

City and County of San Francisco  
GAVIN NEWSOM, *Mayor*



Department of Aging and Adult Services  
ANNE HINTON, *Executive Director*

Office of Public Guardian

TO: Agencies and Health Care Professionals  
Making Referrals to the Public Guardian

Enclosed please find the necessary forms and instructions for making a referral for Probate Conservatorship.

Please read the instructions and forms very carefully. The Affidavit must be filled out completely with original signature. The Capacity Declaration also requires original signature by a medical doctor.

If you have any questions please don't hesitate to call us.

Sincerely yours,

Public Guardian  
Public Conservator

# SAN FRANCISCO PUBLIC GUARDIAN

# INSTRUCTIONS FOR REFERRALS

*Thank you for your inquiry about the conservatorship program. The Public Guardian can only accept referrals for conservatorship if they meet the legal requirements for a conservatorship as set forth in California and local law.*

## LEGAL REQUIREMENTS

1. This office only accepts San Francisco residents.
2. Mental incapacity must be shown by evidence that the proposed conservatee has a deficit in his or her mental functions, and evidence of a correlation between the deficit or deficits and the need for a conservatorship.
3. **Conservator of Person:** There must also be evidence that the proposed conservatee is unable to properly provide for his or her personal needs for physical health, food, clothing, or shelter.
4. **Conservator of the estate:** There must be evidence that the proposed conservatee is substantially unable to manage his or her financial resources or resist fraud or undue influence.
5. To obtain a **temporary conservatorship**, there must be evidence of an urgent need for the temporary conservatorship. An "urgent need" might be the need for a medical procedure or the need to safeguard assets in imminent danger of loss. There can be no petition for a temporary conservatorship without a petition for permanent conservatorship on file.

## FORM REQUIREMENTS

1. **Referral for Conservatorship Form:** The Public Guardian relies upon your independent investigation in determining whether or not to accept the client you are referring. Please complete the Referral for Conservatorship using the information you have collected through your investigation. On page four please put a brief summary of the case.

2. **Affidavit:** The Public Guardian **must** file the Affidavit with the Court in support of the Public Guardian's petition for appointment as conservator. Note, however, that the Affidavit is filed as a confidential document and will not be in the public file.

The Affidavit must contain all available details, **particularly** concerning medical and psychiatric diagnoses, and reasons others cannot serve as conservator (e.g., why a family member in the Bay Area is not suitable). To show incapacity, please provide examples of the proposed conservatee's cognitive limitations. Indicate how much assistance is needed regarding the activities of daily living, and whether or not the client is objecting to medical treatment.

Provide examples of inability to handle calculations and finances and vulnerability to undue influence. Make sure the Affidavit includes evidence of San Francisco residency, and also indicates where he or she is presently placed (if not at the San Francisco residence indicated). If the person is currently placed outside the home (i.e., SNF, Board and Care, Hospital, etc.), please indicate when first admitted and when he or she is set to be discharged and what the discharge plan is. Make sure to indicate if the facility is out-of-county.

In terms of the person's property, please indicate whether or not their residence is still open, and what personal property (possessions, furniture, car, etc.) the proposed conservatee possesses. Include addresses of close relatives of the proposed conservatee, including grandparents and grandchildren. Indicate if the proposed conservatee has an attorney.

*Because we must file the Affidavit with the Court, it **must** be completed. All questions should be answered, even if the answer is "not applicable" or "unsure." Attachments may be used It is not sufficient to provide our office with the blank Affidavit with medical records attached, because confidentiality laws prevent medical records from being submitted to the Court. Ultimately, the Court will not allow us to proceed with the case until an original Affidavit is on file with the Court. **NOTE ALSO THAT THE AFFIDAVIT MUST HAVE A "REAL " SIGNATURE - NOT A RUBBER STAMP OR FACSIMILE SIGNATURE.***

3. **Capacity Declaration - Conservatorship:** This Declaration has been developed by the Court system to cover three purposes. A licensed physician or psychologist must complete it.
  - a. Conservatorship of person and estate only. If you are applying for the Public Guardian to become conservator only without any additional powers, please complete item nos. 1-5 on page one of the form. If the proposed conservatee **cannot** attend the hearing, please explain why at item no. 5 under "Supporting facts"; -- a one sentence diagnosis or explanation is sufficient. If you do not give a reason here, the conservatee **must** attend the hearing.

- b. Conservatorship of the person and estate **with medical powers.** If you are requesting that the Public Guardian petition the Court to become conservator with additional powers to make medical decisions on behalf of the proposed conservatee, please also complete item numbers 1 through 7, *including a diagnosis at item number 6F.* Please indicate whether or not the proposed conservatee is objecting to medical treatment.
  
