Office of the Public Guardian and Conservator (MCPGC)
209 SW 4th Ave., Suite 510 ▪ Portland, Oregon 97204 ▪ Phone (503) 988-4567 ▪ Fax (503) 988-4075
Web: www.multco.us/ads/public-guardian-program ▪ E-mail: mcpgc@multco.us

PROGRAM REFERRAL INFORMATION

INFORMATION AND REFERRAL

The Multnomah County Public Guardian's Office provides information and consultation on matters related to guardianship and conservatorship. We encourage you to call and discuss problem situations or a possible referral. Serious referrals must contain the assessments and information required by the program, to assure that intakes comply with program and court standards, and agency values. We encourage you to enlist the support of team members when completing the attached worksheet. A referral letter or existing narrative from evaluations, reports or case notes may be substituted if this documentation can sufficiently address the areas of incapacity. In either case, we must have the required information to file. Petitioning the court for guardianship and conservatorship is a process involving assessment, documentation and a legal proceeding in the Multnomah County Circuit Court.

ELIGIBILITY AND PROGRAM CRITERIA

Age 18 or over.
Multnomah County resident.
No family or private sector resource willing and able to serve as guardian/conservator.
High risk of abuse, exploitation, loss of life or health.
No less restrictive intervention available.
Meets Oregon Revised Statutes (ORS), court, and program standards for incapacity (see excerpts below).

GUARDIANSHIP (Personal and Health Care Decisions)

The Multnomah County Public Guardian/Conservator petitions the court on cases for which it has agreed to serve as guardian; the court decides whether guardianship and/or conservatorship will be granted. Within statutory and program criteria, we triage referrals for urgency and risk to the individual.

The Public Guardian Office does not conduct the investigations or assessments necessary to determine and document incapacity; we rely on independent professional assessments. **Referrals must be documented sufficiently to allow an intake decision, a responsible and complete court filing, and to support a contested case hearing.**

> "Incapacitated" means a condition in which a person's ability to receive and evaluate information effectively or to communicate decisions is impaired to such an extent that the person presently lacks the capacity to meet the essential requirements for the person's physical health and safety. *"Meeting the essential requirements for physical health and safety" means those actions necessary to provide the health care, food, shelter, clothing, personal hygiene and other care without which serious physical injury or illness is likely to occur." ORS 125.005(5).*

CONSERVATORSHIP (Property and Financial Decisions)

Referrals for conservatorship only may be accepted when the client is an individual with declining capacity who is expected to require guardianship in the foreseeable future. Priority is given to situations involving exploitation or where conservatorship may preserve a more independent lifestyle for the individual.

"Financially incapable" means a condition in which a person is unable to manage financial resources of the person effectively for reasons including, but not limited to, mental illness, mental deficiency, physical illness or disability, chronic use of drugs or controlled substances, chronic intoxication, confinement, detention by a foreign power or disappearance. *"Manage financial resources" means those actions necessary to obtain, administer and dispose of real and personal property, intangible property, business property, benefits and income." ORS 125.005(3)*.

TEMPORARY FIDUCIARY (Emergency Guardianship)

A temporary fiduciary who will exercise the powers of a guardian may be appointed by the court *"if the court makes a specific finding by clear and convincing evidence that the respondent is incapacitated or a minor, that there is an immediate and serious danger to the life or health of the respondent, and that the welfare of the respondent requires immediate action" (ORS 125.600).* Our program gives priority for temporary guardianship/conservatorship to cases of abuse and exploitation.

DOCUMENTATION REQUIREMENTS

Documentation should address both incapacity and the results of that incapacity, as outlined in ORS 125.005(5). Opinions should be supported by facts. The factual information must demonstrate that appointment is necessary as a means of providing continuing care and supervision and must give a clear expectation of what guardianship or conservatorship can and will accomplish. Reports should be recent and suitable for court review.

