act for (name of corporation):

a California nonprofit charitable corporation that meets the requirements for appointment as conservator of the proposed conservatee under Probate Code section 2104. I certify that the corporation's articles of incorporation specifically authorize it to accept appointments as conservator. *(If you checked "I am," explain the circumstances of the corporation's care of, counseling of, or financial assistance to the proposed conservatee in Attachment 19.)*
20. Do you, or does any other person living in your home, have a social worker or parole or probation officer assigned to him or her?

☐ Yes ☐ No

(If you checked "Yes," explain in Attachment 20 and provide the name, address, and telephone number of each social worker, parole officer, or probation officer.)

DECLARATION

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

| | |
|--|--|
| <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%; margin-bottom: 5px;"></div> (TYPE OR PRINT NAME OF PROPOSED CONSERVATOR) | <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%; margin-bottom: 5px;"></div> (SIGNATURE OF PROPOSED CONSERVATOR)* |
|--|--|

*Each proposed conservator must fill out and file a separate screening form.

- Form Adopted for Mandatory Use
Judicial Council of California
GC-355 [Rev. January 1, 2025]

Prob. Code, §§ 2351.2, 2352.5;
Cal. Rules of Court, rule 7.1063
www.courts.ca.gov

| | |
|-------------------------------|--------------|
| CONSERVATORSHIP OF (name): | CASE NUMBER: |
| CONSERVATEE | |

3. c. The location in item 3a is (*check all that apply*):

- (1) ☐ The conservatee's single family home, condominium, or apartment.
- (2) ☐ A relative's or friend's single family home, condominium, or apartment
- (3) ☐ An acute care (a) ☐ hospital (b) ☐ psychiatric hospital.
- (4) ☐ A skilled nursing facility.
- (5) ☐ A ☐ licensed ☐ unlicensed care facility that provides (*if you know*):
 - (a) ☐ intermediate care for adults with developmental disabilities.
 - (b) ☐ residential care for older adults.
 - (c) ☐ assisted-living services (with 7 or more beds).
 - (d) ☐ board and care (with 6 or fewer beds).
- (6) ☐ Another type of residence described ☐ below. ☐ on Attachment 3c.

d. ☐ The location in item 3a uses a ☐ secured (locked) perimeter ☐ delayed egress system to regulate the departure of residents.

e. The location in item 3a ☐ is ☐ is **not** the least restrictive residence appropriate for the conservatee for the reasons given ☐ below ☐ on Attachment 3e.

f. I ☐ plan ☐ do **not** plan to move the conservatee or change the conservatee's residence within the next 12 months for the reasons given ☐ below ☐ on Attachment 3f.

g. The location in item 3a

- (1) ☐ **is** the conservatee's **personal residence** because the conservatee understands or believes, or appears to understand or believe, that it was their permanent residence on the date in item 2; **or** the conservatee cannot form or communicate an understanding or belief about their permanent residence, and it is the residence they last understood or believed, or appeared to understand or believe, to be their permanent residence.
- (2) ☐ **is not** the conservatee's **personal residence** because the conservatee understands or believes, or last understood or believed, that a *different* home or care facility was their permanent residence on the date in item 2.
 The conservatee's personal residence is located at (*street, city, state, and zip code, and, if a care facility, name*):

(3) ☐ **is not** the conservatee's **personal residence** because the conservatee does not understand or believe, and has never understood or believed, that they had a permanent residence on the date in item 2.

4. a. ☐ The conservatee is living in their personal residence. The measures necessary to allow the conservatee to stay in that residence are described (*check all that apply*): ☐ below ☐ on Attachment 4a. ☐ in item 5 ☐ in item 6 ☐ in *Confidential Conservatorship Care Plan—Part 2 (Medical Information)* (form GC-356).

b. (1) ☐ The conservatee is not living in their personal residence but **will** be able to return to live in that residence in the foreseeable future. My plan to help the conservatee return to live in their personal residence is described (*check all that apply*): ☐ below ☐ on Attachment 4b(1) ☐ in item 5 ☐ in item 6 ☐ in *Confidential Conservatorship Care Plan—Part 2 (Medical Information)* (form GC-356).

(2) ☐ The conservatee is not living in their personal residence and will **not** be able to return to live in that residence in the foreseeable future for the reasons described ☐ below ☐ on Attachment 4b(2)

| | |
|--|--------------|
| CONSERVATORSHIP OF (name): CONSERVATEE | CASE NUMBER: |
|--|--------------|

5. The conservatee is currently receiving the following care or assistance. (Check all that apply; you may provide additional information about any item in the space after "other care or assistance" or on Attachment 5j. **Note: Do not discuss confidential medical information on this form. Discuss that information only in Part 2 (form GC-356).**)

- a. ☐ No care or assistance.
- b. ☐ Light housekeeping help.
- c. ☐ Personal caregivers ☐ for _____ hours per day. ☐ 24-hour care.
- d. ☐ Assistance with daily living skills.
- e. ☐ Nursing care.
- f. ☐ Meal preparation assistance.
- g. ☐ Assistance with medication: ☐ Administering. ☐ Setup only.
- h. ☐ Assistance with mobility: ☐ Hands-on. ☐ Standby only.
- i. ☐ In-home hospice services.
- j. ☐ Other care or assistance, as described ☐ below. ☐ on Attachment 5j.

6. a. ☐ The conservatee's current care and treatment are sufficient to meet the conservatee's needs. I plan to continue the care and treatment described in item 5 and *Confidential Conservatorship Care Plan—Part 2 (Medical Information)* (form GC-356).
- b. ☐ The conservatee's current care and treatment are **not** sufficient to meet the conservatee's needs. I have arranged or plan to arrange the care described (check all that apply): ☐ below. ☐ on Attachment 6b. ☐ in item 3b of *Confidential Conservatorship Care Plan—Part 2 (Medical Information)* (form GC-356) to meet those needs.
(Note: Do not discuss confidential medical information on this form. Discuss that information only in form GC-356.)

7. ☐ The conservatee's care needs have been evaluated by a professional. A copy of the evaluation, including a description of the professional's qualifications, is included as Attachment 7.

IMPORTANT: You **must** complete and file Part 2 of the care plan (form GC-356) even if you attach a professional evaluation. If the professional evaluation includes confidential medical information, make sure to redact (block out so no one can read) that information from all copies except the copy filed with the court and the copies delivered to the conservatee, the conservatee's attorney, the conservator of the estate, and the conservator of the estate's attorney.