- c. Conservatorship of the person and estate **with dementia powers.** Please complete the whole form. If the proposed conservatee has a diagnosis of dementia and needs to be placed in a secure ward or facility, the conservator must obtain a court order authorizing this. If the conservatee is being given medication for the treatment of dementia and is objecting to these medications, or they are being concealed in the patient's food, the conservator must also obtain a court order authorizing him to consent to the administration of such medications.

**PLEASE REMEMBER:** the Court is responsible for protecting the rights of proposed conservatees, and they take this responsibility very seriously. So incomplete forms, lack of signatures, insufficient information, etc., will all cause considerable delays in processing your referral. Take the time to submit a complete and compelling referral and affidavit, and the process will go much smoother and more quickly.

*Thank you.*

**RETURN TO:** City and County of San Francisco  
San Francisco Public Guardian  
875 Stevenson Street, 3<sup>rd</sup> Floor  
San Francisco, California 94103  
Telephone No. (415) 355-3555

**REFERRAL FOR CONSERVATORSHIP**

P.G.# \_\_\_\_\_  
(FOR OFFICE USE ONLY)  
REFERRAL DATE \_\_\_\_\_  
AGENCY/NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
TEL. NO. \_\_\_\_\_

NAME OF PROPOSED CONSERVATEE \_\_\_\_\_

ALSO KNOWN AS \_\_\_\_\_

ADDRESS AND PHONE NUMBER \_\_\_\_\_

DOES CLIENT OWN OR RENT? \_\_\_\_\_ DOES CLIENT LIVE ALONE? \_\_\_\_\_

D.O.B. \_\_\_\_\_ BIRTHPLACE \_\_\_\_\_

PARENTS' NAMES \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ IF SPOUSE IS DECEASED \_\_\_\_\_

DATE AND PLACE OF DEATH \_\_\_\_\_

BURIAL SITE \_\_\_\_\_

ETHNICITY \_\_\_\_\_ PRIMARY LANGUAGE \_\_\_\_\_

RELIGIOUS PREFERENCE \_\_\_\_\_ CITIZENSHIP \_\_\_\_\_

IF NATURALIZED, PLEASE GIVE DATE & PLACE OF NATURALIZATION \_\_\_\_\_

IF PROPOSED CONSERVATEE IS NOW HOSPITALIZED, PLEASE GIVE:

HOSPITAL NAME AND ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_ ADMISSION DATE \_\_\_\_\_

REASON FOR HOSPITALIZATION \_\_\_\_\_

DISCHARGE PLAN \_\_\_\_\_

IF PROPOSED CONSERVATEE IS IN BOARD AND CARE HOME, PLEASE GIVE:

NAME OF BOARD AND CARE HOME \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME OF OPERATOR \_\_\_\_\_ TELEPHONE NO. \_\_\_\_\_

DATE ADMITTED \_\_\_\_\_ MONTHLY FEES \_\_\_\_\_

OCCUPATION \_\_\_\_\_ FORMER EMPLOYER \_\_\_\_\_

MILITARY SERVICE (BRANCH & SERIAL NUMBER) \_\_\_\_\_

DATE AND PLACE ENTERED \_\_\_\_\_

DATE AND PLACE SEPARATED \_\_\_\_\_

LOCATION OF MILITARY PAPERS \_\_\_\_\_

**RELATIVES AND FRIENDS**

NAME	ADDRESS	PHONE	RELATIONSHIP

**INCOME**

SOURCE	AMOUNT
SOCIAL SECURITY CLAIM NO. _____	_____
VETERAN'S ADMINISTRATION C# _____	_____
OTHER INCOME SOURCE (S) _____	_____
OTHER PENSION SOURCE (S) _____	_____
PUBLIC ASSISTANCE CASE NO. _____	_____
SSI CLAIM NO. _____	_____

