PROGRAM**** Office of Public Guardian

195 N. 1950 W. SALT LAKE CITY, UT 84116 801-538-4119 FAX 801-538-8243

REFERRAL INFORMATION

**INFORMATION AND REFERRAL**

The Office of Public Guardian (OPG) provides information, resources and consultation on matters related to guardianship and conservatorship. We encourage you to call and ask guardianship related questions and to discuss concerns. If the concern meets OPG criteria a referral must be submitted and contain assessments and information required by the program, to ensure that intakes comply with statutory requirements. We encourage you to enlist the support of the treatment team (if applicable) 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 an individual’s diminished capacity and inability to understand and participate in decision making. We must have the required information to file as evidence with OPG’s petition for guardianship. Petitioning the court for guardianship and conservatorship is a process involving assessment and documentation which includes clear and convincing evidence and a legal proceeding in the respective district court. Also included in the referral should be a list of what less restrictive options have been tried and how they failed to meet to individual’s needs.

**ELIGIBILITY AND PROGRAM CRITERIA**

Age 18 or over.

Utah resident.

No family willing and able to serve as guardian.

Inability to afford or no funds to pay for a private guardian.

High risk of abuse, neglect, exploitation and/or loss of life or health.

No less restrictive options available.

Meets Utah Statute 75-1-201 (22) incapacitated adult (see excerpts below).

**GUARDIANSHIP (Personal and Health Care Decisions)**

OPG will conduct an investigation and gather evidence from all sources to present to the court. The Office of Public Guardian does not conduct capacity assessments necessary to determine and document incapacity; we rely on the assessments of medical and psychological professionals. Referrals must be documented sufficiently to allow an intake decision, a responsible and complete court filing, and to support a contested case hearing.

Defined in Utah Code 75-1-201(22) “Incapacitated” or “incapacity” is measured by the functional limitations and means a judicial determination after proof by clear and convincing evidence that an adult’s ability to do the following is impaired to the extent that the individual lacks the ability, even with appropriate technological assistance, to meet the essential requirements for financial protection or physical health, safety, or self-care:

1. Receive and evaluate information;
2. Make and communicate decisions; or
3. Provide for necessities such as food, shelter, clothing, health, or safety.

The Office of Public Guardian 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 (Rule 549) and program criteria we must take cases that are at the highest priority first. Individual who have been found or are likely to be found legally incapacitated and in need of guardianship and/or conservatorship, and who have no other responsible, willing and able person to serve as their guardian, may be eligible for the Office of Public Guardian’s services. However, due to the OPG’s limited staff and resources, OPG is unable to serve all individuals who may be eligible for its services. Per Rule 549, OPG will give priority to incapacitated individuals, as follows and in the following order:

1. Individuals who are in life-threatening situations, where immediate guardianship assistance or intervention is necessary for the preservation of life or the prevention of serious harm or injury.
2. Individuals who are experiencing abuse, neglect or self-neglect or financial exploitation.
3. Individuals who are at significant risk of experiencing abuse, neglect or self-neglect or financial exploitation.

**EMERGENCY & TEMPORARY GUARDIANSHIP**

Under Utah Code 75-5-310 a petition for emergency guardianship can be filed if:

1. If an incapacitated person has no guardian and an emergency exists or if an appointed guardian is not effectively performing the guardian’s duties and the court further finds that the welfare of the incapacitated person requires immediate action, it may, without notice, appoint an emergency guardian for the person for a specified period not to exceed 30 days pending notice and hearing.

Under Utah Code 75-5-310.5 the court can appoint a temporary guardian:

1. If, after notice and hearing as required by Section 75-5-303, the court finds good cause, the court may:
   1. Appoint a temporary guardian;
   2. Convert and emergency guardian to a temporary guardian if an emergency guardian has been appointed under Section 75-5-310; or
   3. Appoint a different person as temporary guardian to replace an emergency guardian appointed under Section 75-5-310

**DOCUMENTATION REQUIREMENTS**

Documentation submitted with this worksheet should address **BOTH** inability to make decisions **AND** functional limitations as outlined 75-1-201(22) and the results of that diminished capacity. Opinions should be supported by facts. The factual information must demonstrate that appointment is necessary as a means of preservation of life, prevention of serious harm or injury and/or prevention of abuse, neglect and exploitation. Included in this information must be a clear expectation of what guardianship 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 guardian or conservator and the names/addresses of all persons who have information that would support a finding of incapacity.

