STATE OF SOUTH CAROLINA)
)
COUNTY OF LEXINGTON)
)
)
IN THE MATTER OF:)
)
_____)
an alleged incapacitated individual.)
)
)
)
)

▲ PROBATE COURT USE ONLY ▲

IN THE PROBATE COURT
CASE NUMBER 20____-GC-32-_____

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:

FORM #539GC (09/2020)
62-5-303, 62-5-303D, 62-5-403, 62-5-403B, 62-5-403D, 62-5-304, 62-5-407, 62-5-407(B)

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"[1]:

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.*)

---

[1] 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."[2] 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, necessitation the need for a protective order.

Use this space to provide explanations or additional comments.

SWORN to before me this ____ day

of _____, 20___

_____
Signature

Print Name:_____

_____
Notary Public for South Carolina
My Commission Expires: _____

Examiner's Signature:

Print Name: _____

Credentials: _____
(Primary examiner = M.D. or D.O.)
(Secondary examiner = M.D., D.O., R.N., Social worker or psychologist)

Address: _____

Telephone: _____

[2]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.

FORM #539GC (09/2020)
62-5-303, 62-5-303D, 62-5-403, 62-5-403B, 62-5-403D, 62-5-304, 62-5-407, 62-5-407(B)