A professional evaluation of the conservatee's care needs is not required, but is recommended if the circumstances and the conservatee's condition warrant it and the conservatee can afford it.

Note: Include any written evaluation by a professional fiduciary appointed as conservator or proposed for appointment.

| | |
|---|--------------|
| CONSERVATORSHIP OF <i>(name):</i> <div style="text-align: right;">CONSERVATEE</div> | CASE NUMBER: |
|---|--------------|

8. a. (1) ☐ I live with the conservatee.
 (2) ☐ I plan to visit the conservatee on the schedule described ☐ below. ☐ on Attachment 8a.
- b. The steps that I plan to take to ensure that the conservatee is able to visit and communicate with family and friends, consistent with the conservatee's preferences, are described ☐ below. ☐ on Attachment 8b.
9. a. ☐ The conservatee engages in the social or recreational activities described, including location, ☐ below. ☐ on Attachment 9a.
- b. ☐ The conservatee is not able to engage in social or recreational activities for the reasons explained ☐ below. ☐ on Attachment 9b.
10. a. ☐ Any problems brought to my attention by the court, the investigator, or an interested person and my plans to address each of those problems are described ☐ below. ☐ on Attachment 10a.
- b. ☐ No specific problems have been brought to my attention.
11. a. The conservatee's estimated monthly expenses, to the extent I have access to the information needed to estimate them, in each category listed in Probate Code section 2351.2(b)(7), are stated ☐ below. ☐ on Attachment 11a.
- b. ☐ Except for the expenses stated in item 11a, I do not have access to the information needed to estimate the conservatee's monthly expenses.

12. Number of pages attached: _____

Date: _____

 (TYPE OR PRINT NAME OF CONSERVATOR OF THE PERSON)

 (SIGNATURE OF CONSERVATOR OF THE PERSON)

| | |
|--|--------------|
| CONSERVATORSHIP OF (name): CONSERVATEE | CASE NUMBER: |
| INSTRUCTIONS FOR DELIVERING COPIES OF <i>CONFIDENTIAL CONSERVATORSHIP CARE PLAN—PART 1</i> AND <i>CONFIDENTIAL CONSERVATORSHIP CARE PLAN—PART 2 (MEDICAL INFORMATION)</i> BY MAIL | |

You (the conservator, your attorney, or an employee of your attorney) must deliver a copy of *Confidential Conservatorship Care Plan—Part 1* (this form) and *Confidential Conservatorship Care Plan—Part 2 (Medical Information)* (form GC-356) to each person in item 1, below. You must also deliver a copy of this form **without** form GC-356 to each living person in item 2, below, as applicable.

You may send each copy of the care plan by mail; these instructions describe how to do that. Alternatively, you may deliver a copy to someone in person or send a copy electronically to someone who has consented to receive electronic service and provided an electronic service address on *Consent to Electronic Service and Notice of Electronic Service Address* (form EFS-005-CV).

1. **Who must receive the mailing:** You must mail a copy of this form (GC-355) and *Confidential Conservatorship Care Plan—Part 2 (Medical Information)* (form GC-356) to each of the following persons:
 - a. The conservatee;
 - b. The conservatee's attorney;
 - c. The conservator of the estate (if the court appointed one); and
 - d. The attorney for the conservator of the estate.
2. You must **also** mail a copy of this form *without* form GC-356 to each of the persons in the following categories. **But** if the court found that delivery of the care plan to one or more of those persons would result in harm to the conservatee, do not mail a copy of either Part 1 (form GC-355) or Part 2 (form GC-356) to that person or those persons.
 - a. The conservatee's spouse or domestic partner;
 - b. All the conservatee's relatives in the first degree (parents and children 12 years of age and older);
 - c. If the conservatee has no spouse or registered domestic partner *and* no relatives in the first degree, then all the relatives in the second degree (siblings, grandchildren 12 years of age and older, grandparents);
 - d. If the conservatee has a child, sibling, or grandchild under 12 years of age, then a parent, guardian, or other person having legal custody of the child, sibling, or grandchild with whom the child, sibling, or grandchild resides.
3. **When the mailing must be completed:** If the care plan is an initial plan, you must complete the mailing described above no later than the end of the 120th day after the filing date of the Order Appointing Probate Conservator (form GC-340) issued in your case. If the care plan is an update, you must complete the mailing no later than the end of the 10th day before the hearing to consider terminating the conservatorship or no later than the date the court orders.
4. **Before you mail:** Make enough copies of pages 1–4 of this form to be able to send one to each person in the categories in items 1 and 2, above. Make enough copies of form GC-356 to be able to send one to each person in item 1, above.
IMPORTANT: Do **not** send *Confidential Conservatorship Care Plan—Part 2 (Medical Information)* (form GC-356) to anyone except the persons in item 1.
5. **Fill out Proof of Delivery by Mail:** You (the conservator) or your attorney must fill out the Proof of Delivery by Mail on page 5 of this form, including the names, relationships to the conservatee, and mailing addresses of the persons in the categories in items 1 and 2, above, who are entitled to receive a copy of the plan. If the Proof of Delivery by Mail does not have enough space for the names, relationships, and addresses of all the persons who will receive a copy of the plan, you must show the additional names, relationships, and addresses on one or more additional pages and attach those pages to the Proof of Delivery.

 After completing the mailing as described in item 6 below, you or your attorney must date and sign the Proof of Delivery by Mail on page 5 of this form.
6. **How to mail:** You (the conservator), your attorney, or an employee of the attorney, must do the following:
 - a. Place copies of this form and—only to the persons listed in item 1 above—form GC-356 in sealed envelopes with postage fully prepaid addressed to each person at the address shown for that person on the Proof of Delivery by Mail on page 5 of this form or on attached additional pages.
 - b. Deposit (mail) the sealed envelope(s) with the United States Postal Service on the date and from the place (city and state) shown in item 4 at the top of the Proof of Delivery by Mail on page 5 of this form.
7. **File the care plan:** You (the conservator or your attorney) must file with the court the original *Confidential Conservatorship Care Plan—Part 1* (this form) **and** *Confidential Conservatorship Care Plan—Part 2 (Medical Information)* (form GC-356) and a signed and dated Proof of Delivery by Mail (page 5 of this form) with any additional address pages attached.

To the clerk: File this form separately from *Confidential Conservatorship Care Plan—Part 1* (form GC-355) to ensure that the confidential medical information contained in this form is not improperly disclosed.

