

Guidelines for Completing Undertaking to Administer Benefits and Certificate of Incapability

Undertaking to Administer Benefits

This page is to be completed by the person applying to be trustee.

Please add the relationship between the senior and the person who is applying to become the trustee.

The witness should be either a:

- Representative for the Alberta Ministry of Seniors and Community Supports, or
- Commissioner of Oaths, or
- Notary Public, or
- Justice of the Peace.

Certificate of Incapability

This page is to be completed by a doctor, charge nurse or social worker.

Please indicate if there is a relationship between the person completing the form and the senior or the trustee.

The personal information provided to Alberta Seniors and Community Supports, including information provided by the Canada Revenue Agency (CRA), is collected under the authority of the *Seniors Benefit Act (RSA 2000)*, *Seniors Benefits Act General Regulation*, and the *Freedom of Information and Privacy (FOIP) Act (RSA 2000)* and will be managed in accordance with the *FOIP Act*. The information will be used for the purpose of administering the Alberta Seniors Financial Assistance Programs, including the Alberta Seniors Benefit, Special Needs Assistance for Seniors, Dental and Optical Assistance for Seniors and Education Property Tax Assistance for Seniors programs.

If you have any questions about the collection of this information, you can contact:

Seniors Services Division
PO Box 3100
Edmonton, Alberta, Canada T5J 4W3

Telephone (toll-free in Alberta): 1-877-644-9992 or 780-644-9992 in the Edmonton area.

Fax: 780-422-5954.

TO BE COMPLETED BY A CHARGE NURSE, SOCIAL WORKER OR PHYSICIAN

For office use only	File No.
---------------------	----------

Information about the senior:

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. Family or Last Name: First Name Middle Initial			Personal Health Number -			
Mailing Address (No., Street, P.O. Box, RR. No.)			Social Insurance Number 			
City, Town or Village	Province or Territory	Postal Code	Age			
Residence Address (Please include name of long term care facility if applicable)						

**Please note that it must be by reason of a mental illness or a physical illness causing severe mental impairment that a person could be considered incapable of managing his/her own affairs.*

Does the applicant or beneficiary have:	
1. Relatively good general knowledge of what is happening to his/her money or investments?	yes <input type="checkbox"/> no <input type="checkbox"/>
2. Sufficient orientation to time in order to pay bills?	yes <input type="checkbox"/> no <input type="checkbox"/>
3. Sufficient memory to keep track of financial transactions and decisions?	yes <input type="checkbox"/> no <input type="checkbox"/>
4. Sufficient calculating ability to be able to correctly balance accounts and bills?	yes <input type="checkbox"/> no <input type="checkbox"/>
5. Significant impairment of judgment due to altered intellectual function?	yes <input type="checkbox"/> no <input type="checkbox"/>
6. Approximately how long have you known this patient?	
7. Do you consider this person capable of managing his/her own affairs? If no, when is improvement expected? _____	yes <input type="checkbox"/> no <input type="checkbox"/>
8. Diagnosis and date of onset.	_____
9. Comments	_____

Information Provided by:

Given name and initial (Please Print)		Family Name		Signature	
Address (No. Street, P.O. Box, R.R. No.)			Area code ()	Phone No.	Date
City, Town or Village		Province or Territory	Postal Code	Profession	
Are you related to the senior? yes <input type="checkbox"/> no <input type="checkbox"/> If yes, what is the family relationship? _____			Are you related to the Trustee? yes <input type="checkbox"/> no <input type="checkbox"/> If yes, what is the family relationship? _____		