**ASSETS**

**BANK ACCOUNTS**

BANK	BRANCH	ACCT. NO.	TYPE	BALANCE	LOCATION OF PASSBOOK/CHECKS

DOES PROPOSED CONSERVATEE HAVE A SAFE DEPOSIT BOX? \_\_\_\_\_ IF YES, GIVE

BANK	BRANCH	BOX. NO.	LOCATION OF KEY	OTHER NAMES ON

**STOCKS AND BONDS**

DESCRIPTION	NO OF SHARES	LOCATION OF CERTIFICATES
_____	_____	_____
_____	_____	_____
_____	_____	_____

**REAL PROPERTY**

ADDRESS	BLOCK/LOT NO.	CURRENT USE (RENTER, VACANT, OCCUPIED BY CLIENT)
_____	_____	_____

**MORTGAGE ON PROPERTY** \_\_\_\_\_

**LIFE INSURANCE**

COMPANY	POLICY NO.	FACE AMOUNT	BENEFICIARY
_____	_____	_____	_____
_____	_____	_____	_____

**OTHER ASSETS**

\_\_\_\_\_  
\_\_\_\_\_

**HEALTH INSURANCE**

MEDICARE CLAIM NO. \_\_\_\_\_ MEDI-CAL NO. \_\_\_\_\_

OTHER HEALTH INSURANCE \_\_\_\_\_

NAME OF ATTENDING PHYSICIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_

OTHER AGENCIES PROVIDING SERVICES \_\_\_\_\_

TYPE OF SERVICES PROVIDED \_\_\_\_\_

HAS PROPOSED CONSERVATEE MADE A WILL \_\_\_\_\_ IF YES, GIVE

LOCATION OF WILL \_\_\_\_\_

NAME AND ADDRESS OF ATTORNEY \_\_\_\_\_

\_\_\_\_\_ TELEPHONE NO. \_\_\_\_\_

HAS PROPOSED CONSERVATEE MADE BURIAL PROVISIONS? \_\_\_\_\_ IF YES, GIVE

PREFERENCE IN TYPE OF BODY DISPOSITION (CREMATION/BURIAL) \_\_\_\_\_

MORTUARY \_\_\_\_\_ CEMETARY \_\_\_\_\_

DOES PROPOSED CONSERVATEE HAVE A FUNERAL TRUST ACCOUNT? \_\_\_\_\_ IF YES, GIVE

BANK BRANCH \_\_\_\_\_ ACCOUNT NO. \_\_\_\_\_

PLEASE EXPLAIN IN THE SPACE BELOW, WHY IS CONSERVATORSHIP BEING REQUESTED? PLEASE GIVE SUPPORTING FACTS AS TO WHY PROPOSED CONSERVATEE IS UNABLE TO PROVIDE FOR HIS/HER PERSONAL NEEDS FOR PHYSICAL HEALTH, FOOD, CLOTHING OR SHELTER AND/OR SUBSTANTIALLY UNABLE TO MANAGE HIS/HER FINANCIAL RESOURCES OR RESIST FRAUD OR UNDUE INFLUENCE. PLEASE BE AS SPECIFIC AS POSSIBLE AS THE MATTER WILL BE THE BASIS OF CONSERVATORSHIP PETITION.

ARE YOU WILLING TO APPEAR IN COURT TO TESTIFY TO THE ABOVE? YES \_\_\_\_\_ NO \_\_\_\_\_

THIS REFERRAL IS SUBMITTED BY: NAME \_\_\_\_\_  
SIGNATURE

AGENCY \_\_\_\_\_

ADDRESS \_\_\_\_\_

TEL. NO. \_\_\_\_\_

DATE \_\_\_\_\_





4. Proposed conservatee is now at \_\_\_\_\_

\_\_\_\_\_  
Address and Phone of Proposed conservatee

Proposed conservatee's residence was/is: \_\_\_\_\_

\_\_\_\_\_  
I am informed and believe that:

Proposed conservatee will return to residence

Proposed conservatee will be placed

Supporting facts are listed below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. To the best of my knowledge, the following alternatives to conservatorship have been tried or are unsuitable:

a. Other informal assistance?  Yes  No

b. Power of Attorney?  Yes  No

c. Trusts?  Yes  No

Supporting facts are listed below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Proposed conservatee has no known relatives

Proposed conservatee has relatives

Their names addresses, and phones are listed below:

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Relatives can/will not act for the following reasons:

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(Use additional sheets if necessary)

6. I know of the following health services, social services, or estate management assistance provided to the proposed conservatee:

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The following people may have more information:

Name	Address	Phone

I further declare that the foregoing affidavit/declaration contains \_\_\_\_\_ pages total. I make this declaration under penalty of perjury, under the law of the State of California that the foregoing is true and correct, and this declaration is executed on \_\_\_\_\_  
Date

at \_\_\_\_\_  
Place

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Type or Print Name

## **CAPACITY DECLARATION**

### **#1 MOST COMMON MISTAKE: ABILITY TO ATTEND COURT**

**PLEASE PAY ATTENTION:** When filling out item number five "Ability to Attend Court", by stating that your patient is unable to attend the hearing, **YOU MUST** provide details explaining why he or she cannot attend where it says "supporting facts". Supporting facts are facts and diagnoses that the Court might find suitable to excuse the Proposed Conservatee from the hearing. The supporting facts can be brief.