- Form Adopted for Mandatory Use
Judicial Council of California
GC-356 [New January 1, 2025]

| | |
|--------------------------------------|--------------|
| CONSERVATORSHIP OF <i>(name):</i> | CASE NUMBER: |
| CONSERVATEE | |

3. a. ☐ The medical treatment, medications, supports, and devices described in item 2 are sufficient to meet the conservatee's current and foreseeable medical needs.
- b. ☐ The additional medical treatment, medications, supports, or devices described ☐ below ☐ on Attachment 3b are necessary to meet the conservatee's current and foreseeable medical needs.
4. The following health care providers are currently providing treatment or care to the conservatee (*give name, professional license type [e.g., physician, cardiologist or other specialist, dentist, psychotherapist] and license number, and contact information for each; if you know, describe the treatment and care provided*):
- a. Name: _____
 Professional license type: _____ License number: _____
 Mailing address: _____

 Telephone number: _____ Email address: _____
 Treatment or care provided (*if known*): _____
- b. Name: _____
 Professional license type: _____ License number: _____
 Mailing address: _____

 Telephone number: _____ Email address: _____
 Treatment or care provided (*if known*): _____
- c. Name: _____
 Professional license type: _____ License number: _____
 Mailing address: _____

 Telephone number: _____ Email address: _____
 Treatment or care provided (*if known*): _____
- ☐ Additional providers listed on Attachment 4.
5. ☐ Additional confidential medical information is discussed ☐ below. ☐ on Attachment 5.

Date: _____

_____
(TYPE OR PRINT NAME)_____
(SIGNATURE)

| | |
|---|--------------------|
| CONSERVATORSHIP OF <i>(name):</i> _____ <div style="text-align: right; margin-top: 10px;">CONSERVATEE</div> | CASE NUMBER: _____ |
|---|--------------------|

ABOUT THE CONSERVATOR (*continued*)

3. List any other residences for the last five years: _____

4. If you own your home, provide details: Lending Institution (*name and address*): _____
 Purchase price: \$ _____ Estimated market value: \$ _____ Balance owed: \$ _____
5. Expenses:
- Rent / Mortgage: \$ _____ /mo. Gas: \$ _____ /mo. Propane: \$ _____ /mo.
 Electricity: \$ _____ /mo. Garbage: \$ _____ /mo. Water: \$ _____ /mo.
 Home phone: \$ _____ /mo. Cell phone: \$ _____ /mo. Internet: \$ _____ /mo.
 Other: \$ _____ /mo. Explain: _____
6. List all persons who reside with you on a daily or part-time basis (*including the conservatee*):

| | | | |
|------------|------|--------------------|---------------|
| Full Name: | DOB: | Daytime Telephone: | Relationship: |
| | | | |
| Full Name: | DOB: | Daytime Telephone: | Relationship: |
| | | | |
| Full Name: | DOB: | Daytime Telephone: | Relationship: |
| | | | |
| Full Name: | DOB: | Daytime Telephone: | Relationship: |
| | | | |

7. Have you ever been served with a *Three-Day Notice to Pay Rent or Quit Possession of Real Property* pursuant to an oral or written agreement for the rental of residential real property? ☐ No ☐ Yes. If yes, provide the date plus name and address of the lessor or landlord: _____

Income & Benefits:

8. Employment: \$ _____ /mo. Commissions: \$ _____ /mo. Investments: \$ _____ /mo.
 Income from insurance settlement(s) / annuity: \$ _____ /mo. Other income sources: \$ _____ /mo.
 If other income source, explain: _____
9. Do you have checking or savings accounts? ☐ No ☐ Yes If yes, provide details below:

| | |
|---------------|----------|
| Account type: | Balance: |
| | |
| Account type: | Balance: |
| | |

10. Investment Broker (*name and address*): _____

| | |
|--|--------------------|
| CONSERVATORSHIP OF <i>(name):</i> _____ | CASE NUMBER: _____ |
| CONSERVATEE | |

ABOUT THE CONSERVATOR (continued)

11. Public assistance: \$ _____/mo. Social Security: \$ _____/mo. Disability: \$ _____/mo.
 Veteran's Benefits: \$ _____/mo. Other Benefit: \$ _____/mo.
 If other, explain: _____

Debts:

12. Describe all long-term debt other than mortgage listed above (*include second, third, and fourth mortgages, vehicles, business property, rental property, etc.*): _____

13. List all short-term debt including each credit card debt, debt to private parties or family members, etc. Indicate name of creditor and balance owed (*do not include bankruptcy debt*): _____

14. Have you ever been sued? ☐ No ☐ Yes If yes, explain: _____

15. Have you ever sued another person or entity, either individually or on behalf of an entity? ☐ No ☐ Yes If yes, explain: _____

Health:

16. Do you have health insurance? ☐ No ☐ Yes If yes, provide insurance carrier name: _____
 My health insurance covers: ☐ Medical ☐ Dental ☐ Vision
17. Health Status: ☐ Good ☐ Fair ☐ Poor If fair or poor, explain: _____
18. Are you taking any medication (*prescription or over-the-counter*)? ☐ No ☐ Yes If yes, list types and indicate reason: _____

19. List any special health problems: _____
20. Have you ever had a problem with: ☐ Drugs (*prescription or illegal*) ☐ Alcohol ☐ Mental / Emotional problems
 If yes, explain: _____

Education:

21. Highest level completed: _____ Age left school: _____ Degree(s) achieved: _____
 Last school attended: _____ Last year attended: _____
 Reason for leaving: _____

| | |
|--------------------------------------|--------------|
| CONSERVATORSHIP OF <i>(name):</i> | CASE NUMBER: |
| CONSERVATEE | |

ABOUT THE CONSERVATOR (continued)

Employment:

22. List your current employer and all employers over the last five years:

| | | |
|---|------------------|---------------------|
| Name and address (<i>current employer</i>): | | |
| Telephone No.: | Job description: | |
| Date Began: | | |
| Name and address: | | |
| Telephone No.: | Job description: | |
| Date Began: | Date Left: | Reason for leaving: |
| Name and address: | | |
| Telephone No.: | Job description: | |
| Date Began: | Date Left: | Reason for leaving: |
| Name and address: | | |
| Telephone No.: | Job description: | |
| Date Began: | Date Left: | Reason for leaving: |

Vehicles:

