**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/STATUTORY REQUIREMENTS

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, health or safety.
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: **Stephanie Harrington** or **Kristin Riley** 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.

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# REFERRAL WORKSHEET

SERVICE REQUESTED ☐ Guardianship ☐ Conservatorship ☐ Emergency G/C

## REFERRAL INFORMATION

Please supply your name and contact information. (DCHS referrals: name and phone only is okay)

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

## CLIENT 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.) |

## CULTURALLY-SPECIFIC NEEDS

Please identify any culturally-specific needs or sensitivities important to the person that should to be accommodated in the development of an effective working relationship and care plan. This might include cultural or religious associations, gender affinity preferences, sensitivity in discussing particular traumatic events or life experiences, or other communication needs respectful of client preference.

Please limit responses to the size of this box. If additional space is needed, please add to Additional Comments on Page 11.

## 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 | | | |

## OTHER CONTACT INFO

| Email Address |
|---|
| Social Media Contact Info |

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

Please limit responses to the size of this box. If additional space is needed, please add to Additional Comments on Page 11.

## ALTERNATIVES ATTEMPTED

Consistent with State of Oregon statute, national practice standards and Multnomah County values, the MCPGC's program policy is that guardianship/conservatorship is an intervention of last resort. In addition to the eligibility criteria listed in the introductory preface above, referrals must also demonstrate that lesser-restrictive interventions have been creditably attempted and were not successful. Please indicate which methods have been tried and describe the results below:

- ☐ Advanced Directive
- ☐ Health Care Representative
- ☐ Mental/Behavioral Health Commitment or Services
- ☐ Adult Protective Services or Other Case Management
- ☐ Private or Family Guardianship
- ☐ In-Home or Community-Based Caregiving or Support
- ☐ Financial Power of Attorney
- ☐ Representative Payee Services
- ☐ Supported Decision-Making
- ☐ Other (Please Describe)

Please limit responses to the size of this box. If additional space is needed, please add to Additional Comments on Page 11.

## EFFICACY OF GUARDIANSHIP/CONSERVATORSHIP

Guardianship/conservatorship authority is not an automatic "fix" that can resolve every issue. Please describe the practical application of guardian/conservator authority and how it will make a difference in the circumstance (for example, consent for involuntary medication administration):

Please limit responses to the size of this box. If additional space is needed, please add to Additional Comments on Page 11.

## REQUIRED DOCUMENTATION

A complete referral for public guardianship/conservatorship must include a completed psychiatric/cognitive evaluation and a letter from a physician directly supporting the need for guardianship/conservatorship. Other formal documentation such as medical records, authorizations for release of information, or other decision-making documents that can support the need for guardianship/conservatorship are helpful as well but not required.

| | | | |
|---|---|---|---|
| Psychiatric/Cognitive 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) | | | |

## GUARDIANSHIP / CONSERVATORSHIP CRITERIA NARRATIVE

### 1. Events Leading Up to this Referral

Please narrate the situation to date. Be sure to specify all incidents and activities that have contributed or are contributing to the need for guardianship/conservatorship. Examples include: repeated hospitalizations, substantiated abuse or Adult Protective Services involvement, police or other public safety involvement, homelessness, incidences of abuse, self-neglect or financial exploitation. Please include dates if possible.

*Factual information*

Please limit responses to the size of this box. If additional space is needed, please add to Additional Comments on Page 11.

## 2. Ability to Evaluate Information / Communication

Describe the above. Please be specific about the individual's mental status, cognition and executive function. Include the individual's ability to process information and decision-making capability as well as their ability to have meaningful discussions. Include any diagnoses, assessments or evaluations performed by professional staff and their conclusions.

*Factual information*

Please limit responses to the size of this box. If additional space is needed, please add to Additional Comments on Page 11.

## 3. Health Care

Please describe how the individual cannot adequately provide for his/her health and care. Include details around issues related to medical care coordination by self and with others, medication management, attending appointments, labs, follow up with outpatient treatment, use of emergency services such as 911 or hospital ED, hospitalizations (please include dates). Also, speak to the individual's ability to perform Activities of Daily Living (ADL).

*Factual information*

Please limit responses to the size of this box. If additional space is needed, please add to Additional Comments on Page 11.

## 4. Safety / Other Care

Describe how the individual is not able to adequately provide for his/her safety and how/why intervention is needed to avoid serious injury or harm. Include specific incidences such as 911 contact and response, unscheduled elopements, wandering and unsafe proximity to traffic or other dangers. Include potential or actual risk due to abuse or self-neglect as well as financial exploitation by others.

*Factual information*

Please limit responses to the size of this box. If additional space is needed, please add to Additional Comments on Page 11.

## 5. Food/Nutrition / Shelter / Clothing / Hygiene

Please describe how the person does not adequately provide for his/her food/nutrition, shelter, clothing, and hygiene.

- Food/Nutrition: any issues regarding shopping, storage and, meal preparation, without or without assistance; safe ingestion of food, document any nutritional needs required or not being met by their current situation.
- Shelter: is the individual houseless? If not, please indicate the living situation they are in, describing any issues with the house, facility or environment of their immediate surroundings. Include historical living situations if relevant.
- Clothing: the condition of the individual's clothing and wardrobe and ability to upkeep it.
- Hygiene: any issues related to cleanliness, bathing, dental care.

*Factual information*

Please limit responses to the size of this box. If additional space is needed, please add to Additional Comments on Page 11.

## 6. Management of Financial Resources

Describe the individual's financial situation and document their ability to effectively manage their affairs; be sure to include specifics as to their primary expenses and any outstanding debt or collections owed, whether they are receive Medicaid benefits or other public assistance. Describe whether or not a representative payee, money manager, financial power of attorney, or other fiduciary is involved and any issues surrounding these arrangements.

*Factual information*

Please limit responses to the size of this box. If additional space is needed, please add to Additional Comments on Page 11.

# 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 (all real property owned or co-owned by the individual whether improved or unimproved, in-state or out of state)

| | | | | | |
|---|---|---|---|---|---|
| 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

Individuals Entitled to be Legally-Noticed Oregon statute requires certain related individuals are entitled to receive notice upon petitioning the court for guardianship/conservatorship. Please document and include the contact information of any and all of the following known (even if they are currently uninvolved or do not wish involvement): spouses, parents, adult children, current co-habitants, nearest relatives, attorneys.

| | | | | |
|---|---|---|---|---|
| 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) | | | |

## 7. Additional Information

Not captured in the above categories

*Factual information*

## 7. Additional Information (Continued)

Not captured in the above categories

*Factual information*