### **EXAMPLES**

**APPROPRIATE SUPPORTING FACTS:** "the patient is comatose", "the patient wanders and may get lost", "the patient suffers from agitation"; "attending will likely cause extreme distress " or "weakness and frailty".

**INAPPROPRIATE** supporting facts: "he will not understand the hearing" or "she lacks capacity".

\*\*\*\*\* Also, please be aware, if you believe the patient can attend, the facility where that client is living at the time of the hearing will be responsible for escorting him or her to the Court hearing.

**THANK YOU FOR YOUR HELP WITH THE CONSERVATORSHIP PROCESS.  
HOW YOU FILL OUT THIS FORM DOES MAKE A DIFFERENCE!**



CONSERVATORSHIP OF THE  PERSON  ESTATE OF (Name):

CASE NUMBER:

CONSERVATEE  PROPOSED CONSERVATEE

## 6. EVALUATION OF (PROPOSED) CONSERVATEE'S MENTAL FUNCTIONS

**Note to practitioner:** This form is *not* a rating scale. It is intended to assist you in recording your *impressions* of the (proposed) conservatee's mental abilities. Where appropriate, you may refer to scores on standardized rating instruments.

**(Instructions for items 6A–6C):** Check the appropriate designation as follows: **a** = no apparent impairment; **b** = moderate impairment; **c** = major impairment; **d** = so impaired as to be incapable of being assessed; **e** = I have no opinion.)

### A. Alertness and attention

(1) Levels of arousal (lethargic, responds only to vigorous and persistent stimulation, stupor)

a  b  c  d  e

(2) Orientation (types of orientation impaired)

a  b  c  d  e  Person

a  b  c  d  e  Time (day, date, month, season, year)

a  b  c  d  e  Place (address, town, state)

a  b  c  d  e  Situation ("Why am I here?")

(3) Ability to attend and concentrate (give detailed answers from memory, mental ability required to thread a needle)

a  b  c  d  e

### B. Information processing. Ability to:

(1) Remember (ability to remember a question before answering; to recall names, relatives, past presidents, and events of the past 24 hours)

i. Short-term memory a  b  c  d  e

ii. Long-term memory a  b  c  d  e

iii. Immediate recall a  b  c  d  e

(2) Understand and communicate either verbally or otherwise (deficits reflected by inability to comprehend questions, follow instructions, use words correctly, or name objects; use of nonsense words)

a  b  c  d  e

(3) Recognize familiar objects and persons (deficits reflected by inability to recognize familiar faces, objects, etc.)

a  b  c  d  e

(4) Understand and appreciate quantities (deficits reflected by inability to perform simple calculations)

a  b  c  d  e

(5) Reason using abstract concepts. (deficits reflected by inability to grasp abstract aspects of his or her situation or to interpret idiomatic expressions or proverbs)

a  b  c  d  e

(6) Plan, organize, and carry out actions (assuming physical ability) in one's own rational self-interest (deficits reflected by inability to break complex tasks down into simple steps and carry them out)

a  b  c  d  e

(7) Reason logically.

a  b  c  d  e

### C. Thought disorders

(1) Severely disorganized thinking (rambling thoughts; nonsensical, incoherent, or nonlinear thinking)

a  b  c  d  e

(2) Hallucinations (auditory, visual, olfactory)

a  b  c  d  e

(3) Delusions (demonstrably false belief maintained without or against reason or evidence)

a  b  c  d  e

(4) Uncontrollable or intrusive thoughts (unwanted compulsive thoughts, compulsive behavior).

a  b  c  d  e

(Continued on next page)

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

6. (continued)

D. **Ability to modulate mood and affect.** The (proposed) conservatee  has  does NOT have a pervasive and persistent or recurrent emotional state that appears inappropriate in degree to his or her circumstances. (If so, complete remainder of item 6D.)  I have no opinion.

(Instructions for item 6D: Check the degree of impairment of each inappropriate mood state (if any) as follows: a = mildly inappropriate; b = moderately inappropriate; c = severely inappropriate.)