23. Provide the following information for each vehicle you own:

| | | | |
|-----------------------|-------|---------------------|--------------------|
| Year: | Make: | Model: | License Plate No.: |
| Name on Registration: | | Year Insured: | |
| Type of Coverage: | | Amount of Coverage: | |
| Year: | Make: | Model: | License Plate No.: |
| Name on Registration: | | Year Insured: | |
| Type of Coverage: | | Amount of Coverage: | |

Criminal History:

24. Have you ever been arrested or convicted for any crime other than a traffic infraction? (*Note: This question must be answered even if you were only arrested and not convicted, or if convicted, the charges were thereafter dismissed and the record ordered sealed. Include arrests for driving under the influence of alcohol or a controlled substance.*) ☐ No ☐ Yes

If yes, provide the reason for the arrest / charges, whether you were convicted, year, county, and state:

If convicted, what was the sentence? _____ Release date: _____

| | |
|--|--------------------|
| CONSERVATORSHIP OF (name): _____ <div style="text-align: right;">CONSERVATEE</div> | CASE NUMBER: _____ |
|--|--------------------|

ABOUT THE CONSERVATOR (continued)

25. Are you currently or have you ever been on probation or parole? ☐ No ☐ Yes

If yes, explain: _____

Name of Probation or Parole Officer: _____ Telephone No.: _____

26. Are you the plaintiff or defendant in any current or pending criminal or civil matter? ☐ No ☐ Yes

If yes, explain: _____

27. Have you ever applied for a domestic violence restraining order or had one issued against you? ☐ No ☐ Yes

If yes, explain: _____

28. Have you ever been the victim or perpetrator of physical, verbal, emotional, psychological, or sexual abuse? ☐ No ☐ Yes

If yes, explain: _____

Relationship to the Conservatee:

29. Relative Conservators: How are you related to the Conservatee? _____

30. Non-relative Conservators: How did you become acquainted with the Conservatee? _____

31. How long have you known the Conservatee? _____

32. What has been the nature and frequency of contact with the Conservatee prior to petitioning the Court for conservatorship?

ABOUT THE CONSERVATEE

1. Name: _____

Physical Address: _____

Mailing Address: _____

Daytime Telephone No.: _____ Cell: _____ Email: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Will the conservatee need an Interpreter at the Court hearing? ☐ Yes ☐ No

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed ☐ Domestic partners

☐ Currently living apart from spouse. If living apart, explain: _____

2. Conservatee's health insurance: ☐ Private insurance ☐ Tri-Care ☐ Medi-Cal ☐ Medicare ☐ Other: _____

| | |
|---|--------------------|
| CONSERVATORSHIP OF <i>(name):</i> _____ <div style="text-align: right; margin-top: 10px;">CONSERVATEE</div> | CASE NUMBER: _____ |
|---|--------------------|

ABOUT THE CONSERVATEE (continued)

3. Is the Conservatee a client of a Regional Center? ☐ No ☐ Yes If yes, provide details below:
 Regional Center (*name and address*): _____
 Case Manager: _____ Telephone No.: _____
 Date of last *Individual Program Plan* review: _____
 The Conservator was ☐ present in person ☐ present by phone ☐ not present
 If Conservator did not participate, explain: _____
4. Does the Conservatee attend school or an Employment / Day Program / Training Site? ☐ No ☐ Yes If yes, provide details:
 Name and Address: _____
 Usual hours and days of attendance: _____
 School / Program / Employer / Contact person: _____ Telephone No.: _____
5. List all residences / placements of the Conservatee for the last 5 years: _____

6. It is necessary to change the residence of the Conservatee now? ☐ No ☐ Yes
 If yes, explain: _____
7. Does the Conservator work for the Conservatee in any capacity (*health care, housekeeping, etc.*)? ☐ No ☐ Yes
 If yes, explain: _____
8. Will the Conservator be available to transport the Conservatee to medical, dental, optical, audiological, psychiatric, or other appointments? ☐ Yes ☐ No If no, explain how these needs will be met: _____

9. Who will manage the Conservatee's money and pay the bills? _____
10. List persons who have access to the personal mail, bank statements, or other financial records or information of the Conservatee:
- | | | |
|-------|--------------------|---------------|
| Name: | Daytime Telephone: | Relationship: |
| | | |
| Name: | Daytime Telephone: | Relationship: |
| | | |
11. Does a *Durable Power of Attorney* or a *Durable Power of Attorney for Health Care* exist? ☐ No ☐ Yes
12. If yes, where is it located? _____ When was it signed? _____
 Who is named with powers? _____

| | |
|---|--------------------|
| CONSERVATORSHIP OF <i>(name):</i> _____ <div style="text-align: right; margin-top: 10px;">CONSERVATEE</div> | CASE NUMBER: _____ |
|---|--------------------|

ABOUT THE CONSERVATEE (continued)

13. Does the Conservatee have a Will? ☐ No ☐ Yes

If yes, where is the will located? _____ When was it signed? _____

List all beneficiaries and their relationship to the Conservatee:

| | |
|-------|---------------|
| Name: | Relationship: |
| Name: | Relationship: |

14. Does the Conservatee have a Trust(s)? ☐ No ☐ Yes If yes, mark one: ☐ Revocable ☐ Irrevocable

If yes, provide the following: Preparer of Trust (*name*): _____ Date of Trust: _____

Named Trustee(s): _____

List assets and value in Trust:

| | |
|--------|--------|
| Asset: | Value: |
| Asset: | Value: |

15. Is the Conservatee the beneficiary of a Trust? ☐ No ☐ Yes If yes: ☐ Revocable or ☐ Irrevocable

If yes, provide the following: Preparer of Trust (*name*): _____ Date of Trust: _____

Named Trustee(s): _____

Nature of beneficial interest for the Conservatee: _____

16. Is the Conservatee's spouse or registered domestic partner deceased? ☐ No ☐ Yes If yes, date of death: _____

Was there community property? _____

Was there a Will? ☐ No ☐ Yes If yes, provide details below:

Has a probate petition of the Will been filed? ☐ No ☐ Yes If yes, where? _____

Will a probate petition of the Will be filed? ☐ No ☐ Yes If yes, where? _____

| | |
|-------------------------------|--------------|
| CONSERVATORSHIP OF (name): | CASE NUMBER: |
| CONSERVATEE | |

RELATIVES OF THE CONSERVATEE

If a relative listed below is deceased, enter their name and enter the word *deceased* in the mailing address section. Include date of death if known:

| | | |
|---------------------------------------|------------------|--------------------|
| Father | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Mother | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Spouse or Registered Domestic Partner | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Adult Child | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Adult Child | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Brother | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Brother | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Sister | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Sister | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Grandfather | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Grandfather | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Grandmother | Name: | Daytime Telephone: |
| | Mailing Address: | |

| | |
|--------------------------------------|--------------|
| CONSERVATORSHIP OF <i>(name):</i> | CASE NUMBER: |
| CONSERVATEE | |