Medical Statement: To determine an individual’s need for guardianship it is necessary for OPG to have documentation from the treating physician which summarizes the diagnoses, at least one of which relates to the inability to make decisions, and relevant medical issues. This report should outline needed medical decisions, and include a clear statement of opinion about the individual’s incapacity and a recommendation for guardianship.

**AND/OR**

Psychological/Psychiatric Assessment: This should directly address the areas of mental or functional impairment. 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: Office of Public Guardian Intake

1. Attach as an E-mail to utahopg@utah.gov

2. Print a copy and FAX to (801) 538-8243.

3. Print a copy and MAIL to the Office of Public Guardian, 195 North 1950 West, Salt Lake City, UT 84116.

Any questions, please contact us at (801) 538-8255.

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REFERRAL WORKSHEET

SERVICE REQUESTED Guardianship Emergency/Temporary Guardianship

**PERSONAL INFORMATION OF PERSON BEING REFERRED**

|  |  |
| --- | --- |
| Exact Full Name | Date of Referral |
| Date of Birth | Marital Status |
| Social Security # | VA # |
| Medicaid # | Medical Insurance |

**CURRENT LOCATION OF INDIVIDUAL**

Please indicate the individual’s current, immediate location. Facility Hospital Own Home

Own

Rent

Facility of Hospital Name (if applicable)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Street Address | Room # | City | State | Zip |
| Phone | Alt. Phone, Fax, Cell, E-mail (specify) | | | |
| Expected Date of Discharge (if any) | Name and Number of Contact Person | | | |

**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 | | | |

**REFERRAL SOURCE CONTACT INFORMATION**

Please supply your name and contact information.

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

Medical and Mental Health Professionals Who Have Treated or Evaluated

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|  | | | | | | | | | |
|  | 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) | | | | |
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**CONTACTS**

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

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|  | | | | |
| Name, Title | Agency, Office, or Hospital Name | | | |
| Street Address | Room # | City | State | Zip |
| Phone | Alt. Phone, Fax, Cell, E-mail (specify) | | | |
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| Name, Title | Agency, Office, or Hospital Name | | | |
| Street Address | Room # | City | State | Zip |
| Phone | Alt. Phone, Fax, Cell, E-mail (specify) | | | |
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| Name, Title | Agency, Office, or Hospital Name | | | |
| Street Address | Room # | City | State | Zip |
| Phone | Alt. Phone, Fax, Cell, E-mail (specify) | | | |
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Supports (Spouse, parents, adult children, co-habitants, nearest relatives, attorneys. Include all-even uninvolved .

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| 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) | | | |
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| Name | Relationship | | | |
| Street Address | Room # | City | State | Zip |
| Phone | Alt. Phone, Fax, Cell, E-mail (specify) | | | |
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| Name | Relationship | | | |
| Street Address | Room # | City | State | Zip |
| Phone | Alt. Phone, Fax, Cell, E-mail (specify) | | | |
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| **FOR THIS REFERRAL TO BE CONSIDERED, PLEASE ATTACH THE BELOW INFORMATION:** | | | |
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| **Psychological / Psychiatric Evaluation** | **No** | **Yes** | **(Attach Copy)** |
| **Physician Letter** | **No** | **Yes** | **(Attach Copy)** |
| **Medical History & Physical** | **No** | **Yes** | **(Attach Copy)** |

**GUARDIANSHIP / CRITERIA NARRATIVE**

1. Please provide us with a written description of what you expect a guardian to do. Items you may want to include in this narrative are:
   1. Does this person adequately provide for their healthcare?
   2. Does this person adequately provide for their food, nutrition and shelter?
   3. Does this person adequately provide for their clothing or personal hygiene?
   4. Does this person adequately provide for their safety and/or other care, without which serious injury is likely to occur?
   5. Is this person able to manage their financial resources?
   6. Has there been APS involvement with this person?

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* 1. Other relevant information