Referral Worksheet/Letter: The worksheet (see attached) should contain the factual information that supports the request for the appointment of a fiduciary (guardian or conservator) and the names/addresses of all persons who have information that would support a finding of incapacity or financial incapability.

Medical Statement: Local court standards require submission of a letter from the treating physician which summarizes the diagnoses, at least one of which relates to the incapacity, as well as other relevant medical issues. This report should outline needed medical decisions, and include a clear statement of opinion about incapacity and a recommendation for guardianship.

Psychological/Psychiatric Assessment: This should directly address the areas of mental or functional incapacity. Extensive testing is not required if simple or partial instruments display the deficit(s) clearly and are interpreted. In cases involving judgment and insight deficits only, psychological testing is essential, as well as discussion by the clinician concerning the link between reported harmful behavior and the deficit(s).

WORKSHEET SUBMISSION INSTRUCTIONS

To submit the below worksheet for referral, save a copy of this PDF document to your computer (enabled for Adobe Reader users), then send **Attention: Kristin Riley** or **Mark Sanford** using one of the following methods:

1. **Attach as an E-mail** to mcpgc@multco.us.
2. **Print a copy and FAX** to (503) 988-4075.
3. **Print a copy and MAIL** to the MCPGC at 209 SW 4th Avenue, Suite 510, Portland, OR 97204.
4. For Multnomah County users: **Print a copy and INTEROFFICE MAIL** to 167/1/510.

Any questions, please contact us at (503) 988-4567.

Office of the Public Guardian and Conservator (MCPGC)
209 SW 4th Ave., Suite 510 ▪ Portland, Oregon 97204 ▪ Phone (503) 988-4567 ▪ Fax (503) 988-4075
Web: www.multco.us/ads/public-guardian-program ▪ E-mail: mcpgc@multco.us

REFERRAL WORKSHEET

SERVICE REQUESTED ☐ **Guardianship** ☐ **Conservatorship** ☐ **Emergency G/C**

PERSONAL INFORMATION

Last Name	**First Name**	**Middle**
Prefers to be Called (if different from above)	**Aliases**	

Date of Birth	**Marital Status**	**Social Security Number**

Primary Medical Insurance (Medicaid, Medicare, etc.)	**Primary Medical Number**
Secondary Medical Insurance	**Secondary Medical Number**
Other Medical Insurance (VA, Tribal Benefits, etc.)	**Other Medical Number**

PHYSICAL DESCRIPTION AND PREFERENCES

Height	**Weight**	**Eye Color**	**Hair**
Gender Identity (Client Preference)		**Physical Gender**	
Race / Ethnicity (Client Preference, multiple listings or "none" okay)			
Language (Client Preference)		**Primary Language** (if different from English)	
Mobility Needs (Wheelchair, Prosthetics)		**Other Ability Needs** (Visual, Auditory, etc.)	

INTERACTION AND COMMUNICATION NEEDS

Please identify any specific trauma-informed and person-centered approaches proven effective in interacting and working with this person. This might include cultural or gender affinity preferences, sensitivity in discussing particular traumatic events or life experiences, or other communication style methods respectful of client preference.

CURRENT LOCATION

Please indicate the individual's current, immediate location.

Facility or Hospital Name (if applicable)				
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			
Expected Date of Discharge (if any)	Notes Re: this Location			

PERMANENT OR REGULAR RESIDENCE

Please indicate where the individual regularly resides, if different from above.

Facility Name (if applicable)				
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			
Dates	Notes Re: this Location			

MAILING ADDRESS

If different from above.

Attention (if not to the individual)				
Street Address or PO Box	Room #	City	State	Zip

OTHER CONTACT INFO

Personal Cell Phone
Email Address
Social Media Contact Info

CONTACT NOTES

Please identify any challenges in contacting the client either in-person or through the above options.