Anger	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Euphoria	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Helplessness	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Anxiety	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Depression	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Apathy	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Fear	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Hopelessness	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Indifference	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>
Panic	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>	Despair	a <input type="checkbox"/>	b <input type="checkbox"/>	c <input type="checkbox"/>				

E. The (proposed) conservatee's periods of impairment from the deficits indicated in items 6A–6D

- (1)  do NOT vary substantially in frequency, severity, or duration.
- (2)  do vary substantially in frequency, severity, or duration (explain; continue on Attachment 6E if necessary):

F.  (Optional) Other information regarding my evaluation of the (proposed) conservatee's mental function (e.g., diagnosis, symptomatology, and other impressions) is  stated below  stated in Attachment 6F.

**ABILITY TO CONSENT TO MEDICAL TREATMENT**

7. Based on the information above, it is my opinion that the (proposed) conservatee
- a.  has the capacity to give informed consent to any form of medical treatment. The opinion is limited to medical consent capacity.
  - b.  lacks the capacity to give informed consent to any form of medical treatment because he or she is **either** (1) unable to respond knowingly and intelligently regarding medical treatment **or** (2) unable to participate in a treatment decision by means of a rational thought process, **or both**. The deficits in the mental functions described in item 6 above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of medical decisions. This opinion is limited to medical consent capacity.

(Declarant must initial here if item 7b applies: \_\_\_\_\_.)

8. 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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**ATTACHMENT TO FORM GC-335, CAPACITY DECLARATION—CONSERVATORSHIP,  
ONLY FOR (PROPOSED) CONSERVATEE WITH DEMENTIA**

9. It is my opinion that the (proposed) conservatee  HAS  does NOT have dementia as defined in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*.
- a.  **Placement of (proposed) conservatee.** (If the (proposed) conservatee requires placement in a secured-perimeter residential care facility for the elderly, please complete items 9a(1)–9a(5).)
- (1) The (proposed) conservatee needs or would benefit from placement in a restricted and secure facility because (state reasons; continue on Attachment 9a(1) if necessary):
  
  - (2) The (proposed) conservatee's mental function deficits, based on my assessment in item 6 of form GC-335, include (describe; continue on Attachment 9a(2) if necessary):
  
  - (3)  The (proposed) conservatee HAS capacity to give informed consent to this placement.
  - (4)  The (proposed) conservatee does NOT have capacity to give informed consent to this placement. The deficits in mental function assessed in item 6 of form GC-335 and described in item 9a(2) above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of his or her actions with regard to giving informed consent to placement in a restricted and secure environment.
  - (5) A locked or secured-perimeter facility  is  is NOT the least restrictive environment appropriate to the needs of the (proposed) conservatee.
- b.  **Administration of dementia medications.** (If the (proposed) conservatee requires administration of psychotropic medications appropriate to the care of dementia, please complete items 9b(1)–9b(5).)
- (1) The (proposed) conservatee needs or would benefit from the following psychotropic medications appropriate to the care of dementia, for the reasons stated in item 9b(5) (list medications; continue on Attachment 9b(1) if necessary):
  
  - (2) The (proposed) conservatee's mental function deficits, based on my assessment in item 6 of form GC-335, include (describe; continue on Attachment 9b(2) if necessary):
  
  - (3)  The (proposed) conservatee HAS capacity to give informed consent to the administration of psychotropic medications appropriate to the care of dementia.
  - (4)  The (proposed) conservatee does NOT have the capacity to give informed consent to the administration of psychotropic medications appropriate to the care of dementia. The deficits in mental function assessed in item 6 of form GC-335 and described in item 9b(2) above significantly impair the (proposed) conservatee's ability to understand and appreciate his or her actions with regard to giving informed consent to the administration of psychotropic medications for the treatment of dementia.
  - (5) The (proposed) conservatee needs or would benefit from the administration of the psychotropic medications listed in item 9b(1) because (state reasons; continue on Attachment 9b(5) if necessary):

10. 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)

**DECLARATION OF ATTENDING PHYSICIAN RE  
CONSERVATEE'S ABILITY TO RETURN TO AND CONTROL RESIDENCE**

I, \_\_\_\_\_ hereby declare:

1. That I am a licensed California physician acting within the scope of my licensure.

2. My address and telephone number are:

\_\_\_\_\_  
\_\_\_\_\_

3. That I am the physician for \_\_\_\_\_, who is presently located at:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. That, based upon my observations and diagnosis, it is my opinion that the above-named, proposed conservatee/conservatee is unable to return to his/hr residence or control the residence, due to the following reasons. (Use attachment if more space is needed.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. That it is my opinion that, due to proposed conservatee/conservatee's inability to return to and control his/her residence, it is necessary that the proposed conservatee/conservatee's reside in a skilled nursing facility for long term care to avert the risk of irreparable harm.

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

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature