



## *Filing a Guardianship Action in Chester County Probate Court*

- A. Summons and Petition for Appointment of Guardian**  
(Form #530GC---only healthcare decisions)
  
- B. Notice of Right to Counsel** (Form #524GC)
  
- C. Examiner's Report & Affidavit Regarding Capacity**  
(Form #539GC--- will need 2 – from different examiners)
  
- D. Applicant's Credit Report.**
  
- E. Applicant's Criminal Background Check**  
(which is a SLED check for S.C residents or a check from  
the state of residence for out-of-state residents)
  
- F. Filing fee of \$150.00.**

Chester County Probate Court  
1476 J A Cochran Bypass  
P O Box 580  
Chester, SC 29706  
803-385-2604

STATE OF SOUTH CAROLINA )  
 )  
COUNTY OF CHESTER )  
 )  
IN THE MATTER OF: )  
 )  
\_\_\_\_\_, )  
an alleged incapacitated individual. )

▲ PROBATE COURT USE ONLY ▲
----------------------------

, )  
 )  
vs. )  
 )  
, )  
 )  
Respondent(s). )

IN THE PROBATE COURT  
CASE NUMBER \_\_\_\_\_

**NOTICE OF RIGHT TO COUNSEL**

You, the alleged incapacitated individual, have the right to choose your own attorney to represent you in the above matter.

If a notice of appearance by your own attorney has not been received by the Court within fifteen (15) days from the filing of the proof of service in this matter, the court will appoint an attorney for you.

Executed this \_\_\_\_ day of \_\_\_\_\_, 2020.

Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Preferred Telephone: \_\_\_\_\_  
Secondary Telephone: \_\_\_\_\_  
Email: \_\_\_\_\_

Attorney Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Firm Name: \_\_\_\_\_  
Bar Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Telephone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Attorney for: \_\_\_\_\_



Case Number: \_\_\_\_\_

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

Payment of the filing fee or filing of a *Motion and Affidavit to Proceed In Forma Pauperis* (see Form SCCA405PC) is required when this petition is filed. The petition is intended to be used when a petitioner is seeking the appointment of a Guardian for an alleged incapacitated individual (A.I.I.). It can also be used when a petitioner seeks to have a Successor Guardian appointed for an incapacitated individual. The following actions may be requested with the filing of the attached Petition:

• **FINDING OF INCAPACITY**

- The Petitioner may be seeking to have the A.I.I. found to be an incapacitated individual for the purpose of the appointment of a Guardian. This is determined by the Court based upon a physician's examination and report and other relevant evidence. Generally, if there is no finding of incapacity, the court will not be able to proceed with any other action regarding the person who is alleged to be incapacitated.
- **If authority is needed to make decisions regarding health care, medical treatment, medical decisions, or appropriate placement for the A.I.I., please read below for situations in which a guardianship may be needed and check the appropriate box(es) in the Petition:**
  - **APPOINTMENT OF GUARDIAN (including appointment on an EMERGENCY or TEMPORARY basis; see Forms #512GC and #513GC)** - Can be used to request appointment of an individual, including a professional Guardian, on an emergency, temporary, and/or permanent basis to be the substitute health care decision-maker for an alleged incapacitated individual.
  - **APPOINTMENT OF SUCCESSOR GUARDIAN** - Can be used to request appointment of a successor to the permanent Guardian.
  - **IF NOMINATED TO SERVE IN A WILL** – Based on the facts of the case and the filings of the parties, pursuant to S.C. Code Ann. § 62-1-100, it is within the discretion of the Court to determine whether a testamentary Guardian designation in a will executed by a parent or spouse prior to January 1, 2019, the effective date of the revisions to Article 5 of the S.C. Probate Code, will fall under the processes and procedures of the 1987 Probate Code or under the processes and procedures enacted by the 2017 amendments. *(See §62-5-301 of the 1987 Probate Code versus the changes to §62-5-301 enacted by the 2017 amendments.)*
- **RIGHTS AND POWERS OF THE ALLEGED INCAPACITATED INDIVIDUAL**
  - S.C. Code Ann. § 62-5-303(B)(7) requires that the petitioner must indicate in the petition what rights the Court is being asked to remove from the A.I.I. For guardianships those rights are stated in S.C. Code Ann. § 62-5-304A. The burden of proof will be on the petitioner to show why certain rights should be removed. Rights not asked to be removed or not stated as being removed in the court order will be retained.
  - If the A.I.I. is found to be incapacitated based on mental illness, “mental deficiency,” “mental defect,” or an impairment other than solely a physical impairment or disability, the court is required to report the name of the incapacitated individual to the State Law Enforcement Division (SLED), pursuant to S.C. Code Ann. § 23-31-1020. **He or she will not be allowed to purchase, possess, or have access to firearms or ammunition, pursuant to S.C. Code Ann. § 23-31-1040(A).**



Case Number: \_\_\_\_\_

If the A.I.I. has not been physically present in South Carolina for the period of time described above, explain what connections the A.I.I. has to South Carolina. Please refer to SC Code §§ 62-5-700 through 62-5-711.

5. **Venue** (check all that apply):

Venue for this proceeding is proper in this county because the A.I.I.:

- resides in this county and has resided in this county for more than six (6) months;
- resides in this county (this is his/her county of residence);
- is physically present in this county at this time; or
- is admitted to an institution in this county pursuant to an order of a court of competent jurisdiction, but this is not the county of residence.

If the A.I.I. has not resided in this county for the six (6) months preceding this action, state the address where the A.I.I. did reside or where he/she is currently residing:

6. **Information about family of the A.I.I.** – You must provide information about the spouse and any children of the A.I.I.; if there is no spouse or adult children, then list his/her parents. If no parents are living, then list the closest adult relative(s).

**\*\*Spouse:**

Address:

City/State/Zip:

Telephone: (Home): (Cell):

Email:

**\*\*If deceased, a certified death certificate is required.**

Children of A.I.I.:

Name	Address	Year of Birth
------	---------	---------------

**(IF REQUIRED) Living Parents of A.I.I.:**

Name	Address
------	---------

**(IF REQUIRED) Closest Living Adult Relative(s) of A.I.I.** – use additional paper if needed:

Adult Relative:

Address:

City/State/Zip:

Telephone: (Home): (Cell):

Email:

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

Name	Address	Relationship to A.I.I.
------	---------	------------------------

Case Number: \_\_\_\_\_

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

(If you are the A.I.I. in this matter, you should be prepared to defend the assertion that any of the following rights should be removed; however, the burden is on the Petitioner to show why.)

Do you believe the A.I.I. should **retain** the following rights to:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Make decisions about health care and medical treatment? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| b. Choose a physician?                                     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| c. Make end-of-life decisions?                             | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| d. Authorize disclosure of confidential information?       | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| e. Choose where to live?                                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| f. Participate in social and religious activities?         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| g. Vote?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| h. Consent to or refuse educational services?              | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| i. Contract for marriage?                                  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| j. File for divorce?                                       | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| k. Travel independently?                                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| l. Be employed without Guardian consent?                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| m. Operate a vehicle?                                      | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| n. Pay his or her bills?                                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| o. Enter into contracts?                                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| p. Bring or defend a lawsuit?                              | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| q. Make gifts?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| r. Create a will?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| s. Create a trust?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

If you answered NO to any of the above-listed rights, please explain:

9. Any other rights and powers not specifically stated here that the Court should address:

10. Please note any of the rights in Question 8 you believe should be given to the Guardian (*vested in the Guardian*) to exercise on behalf of the incapacitated individual and/or for which the written consent of the Guardian should be obtained prior to exercising such right. Some rights, such as voting, cannot be given to the Guardian.