RELATIVES OF THE CONSERVATEE *(continued)*

| | | |
|--|------------------|--------------------|
| Grandmother | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Adult Grandchild | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Adult Grandchild | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Relative pursuant to PC Section 1821(b) | Name: | Daytime Telephone: |
| | Mailing Address: | |
| Relative pursuant to PC Section 1821(b) | Name: | Daytime Telephone: |
| | Mailing Address: | |

NEIGHBORS AND CLOSE FRIENDS OF THE CONSERVATEE:

| | | |
|--------------|------------------|-------------------|
| Neighbor | Name: | Daytime Telephone |
| | Mailing Address: | |
| Neighbor | Name: | Daytime Telephone |
| | Mailing Address: | |
| Close Friend | Name: | Daytime Telephone |
| | Mailing Address: | |
| Close Friend | Name: | Daytime Telephone |
| | Mailing Address: | |

Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: _____

(TYPE OR PRINT NAME OF PERSON COMPLETING THIS FORM)

(SIGNATURE OF PERSON COMPLETING THIS FORM)

CONFIDENTIAL

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| | | |
|--|--|--------------------|
| ATTORNEY OR PARTY WITHOUT ATTORNEY NAME: FIRM NAME: STREET ADDRESS: CITY: STATE: ZIP CODE: TELEPHONE NO.: FAX NO.: EMAIL ADDRESS: ATTORNEY FOR (name): | | FOR COURT USE ONLY |
| SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME: | | |
| CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (name): <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE | | |
| CONFIDENTIAL CAPACITY ASSESSMENT AND DECLARATION—PROBATE CONSERVATORSHIP | | CASE NUMBER: |

This form is intended to record the results of a capacity assessment of the person named in item 2, to describe the assessing clinician's conclusions about the person's mental functioning and capacity, and to submit the results and conclusions under oath to the court. The petitioner completes items 1 and 2 to give instructions to the clinician. The clinician completes the remainder of the form.

PETITIONER'S INSTRUCTIONS TO CLINICIAN

1. **Assessments requested.** In addition to completing Parts I and II (pages 2–4), please complete the following items in Part III (pages 5–6) to assess the person's ability to perform the action or capacity to make the decision indicated (*check all that apply*):
- ☐ Item 20: Give or withhold informed consent to medical treatment specified in the petition. (Prob. Code §§ 811, 813, 2357.)
 - ☐ Item 21: Give or withhold informed consent to medical treatment generally. (*Id.*, §§ 811, 1880–1891, 2355.)
 - ☐ Item 22: Give or withhold informed consent to placement in a secured-perimeter (locked) residential care facility for the elderly. (*Id.*, §§ 811, 2356.5.)
 - ☐ Item 23: Give or withhold informed consent to administration of medication appropriate for care and treatment of major neurocognitive disorders (e.g., dementia). (*Id.*, §§ 811, 813, 2356.5.)

Note to petitioner: Provide a copy of the petition to the clinician who will be assessing the person named in item 2 for the clinician's reference. Do **not** attach *Confidential Supplemental Information* (form GC-312).

2. **Person to be assessed**

Name:
Address:
Telephone number: Email address:
Date of birth:
Highest level of education completed (*grade or degree*):
Marital or partnership status: ☐ single ☐ married/partnered ☐ dissolved ☐ widowed
Preferred language: ☐ speaks ☐ reads ☐ writes

TO THE CLINICIAN: Provide your contact and license information below.

3. a. Name:
b. Office address:
Telephone number: Email address:
4. a. ☐ I am a California-licensed physician. License no:
b. ☐ I am a California-licensed psychologist practicing within the scope of my license. License no:
☐ I have at least two years' experience diagnosing major neurocognitive disorders (including dementia).
c. I have been practicing as a licensed physician or psychologist for _____ years.

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| | |
|--|--------------|
| CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (name): <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE | CASE NUMBER: |
|--|--------------|

Information about the assessment

5. a. The person named in item 2 ☐ is ☐ is **not** a patient under my continuing care and treatment.
b. I have known this person for (specify length of time in months or years):
6. a. Date of the examination on which this assessment is based or, if based on multiple examinations, the date I most recently examined the person:
b. Time spent in most recent examination:
7. My responses to the questions and prompts on this form are based on (check all that apply):
- a. ☐ My examination of this person for the purpose of assessing the person's abilities and capacities.
b. ☐ Multiple examinations of this person for purposes of general health care and medical treatment.
c. ☐ Administration of standardized examinations or tools that measure the person's mental functioning. All tests administered and dates of administration are listed ☐ below ☐ in Attachment 7c.
- d. ☐ My review of the person's medical records.
e. ☐ Discussions with other practitioners responsible for providing health care to the person. These discussions are described ☐ below ☐ in Attachment 7e.
- f. ☐ Discussions with team members or other professionals who participated in the person's assessment. These discussions are described ☐ below ☐ in Attachment 7f.
- g. ☐ Discussions with the person's family or friends; names and relationships are given ☐ below ☐ in Attachment 7g.
- h. ☐ Other sources of information, which are described ☐ below ☐ in Attachment 7h.

REPORT OF ASSESSMENT

If a question or prompt does not apply to an ability or capacity checked in item 1 or your assessment does not address a question or prompt, please check the appropriate box in that item or, if there is no box, leave the item blank. Secure or destroy your copy of the petition. Do not send it to the court.

PART I. GENERAL PHYSICAL AND MENTAL HEALTH This part describes the general state of the physical and mental health of the person named in item 2. ☐ Information focused on the effect of the person's health on their mental function is given in items 16–18.

8. Physical health

- a. Overall physical health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know
b. Overall physical health is likely to: ☐ Improve ☐ Remain stable ☐ Deteriorate ☐ I don't know
☐ The person should be reevaluated in _____ weeks.
c. Chronic conditions that require ongoing care and treatment are listed ☐ below ☐ in Attachment 8c.

9. Mental health

- a. Overall mental health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know
b. Overall mental health is likely to: ☐ Improve ☐ Remain stable ☐ Deteriorate ☐ I don't know
☐ The person should be reevaluated in _____ weeks.
c. All known diagnosed mental health disorders (current *Diagnostic and Statistical Manual of Mental Disorders*) are listed ☐ below ☐ in Attachment 9c.

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| | |
|--|--------------|
| CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (name): <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE | CASE NUMBER: |
|--|--------------|

PART II. MENTAL FUNCTIONING This part documents the existence and extent of any deficits found by my assessment of the mental functioning of the person described in item 2. Deficits are indicated in items 10–14 as follows:

a = no deficit; **b** = mild deficit; **c** = moderate deficit; **d** = major deficit or no function; **e** = not applicable or not assessed

10. Alertness and attention (ability to recognize and react to a stimulus)

- a. Level of arousal or consciousness (deficit may be shown by lethargy, lack of response without constant stimulation, or stupor) ☐ a ☐ b ☐ c ☐ d ☐ e
- b. Orientation to:
- (1) Time (When? Year, month, day, hour) ☐ a ☐ b ☐ c ☐ d ☐ e
- (2) Place (Where? State, city, address) ☐ a ☐ b ☐ c ☐ d ☐ e
- (3) Person (Who? Name, relationship) ☐ a ☐ b ☐ c ☐ d ☐ e
- (4) Situation (What? How? Why?) ☐ a ☐ b ☐ c ☐ d ☐ e
- c. Ability to attend to and concentrate on tasks (ability to attend to a stimulus; concentrate on a stimulus over brief time periods) ☐ a ☐ b ☐ c ☐ d ☐ e

Notes:

11. Information processing

- a. Memory
- (1) Immediate recall ☐ a ☐ b ☐ c ☐ d ☐ e
- (2) Short-term memory and learning (the ability to encode, store, and retrieve information) ☐ a ☐ b ☐ c ☐ d ☐ e
- (3) Long-term memory (ability to remember information from the past) ☐ a ☐ b ☐ c ☐ d ☐ e
- b. Understanding (the ability to receive and accurately process information given in written, spoken, visual, or other media) ☐ a ☐ b ☐ c ☐ d ☐ e
- c. Communication (the ability to express oneself and indicate preferences in speech, writing, signs, pictures, etc.) ☐ a ☐ b ☐ c ☐ d ☐ e
- d. Visual-spatial reasoning (recognition of familiar objects; spatial perception, problem solving, and design) ☐ a ☐ b ☐ c ☐ d ☐ e
- e. Quantitative reasoning (the ability to understand basic quantities and make simple calculations) ☐ a ☐ b ☐ c ☐ d ☐ e
- f. Verbal reasoning (the ability to compare options, to reason using abstract concepts, and to reason logically about outcomes) ☐ a ☐ b ☐ c ☐ d ☐ e
- g. Executive functioning (the ability to plan, organize, and carry out actions (assuming physical ability) in one's own rational self-interest) ☐ a ☐ b ☐ c ☐ d ☐ e

Notes:

12. Thought disorders

- a. Organization of thinking (deficit may be demonstrated by severely disorganized, nonsensical, or incoherent thinking) ☐ a ☐ b ☐ c ☐ d ☐ e
- b. Correspondence of thoughts to reality (deficit may be demonstrated by hallucinations or delusions) ☐ a ☐ b ☐ c ☐ d ☐ e
- c. Control of thoughts (deficit may be demonstrated by uncontrollable, repetitive, or intrusive thoughts) ☐ a ☐ b ☐ c ☐ d ☐ e

Notes:

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| | |
|--|--------------|
| CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (name): <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE | CASE NUMBER: |
|--|--------------|

a = no deficit; **b** = mild deficit; **c** = moderate deficit; **d** = major deficit or no function; **e** = not applicable or not assessed

13. **Ability to modulate mood and affect** (deficit may be demonstrated by pervasive and persistent or recurrent mood or affect inappropriate in kind or degree to the circumstances) ☐ a ☐ b ☐ c ☐ d ☐ e

Notes:

14. **Ability to accept and cooperate with appropriate care or assistance** (deficit may be demonstrated by inability to acknowledge illness or disorder, acting without regard for consequences, or inability or refusal to accept appropriate care) ☐ a ☐ b ☐ c ☐ d ☐ e

Notes:

15. **Variation** (some or all of the deficits noted above vary in frequency, severity, or duration):

☐ Yes ☐ No ☐ I don't know Variation of deficits is described ☐ below ☐ in Attachment 15.

Possible Temporary or Reversible Causes of Mental Function Deficits

16. Medications

- a. Is the person currently taking any medication—prescription or nonprescription—that may impair the person's mental functioning?

☐ Yes ☐ No ☐ I don't know ☐ Not applicable

If yes, each of those medications, with dosage and treatment indications, is listed ☐ below ☐ in Attachment 16a.

| Name | Dosage/Schedule | Indications |
|------|-----------------|-------------|
|------|-----------------|-------------|

- b. ☐ Each medication listed in item 16a can impair a person's mental functioning as explained
☐ below ☐ in Attachment 16b.

17. **Reversible causes** Have temporary or reversible causes of mental impairment been considered, assessed, diagnosed, or treated?

☐ Yes ☐ No ☐ I don't know All causes considered are discussed ☐ below ☐ in Attachment 17.

18. **Physical or emotional factors** Are there physical or emotional factors (e.g., hearing, vision, or speech impairment; bereavement; or others) present that could diminish the person's capabilities and that could improve with time, treatment, or assistive devices?

☐ Yes ☐ No ☐ I don't know All causes considered are discussed ☐ below ☐ in Attachment 18.

☐ Applicable physical or emotional factors are described

Effect on Ability to Perform Everyday Activities

19. In my professional opinion, the mental function deficits, if any, identified in items 10–14 ☐ will ☐ will not significantly impair the person's ability to perform some or all activities of daily living (e.g., eating, cooking, toileting, bathing, dressing) or instrumental activities of daily living (e.g., shopping, scheduling appointments, paying bills, using a credit card or checks, taking medication). More details about specific activities and reasons for my opinion are given (check all that apply):

☐ below ☐ in Attachment 19 ☐ in the attached *Everyday Activities Attachment* (form GC-335A).

☐ I do not have enough information to form an opinion on this issue.

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| CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (name): | CASE NUMBER: |
| <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE | |

PART III. CAPACITY TO GIVE OR WITHHOLD INFORMED CONSENT This part documents my professional conclusions about each issue checked in item 1. The conclusions are based on my assessment of the level of the person's mental functions described in Part II.

20. ☐ **Capacity to give or withhold informed consent to medical treatment specified in the petition** (Probate Code, § 2357.)
 The following medical treatment has been recommended for the person (*describe*):

Based on my assessment of the person's applicable mental functions and abilities, it is my professional opinion that:

- a. ☐ The person **has** the capacity to give or withhold informed consent to the recommended medical treatment because the person can do **all** of the following: (1) respond knowingly and intelligently to questions about the treatment; (2) participate in the treatment decision by means of a rational thought process; and (3) understand (A) the nature and seriousness of the diagnosed disorder, (B) the nature of the recommended treatment, (C) the probable degree and duration of and benefits and risks of the recommended treatment, (D) the consequences of lack of treatment, and (E) the nature, risks, and benefits of any reasonable alternatives to the recommended treatment.
- b. ☐ The person **lacks** the capacity to give or withhold informed consent to the recommended medical treatment because the person **cannot do at least one** of the following: (1) respond knowingly and intelligently to questions about the treatment, (2) participate in the treatment decision by means of a rational thought process, or (3) understand at least one of the following: (A) the nature and seriousness of the diagnosed disorder, (B) the nature of the recommended treatment, (C) the probable degree and duration of and benefits and risks of the recommended treatment, (D) the consequences of lack of treatment, or (E) the nature, risks, and benefits of any reasonable alternatives to the recommended treatment.
- ☐ These conclusions are further explained ☐ below ☐ in Attachment 20b.

- c. ☐ I do not have enough information to form an opinion on this issue.

21. ☐ **Capacity to give or withhold informed consent to medical treatment generally** (Probate Code, §§ 811, 1881.)

Based on my assessment of the person's applicable mental functions and abilities, it is my professional opinion that:

- a. ☐ The person **has** the capacity to give or withhold informed consent to medical treatment because the person can do **all** of the following: (1) respond knowingly and intelligently to questions about at least some forms of medical treatment; (2) participate in at least some treatment decisions by means of a rational thought process; and (3) understand (A) the nature and seriousness of some diagnosed disorders, (B) the nature of some recommended treatments, (C) the probable degree and duration of and benefits and risks of at least some forms of treatment, (D) the consequences of lack of at least some forms of treatment, and (E) the nature, risks, and benefits of any reasonable alternatives to at least some forms of treatment.
- b. ☐ The person **lacks** the capacity to give or withhold informed consent to any form of medical treatment because **either** (1) the person is unable to respond knowingly and intelligently to questions about their medical treatment **or** (2) the person is unable to participate in treatment decisions by means of a rational thought process, which means the person cannot understand at least one of the following: (A) the nature and seriousness of any illness, disorder, or defect that they have or may develop; (B) the nature of any medical treatment that is or may be recommended by their health-care providers; (C) the probable degree and duration of any benefits and risks of any medical intervention that is or may be recommended by the person's health-care providers and the consequences of lack of treatment; or (D) the nature, risks, and benefits of any reasonable alternatives.

The person's lack of capacity to give or withhold informed consent is linked to one or more mental function deficits described in Part II.

☐ These conclusions are further explained ☐ below ☐ in Attachment 21b.

- c. ☐ I do not have enough information to form an opinion on this issue.

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| CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (name): <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE | CASE NUMBER: |
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22. ☐ **Capacity to give or withhold informed consent to placement in a secured-perimeter residential facility for persons with major neurocognitive disorders** (Probate Code, § 2356.5.)
- a. ☐ The person has a major neurocognitive disorder (such as dementia) as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*. See Part I of this form for more information.
- b. ☐ The person needs or would benefit from placement in a restricted and secure environment for the reasons (for example, wandering, violence, or rejecting care) explained ☐ below ☐ in Attachment 22b.
- c. Based on my assessment of the person's relevant mental functions and abilities, it is my professional opinion that:
- (1) ☐ The person **has** the capacity to give or withhold informed consent to this placement.
- (2) ☐ The person **lacks** the capacity to give or withhold informed consent to this placement. The mental function deficit or deficits described in Part II significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of giving consent to placement in a restricted, secured-perimeter residential facility.
☐ These conclusions are further explained ☐ below ☐ in Attachment 22c.
- d. ☐ The proposed placement in a locked or secured-perimeter facility ☐ is ☐ is **not** the least restrictive environment appropriate to the person's needs.
- e. ☐ I do not have enough information to form an opinion on this issue.
23. ☐ **Capacity to give or withhold informed consent to administration of medication for treatment of major neurocognitive disorders** (Probate Code, § 2356.5.)
- a. ☐ The person has a major neurocognitive disorder (such as dementia) as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*. See Part I of this form for more information.
- b. ☐ The person needs or would benefit from appropriate medications for the care and treatment of major neurocognitive disorders (including dementia). Any medications and the need or potential benefit of each are described ☐ below ☐ in Attachment 23b.
- c. Based on my assessment of the person's relevant mental functions and abilities, it is my professional opinion that:
- (1) ☐ The person **has** the capacity to give or withhold informed consent to the administration of medications appropriate for the care and treatment of major neurocognitive disorders (including dementia).
- (2) ☐ The person **lacks** the capacity to give or withhold informed consent to the administration of medications appropriate to the care and treatment of major neurocognitive disorders (including dementia). The mental function deficit or deficits described in Part III significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of giving consent to the administration of medications for the care and treatment of major neurocognitive disorders (including dementia).
☐ These conclusions are further explained ☐ below ☐ in Attachment 23c.
- d. ☐ I do not have enough information to form an opinion on this issue.
24. ☐ Other information regarding my assessment of the person's mental functions, any deficits in those functions, and any resulting significant impairments to the person's ability to understand and appreciate the consequences of acts or decisions is given in Attachment 24.
25. Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT NAME)

(SIGNATURE OF DECLARANT)

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| CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (name): <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE | CASE NUMBER: |
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EVERYDAY ACTIVITIES ATTACHMENT TO CONFIDENTIAL CAPACITY ASSESSMENT AND DECLARATION—PROBATE CONSERVATORSHIP (FORM GC-335)

This form is for optional use in a probate conservatorship proceeding, in conjunction with *Confidential Clinical Assessment and Declaration—Probate Conservatorship* (form GC-335), to indicate the ability of the person described in item 1 to perform activities of daily living and instrumental activities of daily living.

