



CIRCUIT COURT FOR _____, MARYLAND

City/County

Located at _____ Case No. _____

Court Address

In the Matter of

Name of Alleged Disabled Person

Docket Reference

LICENSED CERTIFIED SOCIAL WORKER-CLINICAL (LCSW-C) CERTIFICATE (Md. Rule 10-202(a))

NOTE TO LICENSED SOCIAL WORKER-CLINICAL (LCSW-C): A petitioner will use this certificate in a legal proceeding to request a guardian for the patient named below. The petitioner must submit the original certificate. Your answers must be specific and detailed and based on your personal evaluation of the patient. Address each issue contained in the certificate that may interfere with the patient's ability to make responsible decisions about health care, food, clothing, shelter, or property. You may complete the form yourself or have another person fill it out under your supervision. You must sign the certificate. Your testimony about its contents may be required at a hearing. Attach additional sheets, if necessary.

PATIENT'S NAME: _____

PATIENT'S ADDRESS: _____

PATIENT'S DATE OF BIRTH: _____ PATIENT'S SEX: _____

I, _____ LCSW-C's Name

Address

_____, am a _____ graduate of _____

Telephone Number

Year

School

I am licensed in the United States in the following state(s): _____

My license number is _____ My specialty is _____

I have known this patient for _____ Length of Time. My history of involvement with the patient is as follows:

Empty rectangular box for history of involvement.

Evaluation and Diagnosis

I personally evaluated the above-named patient on _____ Date(s)

(include date of most recent evaluation, as well as any other relevant visits). The most recent evaluation

lasted approximately _____ Length of Time. I performed or ordered the following tests and/or procedures:

Horizontal lines for listing tests and/or procedures.

I communicated with the patient in the following manner:

- English
- Other language or means (explain):

Upon examination of the patient, I report the following findings:

PHYSICAL AND MENTAL CONDITIONS

Physical conditions

- None
- The patient has the following physical diagnoses:

.....

.....

Overall physical health: Excellent Good Fair Poor

Explain:

.....

.....

Overall physical health will: Improve Be stable Decline Uncertain

Explain:

.....

.....

Mental conditions

- None
- The patient has the following mental (DSM-5) diagnoses (attach additional sheets if needed):

<u>Diagnostic Code</u>	<u>Description</u>
.....
.....	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
.....
.....	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
.....
.....	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

Overall mental health will: Improve Be stable Decline Uncertain

If improvement is possible, the individual should be re-evaluated in.....weeks.

The mental diagnosis/diagnoses affect functioning as follows:

.....

.....

.....

Do temporary causes of mental impairment exist? Yes No Uncertain

If yes, have they been evaluated and treated? Yes No Explain:

Do reversible causes of mental impairment exist? Yes No Uncertain

If yes, have they been evaluated and treated? Yes No Explain:

List all medications:

<u>Name</u>	<u>Purpose</u>	<u>Dosage/Schedule</u>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
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Reversible or temporary somatic factors

Are there factors (hearing, vision or speech impairment, etc.) that incapacitate the patient that could improve with time, treatment, or assistive devices?

Yes No Uncertain

Explain:

COGNITIVE FUNCTION

Alertness/level of consciousness

Overall impairment: None Mild Moderate Severe Non-responsive

Describe below or in attachment

Memory, cognitive, and executive functioning

Overall impairment: None Mild Moderate Severe Non-responsive

Describe below or in attachment

Fluctuation

Symptoms vary in frequency, severity, or duration: Yes No Uncertain

Describe below or in attachment

EVERYDAY FUNCTIONING

The patient is **capable** of performing the Instrumental Activities of Daily Living (IADLs) (select all that apply):

- Managing finances effectively
- Managing transportation needs
- Managing communication (e.g., telephone and mail)
- Managing medication
- Other executive functions (describe):

The patient is **capable** of participating in the following civil or legal matters (select all that apply):

- Signing documents
- Retaining legal counsel
- Participating in legal proceedings
- Other (describe):

Institutional Care

The patient **does** **does not** require institutional care.

Need for Guardian of Person

In my professional opinion, within a reasonable degree of certainty within the social work profession, the patient has a disability which (**select one**) does does not prevent him/her from making or communicating **any** responsible decisions concerning his/her **person**.

OR

In my professional opinion, within a reasonable degree of certainty within the social work profession, the patient has a disability which (**select one**) does does not prevent him/her from making or communicating **some** responsible decisions concerning his/her **person**. The patient, for example, is able to make decisions regarding:

but is unable to make decisions regarding:

Need for Guardian of Property

In my professional opinion, within a reasonable degree of certainty within the social work profession, the patient has a disability which (**select one**) does does not prevent him/her from making or communicating **any** responsible decisions concerning his/her **property** and has a demonstrated inability to manage his/her **property** and affairs effectively because of physical or mental disability.

OR

In my professional opinion, within a reasonable degree of certainty within the social work profession, the patient has a disability which (**select one**) does does not prevent him/her from making or communicating **some** responsible decisions concerning his/her **property**. The patient, for example, is able to make decisions regarding:

.....
.....

but is unable to make decisions regarding:

.....
.....

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of the foregoing paper are true.

.....
Date

.....
LCSW-C's Signature

.....
Printed Name