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

- a. Why do you believe the A.I.I. needs a Guardian/Successor Guardian to provide continuing care and supervision? Provide a brief description of the nature and extent of the alleged incapacity. (See 62-5-403(B)(6)).
- b. Is there a less restrictive alternative? If so, please explain.

Case Number: \_\_\_\_\_

- c. In what ways is the alleged incapacitated individual able to provide for health, education, maintenance, and support for himself/herself and his or her dependents?
- d. Is it necessary to hold any type of emergency or temporary proceeding to protect the physical person of the A.I.I., to make immediate decisions concerning health care or medical treatment, or is the appointment of a temporary Guardian necessary before a final hearing can be held on this Summons and Petition? (*If seeking emergency or temporary relief, use Form #512GC or Form #513GC.*)
- NO.     YES. If yes, please explain:

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

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

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

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

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

Name:

Relationship to A.

Address:

City/State/Zip:

Telephone: (Home):                      (Cell):

Email:

- i. Priority of appointment for the proposed Guardian (*Petitioner or person named in 11h., above*):

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

Case Number: \_\_\_\_\_

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

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

**VERIFICATION**

The Petitioner, being sworn, states: That the facts set forth in the foregoing Petition are true to the best of the Petitioner's knowledge, information, and belief.

SWORN to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Applicant/Petitioner  
Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Print Name: \_\_\_\_\_  
Notary Public for: \_\_\_\_\_ (State)  
My Commission Expires: \_\_\_\_\_ (Date)

Preferred Telephone: \_\_\_\_\_  
Secondary Telephone: \_\_\_\_\_  
Email: \_\_\_\_\_

SWORN to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Co-Applicant/Petitioner  
Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Print Name: \_\_\_\_\_  
Notary Public for: \_\_\_\_\_ (State)  
My Commission Expires: \_\_\_\_\_ (Date)

Preferred Telephone: \_\_\_\_\_  
Secondary Telephone: \_\_\_\_\_  
Email: \_\_\_\_\_

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

**QUALIFICATION AND STATEMENT OF ACCEPTANCE**

I agree to serve as appointed and to perform the duties and discharge the trust of the office of (*check the applicable choices*):  Conservator,  Special Conservator,  Successor Conservator for \_\_\_\_\_ (*Name of A.I.I.*).

Executed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Signature: \_\_\_\_\_  
Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_  
Printed Name: \_\_\_\_\_

STATE OF SOUTH CAROLINA )  
 )  
COUNTY OF CHESTER )  
 )  
IN THE MATTER OF: )  
 )  
\_\_\_\_\_, )  
 )  
an alleged incapacitated individual. )



IN THE PROBATE COURT  
CASE NUMBER \_\_\_\_\_

**EXAMINER REPORT AND AFFIDAVIT  
REGARDING CAPACITY**

Please answer the following questions concerning the alleged incapacitated individual (hereinafter, "patient") and provide explanations or additional comments and details at the end of this form or on an attached sheet of paper.

- 1. Patient's name:
- 2. Have you treated the patient previously? Yes  No   
If yes, how long?
- 3.
  - a) Date(s) and place(s) of all examination(s) within previous ninety (90) days:
  
  - b) Date(s) and place(s) of all examination(s) relied upon in making this report:
- 4. Please provide a diagnosis and assessment of the patient's mental and physical condition, including whether he/she is taking any medications that may affect his/her actions:

Are additional tests or assessments, such as lab tests, neuroimaging/MRI, neuropsychological testing, or other tests needed in order to give a more definitive diagnosis? If so, what further tests or examinations are needed?