The person whose abilities are described on this form

1. a. Name:
b. Address:
Telephone number: Email address:
Date of birth:

The person who is completing this form

2. a. Name:
b. Office address:
Telephone number: Email address:
3. a. ☐ I am a California-licensed. ☐ physician ☐ psychologist ☐ nurse practitioner ☐ physician assistant
☐ registered nurse ☐ clinical social worker ☐ occupational therapist
☐ other licensed professional (*specify profession*):
b. My license number is:
4. Check the box or boxes that apply to you.
 - a. ☐ I am the clinician who conducted the assessment of the person named in item 1 documented on the *Confidential Clinical Assessment and Declaration—Probate Conservatorship* (form GC-335) to which this form is attached, and I completed that form. The conclusions and opinions given in this form are based on the same assessment.
 - b. ☐ I work or consult with the clinician who completed the *Confidential Clinical Assessment and Declaration—Probate Conservatorship* (form GC-335) to which this form is attached, and I participated in that clinician's assessment of the person named in item 1. The conclusions and opinions in this form are based on my participation in that assessment.
 - c. ☐ The conclusions and opinions given in this form are based on the application of my knowledge, experience, and training to my personal observations of the person named in item 1, as described below.

Items 5–11 describe my conclusions about the ability of the person named in item 1 to perform activities in each of the listed categories based on information gathered as described in item 4.

Activities of Daily Living (care of self and related activities)

5. **Maintain adequate hygiene** (for example, bathing, grooming, dressing, caring for teeth, going to the toilet)
☐ Able; fully independent ☐ Able with advice and passive support ☐ Able only with active assistance ☐ Unable, even with assistance ☐ I don't know
Comments ☐ below ☐ in Attachment 5.

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| CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (name): <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE | CASE NUMBER: |
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Activities of Daily Living (care of self and related activities)

6. Prepare meals and eat for adequate nutrition

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 6.

7. Identify abuse or neglect and protect self from harm

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 7.

Instrumental Activities of Daily Living

8. Financial (if appropriate, note dollar limits)

a. Protect and spend small amounts of cash

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 8a.

b. Manage and use checks; pay monthly bills

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 8b.

c. Enter into a contract (including, for example, to buy, sell, or lease real property or to obtain and use a credit card)

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 8c.

9. Resist fraud or undue influence (for example, has a history of being a victim of fraud or undue influence)

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 9.

10. Medical

a. Choose and direct caregivers

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 10a.

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| <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE | |

10. b. Admit self to health-care facility

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 10b.

c. Manage own medication (take proper dose as scheduled; refill or renew prescriptions as needed)

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 10c.

d. Contact help if ill or in an emergency

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 10d.

11. Home and community life

a. Maintain a reasonably safe and clean home or other living environment; arrange for home maintenance or repair

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 11a.

b. Recognize and avoid common hazards (for example, a hot stove or poisons)

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 11b.

c. Access transportation (for example, drive a car or use public transportation)

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 11c.

a. Initiate and follow a schedule of daily activities

- ☐ Able; fully independent
 ☐ Able with advice and passive support
 ☐ Able only with active assistance
 ☐ Unable, even with assistance
 ☐ I don't know
- Comments ☐ below ☐ in Attachment 11d.


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| CONSERVATORSHIP OF THE <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (name): <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE | CASE NUMBER: |
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12. ☐ Other information regarding my assessment of the person's ability to perform activities of daily living or instrumental activities of daily living, including any significant impairments to that ability, is given ☐ below ☐ in Attachment 12.

13. Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

| | | |
|-------------------------------|---|-----------------------------------|
| _____ (TYPE OR PRINT NAME) |  | _____ (SIGNATURE OF DECLARANT) |
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| ATTORNEY OR PARTY WITHOUT ATTORNEY NAME: FIRM NAME: STREET ADDRESS: CITY: STATE: ZIP CODE: TELEPHONE NO.: FAX NO.: EMAIL ADDRESS: ATTORNEY FOR (name): | FOR COURT USE ONLY FILE IN CONFIDENTIAL FOLDER |
| SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME: | |
| CONSERVATORSHIP OF <input type="checkbox"/> PERSON <input type="checkbox"/> ESTATE OF (name): <input type="checkbox"/> CONSERVATEE <input type="checkbox"/> PROPOSED CONSERVATEE | |
| CONFIDENTIAL DECLARATION ON MEDICAL ABILITY TO ATTEND HEARING—PROBATE CONSERVATORSHIP | CASE NUMBER: |

The person requesting the declaration must complete item 1.

1. A petition that requires a hearing
 - a. ☐ has been filed in the conservatorship proceeding named above and set for hearing on (date):
 - b. ☐ will be filed in the conservatorship proceeding named above.

INSTRUCTIONS TO DECLARANT (PRACTITIONER)

The (proposed) conservatee is expected to attend the hearing, but may be excused if medically unable to attend. *Please complete items 2–6, below, to give your professional opinion whether the (proposed) conservatee is medically able to attend.*

Note: Emotional or psychological instability does not qualify as medical inability to attend unless, because of that instability, attending the hearing is likely to cause the (proposed) conservatee serious and immediate physiological damage.

DECLARANT'S CONTACT INFORMATION AND QUALIFICATIONS

2. Name:
3. Office address, telephone number, and email:
4. a. ☐ I am a California-licensed ☐ physician ☐ psychologist ☐ nurse practitioner ☐ physician assistant
☐ registered nurse ☐ other medical practitioner (specify):
 My license number is:
 - b. ☐ I am an accredited practitioner of a religion that calls for reliance on prayer alone for healing. The (proposed) conservatee is an adherent of my religion and is under my treatment.
 Accrediting religious organization (name):
5. a. I last examined the (proposed) conservatee on (date):
 b. The (proposed) conservatee ☐ is ☐ is **not** a patient under my ongoing care and treatment.

MEDICAL ABILITY TO ATTEND COURT HEARING

6. a. ☐ The (proposed) conservatee is medically able to attend a court hearing (check all that apply):
☐ in person ☐ remotely.
 - b. ☐ The (proposed) conservatee is medically unable to attend a court hearing (check one):
 (1) ☐ from (date): until (date):
 (2) ☐ for the foreseeable future.
 - c. **Factual basis for conclusion** (Supporting facts are stated ☐ below ☐ on Attachment 6c.)

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:



(TYPE OR PRINT NAME)

(SIGNATURE OF DECLARANT)

Page 1 of 1