MEDICAL DOCUMENTATION

Psychological / Psychiatric Evaluation	☐ No	☐ Yes	(Attach Copy)
Physician Letter	☐ No	☐ Yes	(Attach Copy)
Medical History & Physical	☐ No	☐ Yes	(Attach Copy)
Authorization for Release of Information	☐ No	☐ Yes	(Attach Copy)

Physicians Who Have Treated or Evaluated

1	Name, Title	Office or Hospital Name			
	Street Address	Room #	City	State	Zip
	Phone	Alt. Phone, Fax, Cell, E-mail (specify)			
2	Name, Title	Office or Hospital Name			
	Street Address	Room #	City	State	Zip
	Phone	Alt. Phone, Fax, Cell, E-mail (specify)			

ALTERNATIVES

Lesser-Restrictive Alternatives to Guardianship and Conservatorship Considered/Employed

Please indicate any alternative methods employed to meet the individual's needs and the reasons why these methods were not effective. Some alternatives might include Advance Directive for health care decision-making, Mental Health commitment and services, Adult Protective Services or other case management, financial Power of Attorney, Representative Payee services, or other money management alternatives.

GUARDIANSHIP / CONSERVATORSHIP CRITERIA NARRATIVE

1. Ability to Evaluate Information / Communication

The person is an adult whose ability to receive and evaluate information effectively or communicate decisions is impaired.

Factual information

2. Health Care

The person does not adequately provide for his/her health care.

Factual information

3. Food / Shelter

The person does not adequately provide for his/her food, nutrition and shelter.

Factual information

4. Clothing / Hygiene

The person does not adequately provide for clothing or personal hygiene.

Factual information

5. Safety / Other Care

The person does not adequately provide for his/her safety and/or other care, without which serious physical injury is likely to occur.

Factual information

6. Management of Financial Resources

The person is unable to manage financial resources effectively.

Factual information

7. Other Relevant Information

Not captured in the above categories

Factual information

INCOME AND ASSETS

Monthly Income (Social Security, SSI, pensions, etc.)

Source	Contact Info (if necessary)	Amount
Source	Contact Info (if necessary)	Amount
Source	Contact Info (if necessary)	Amount

Bank Accounts or Other Accounts

Bank Name and Branch	Account Number	Balance
Bank Name and Branch	Account Number	Balance

Real Property

1	Street Address	Room #	City	State	Zip	
	Name on Title	Phone, Fax, Cell, E-mail (specify)				
2	Street Address	Room #	City	State	Zip	
	Name on Title	Phone, Fax, Cell, E-mail (specify)				

Personal Property (Automobiles, furniture, jewelry, household furnishings, etc.)

1	Description	Estimated Value
2	Description	Estimated Value
3	Description	Estimated Value

Other Property (Insurance policies, stocks, bonds, funeral arrangements, etc.)

1	Description	Cash Value
2	Description	Cash Value
3	Description	Cash Value

CONTACTS

Persons Having Direct Knowledge of Incapacities Outlined Above (Case manager, social worker, nurse, physician, family, others)

Name, Title	Agency, Office, or Hospital Name			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			
Name, Title	Agency, Office, or Hospital Name			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			
Name, Title	Agency, Office, or Hospital Name			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			

Individuals Entitled to be Noticed (Spouse, parents, adult children, co-habitants, nearest relatives, attorneys. Include all, even uninvolved.)

Name	Relationship			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			
Name	Relationship			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			
Name	Relationship			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			
Name	Relationship			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			

Individuals Nominated, or Acting as, Fiduciary, Trustee, Power of Attorney, or Health Care Representative

Name	Relationship			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			
Name	Relationship			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			
Name	Relationship			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			

REFERRAL SOURCE CONTACT INFORMATION

Please supply your name and contact information. (Not required for Department of County Human Services and other regular referral sources)

Name, Title	Agency, Office, or Hospital Name			
Street Address	Room #	City	State	Zip
Phone	Alt. Phone, Fax, Cell, E-mail (specify)			