- 5. Please specify which diagnoses and/or condition(s) are progressive, permanent, or temporary.  
Progressive:  
Permanent:  
Temporary:
- 6. Please describe the nature and extent of any incapacity, including specific impairments:

7. Please describe the nature and extent of the patient's abilities, including those that would allow him/her to accomplish certain tasks with reasonably available "supports and assistance"<sup>1</sup>:
8. Does the patient have the capacity to retain the following rights (If you cannot attest to yes or no, please explain what additional test/s can be done to achieve that information):
- a) Marry or divorce? Yes  No  Unknown
  - b) Reside in a place of his/her choosing, and consent or withhold consent to any residential or custodial placement? Yes  No  Unknown
  - c) Travel without the consent of a guardian? Yes  No  Unknown
  - d) Give, withhold, or withdraw consent and make other informed decisions relative to medical, mental, and physical examinations, care, treatment, and therapies? Yes  No  Unknown
  - e) Make end-of-life decisions including, but not limited to, a "do not resuscitate" order or the application of any medical procedures intended solely to sustain life, and consent or withhold consent to artificial nutrition and hydration? Yes  No  Unknown
  - f) Consent or refuse consent to hospitalization and discharge or transfer to a residential setting, group home, or other facility for additional care and treatment? Yes  No  Unknown
  - g) Authorize disclosures of confidential information? Yes  No  Unknown
  - h) Operate a vehicle\*? Yes  No  Unknown
  - i) Vote? Yes  No  Unknown
  - j) Be employed without the consent of a guardian? Yes  No  Unknown
  - k) Consent to or refuse educational services? Yes  No  Unknown
  - l) Participate in social, religious or political activities? Yes  No  Unknown
  - m) Buy, sell, or transfer real or personal property or transact business of any type? Yes  No  Unknown
  - n) Make, modify, or terminate contracts? Yes  No  Unknown
  - o) Bring or defend any action at law or equity? Yes  No  Unknown
  - p) Any other rights and powers? Please list.

COMPLETE EXPLANATION(S) FOR QUESTIONS a) through p) HERE.

If more space is required, use additional sheets and attach.

(\*If you answered "yes" to h), please state below whether a full driving evaluation has been conducted.)

<sup>1</sup> As defined in S.C. Code Ann. § 62-5-101(23), "Supports and assistance" includes:

(a) systems in place for the alleged incapacitated individual to make decisions in advance or to have another person to act on his behalf, including, but not limited to, having an agent under a durable power of attorney, a health care power of attorney, a trustee under a trust, a representative payee to manage social security funds, a Declaration of Desire for Natural Death (living will), a designated health care decision maker under Section 44-66-30, or an educational representative designated under Section 59-33-310 to Section 59-33-370; and

(b) reasonable accommodations that enable the alleged incapacitated individual to act as the principal decision maker, including, but not limited to, using technology and devices; receiving assistance with communication; having additional time and focused discussion to process information; providing tailored information oriented to the comprehension level of the alleged incapacitated individual; and accessing services from community organizations and governmental agencies.

9. Would the patient benefit from:

- a) Therapy or treatment? Yes  No
- b) Medical aids or equipment? Yes  No
- c) An operation or medical procedure(s)? Yes  No
- d) Psychiatric treatment? Yes  No

10. Has the patient had in the last six months:

- a) Hospitalization(s)? Yes  No
- b) Therapy or treatment? Yes  No
- c) Inpatient or outpatient surgery? Yes  No
- d) Major medical test(s)? Yes  No
- e) Psychological or psychiatric testing? Yes  No

11. In your opinion, does the patient have the ability to:

- a) effectively manage his/her property or individual financial affairs, provide for his/her support, or for the support of his/her legal dependents? Yes  No

If yes, is the ability limited in any way? Please explain:

- b) meet the essential requirements for his/her physical health, safety, or self-care. Yes  No

If yes, is the ability limited in any way? Please explain:

12. The patient continues to perform the following activities of daily living:

13. Does the patient have:

- a) A power of attorney? Yes  No  Unknown
- b) A healthcare power of attorney? Yes  No  Unknown
- c) A "living will"? Yes  No  Unknown

14. Does the patient have any of the following coverages?

- a) Health insurance? Yes  No  Unknown
- b) Medicare? Yes  No  Unknown
- c) Medicaid? Yes  No  Unknown
- d) Veteran's health care? Yes  No  Unknown

15. Does the patient have a primary caregiver?

Yes  No

If yes, provide caregiver's name, address, and relationship to the patient.

16. Please identify the persons with whom you met or consulted regarding the patient's mental or physical condition:



STATE OF SOUTH CAROLINA )  
 )  
COUNTY OF CHESTER )  
 )  
IN THE MATTER OF: )  
 )  
\_\_\_\_\_, )  
 )  
an alleged incapacitated individual. )

▲ PROBATE COURT USE ONLY ▲
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IN THE PROBATE COURT  
CASE NUMBER \_\_\_\_\_

**EXAMINER REPORT AND AFFIDAVIT  
REGARDING CAPACITY**

Please answer the following questions concerning the alleged incapacitated individual (hereinafter, "patient") and provide explanations or additional comments and details at the end of this form or on an attached sheet of paper.

- 1. Patient's name:
- 2. Have you treated the patient previously? Yes  No   
If yes, how long?
- 3.
  - a) Date(s) and place(s) of all examination(s) within previous ninety (90) days:
  
  - b) Date(s) and place(s) of all examination(s) relied upon in making this report:
- 4. Please provide a diagnosis and assessment of the patient's mental and physical condition, including whether he/she is taking any medications that may affect his/her actions:

Are additional tests or assessments, such as lab tests, neuroimaging/MRI, neuropsychological testing, or other tests needed in order to give a more definitive diagnosis? If so, what further tests or examinations are needed?

- 5. Please specify which diagnoses and/or condition(s) are progressive, permanent, or temporary.  
Progressive:  
Permanent:  
Temporary:
- 6. Please describe the nature and extent of any incapacity, including specific impairments:

7. Please describe the nature and extent of the patient's abilities, including those that would allow him/her to accomplish certain tasks with reasonably available "supports and assistance"<sup>1</sup>:
8. Does the patient have the capacity to retain the following rights (If you cannot attest to yes or no, please explain what additional test/s can be done to achieve that information):
- a) Marry or divorce? Yes  No  Unknown
  - b) Reside in a place of his/her choosing, and consent or withhold consent to any residential or custodial placement? Yes  No  Unknown
  - c) Travel without the consent of a guardian? Yes  No  Unknown
  - d) Give, withhold, or withdraw consent and make other informed decisions relative to medical, mental, and physical examinations, care, treatment, and therapies? Yes  No  Unknown
  - e) Make end-of-life decisions including, but not limited to, a "do not resuscitate" order or the application of any medical procedures intended solely to sustain life, and consent or withhold consent to artificial nutrition and hydration? Yes  No  Unknown
  - f) Consent or refuse consent to hospitalization and discharge or transfer to a residential setting, group home, or other facility for additional care and treatment? Yes  No  Unknown
  - g) Authorize disclosures of confidential information? Yes  No  Unknown
  - h) Operate a vehicle\*? Yes  No  Unknown
  - i) Vote? Yes  No  Unknown
  - j) Be employed without the consent of a guardian? Yes  No  Unknown
  - k) Consent to or refuse educational services? Yes  No  Unknown
  - l) Participate in social, religious or political activities? Yes  No  Unknown
  - m) Buy, sell, or transfer real or personal property or transact business of any type? Yes  No  Unknown
  - n) Make, modify, or terminate contracts? Yes  No  Unknown
  - o) Bring or defend any action at law or equity? Yes  No  Unknown
  - p) Any other rights and powers? Please list.

COMPLETE EXPLANATION(S) FOR QUESTIONS a) through p) HERE.

If more space is required, use additional sheets and attach.

(\*If you answered "yes" to h), please state below whether a full driving evaluation has been conducted.)

<sup>1</sup> As defined in S.C. Code Ann. § 62-5-101(23), "Supports and assistance" includes:

(a) systems in place for the alleged incapacitated individual to make decisions in advance or to have another person to act on his behalf, including, but not limited to, having an agent under a durable power of attorney, a health care power of attorney, a trustee under a trust, a representative payee to manage social security funds, a Declaration of Desire for Natural Death (living will), a designated health care decision maker under Section 44-66-30, or an educational representative designated under Section 59-33-310 to Section 59-33-370; and

(b) reasonable accommodations that enable the alleged incapacitated individual to act as the principal decision maker, including, but not limited to, using technology and devices; receiving assistance with communication; having additional time and focused discussion to process information; providing tailored information oriented to the comprehension level of the alleged incapacitated individual; and accessing services from community organizations and governmental agencies.

9. Would the patient benefit from:

- a) Therapy or treatment? Yes  No
- b) Medical aids or equipment? Yes  No
- c) An operation or medical procedure(s)? Yes  No
- d) Psychiatric treatment? Yes  No

10. Has the patient had in the last six months:

- a) Hospitalization(s)? Yes  No
- b) Therapy or treatment? Yes  No
- c) Inpatient or outpatient surgery? Yes  No
- d) Major medical test(s)? Yes  No
- e) Psychological or psychiatric testing? Yes  No

11. In your opinion, does the patient have the ability to:

- a) effectively manage his/her property or individual financial affairs, provide for his/her support, or for the support of his/her legal dependents? Yes  No

If yes, is the ability limited in any way? Please explain:

- b) meet the essential requirements for his/her physical health, safety, or self-care. Yes  No

If yes, is the ability limited in any way? Please explain:

12. The patient continues to perform the following activities of daily living:

13. Does the patient have:

- a) A power of attorney? Yes  No  Unknown
- b) A healthcare power of attorney? Yes  No  Unknown
- c) A "living will"? Yes  No  Unknown

14. Does the patient have any of the following coverages?

- a) Health insurance? Yes  No  Unknown
- b) Medicare? Yes  No  Unknown
- c) Medicaid? Yes  No  Unknown
- d) Veteran's health care? Yes  No  Unknown

15. Does the patient have a primary caregiver?

Yes  No

If yes, provide caregiver's name, address, and relationship to the patient.

16. Please identify the persons with whom you met or consulted regarding the patient's mental or physical condition:

17. **BASED UPON MY EVALUATION OF THIS PATIENT:**

- a.  I **DO NOT** BELIEVE THIS PATIENT IS "INCAPACITATED."<sup>2</sup> I do not find that he/she lacks the ability to effectively receive, evaluate, and respond to information or make or communicate decisions such that a person, even with appropriate, reasonably available support and assistance cannot:
  - a) meet the essential requirements for his/her physical health, safety, or self-care, necessitating the need for a guardian; or
  - b) manage his/her property or financial affairs or provide for his/her support of for the support of his/her legal dependents, necessitating the need for a protective order.
  
- b.  I **DO** BELIEVE THIS PATIENT IS "INCAPACITATED" to such an extent, that he/she lacks the ability to effectively receive, evaluate, and respond to information or make or communicate decisions such that a person, even with appropriate, reasonably available support and assistance cannot:
  - a) meet the essential requirements for his/her physical health, safety, or self-care, necessitating the need for a guardian; or
  - b) manage his/her property or financial affairs or provide for his/her support of for the support of his/her legal dependents, necessitating the need for a protective order.

Use this space to provide explanations or additional comments.

SWORN to before me                      day of  
this    20                      .

Examiner's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_  
Credentials: \_\_\_\_\_

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

\_\_\_\_\_  
Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Notary Public for: \_\_\_\_\_  
(State)

Telephone: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_  
(Date)

<sup>2</sup>As defined in S.C. Code Ann. § 62-5-101(13), "Incapacity" means the inability to effectively receive, evaluate, and respond to information or make or communicate decisions such that a person, **even with appropriate, reasonably available support and assistance cannot:**

a) meet the essential requirements for his/her physical health, safety, or self-care, necessitating the need for a guardian; or  
b) manage his property or financial affairs or provide for his support of for the support of his legal dependents, necessitating the need for a protective order.