Please answer the following questions concerning the above person. Please provide details at the end of this form or an attached sheet of paper.

1. Have you treated this person before
   If yes, give brief history.
   Yes [ ] No [ ]

2. Has this person ever been rated or found:
   - disabled [Yes [ ] No [ ] Unknown [ ]]
   - mentally ill or incompetent [Yes [ ] No [ ] Unknown [ ]]
   - chemically dependent [Yes [ ] No [ ] Unknown [ ]]

3. Can the above person:
   - care for self (personal hygiene) [Yes [ ] No [ ] Unknown [ ]]
   - prepare meals and/or clean house [Yes [ ] No [ ] Unknown [ ]]
   - maintain bank accounts or funds [Yes [ ] No [ ] Unknown [ ]]
   - pay bills [Yes [ ] No [ ] Unknown [ ]]
   - live independently [Yes [ ] No [ ] Unknown [ ]]
   - operate a car [Yes [ ] No [ ] Unknown [ ]]
   - take medications unsupervised [Yes [ ] No [ ] Unknown [ ]]

4. Would the above person benefit from:
   - further education [Yes [ ] No [ ] Unknown [ ]]
   - further training [Yes [ ] No [ ] Unknown [ ]]
   - therapy of some sort [Yes [ ] No [ ] Unknown [ ]]
   - medical aids or equipment [Yes [ ] No [ ] Unknown [ ]]
   - an operation or medical procedure(s) [Yes [ ] No [ ] Unknown [ ]]
   - structured living arrangements [Yes [ ] No [ ] Unknown [ ]]

5. Has the above person had in the last six months:
   - hospitalization(s) [Yes [ ] No [ ] Unknown [ ]]
   - therapy or treatment [Yes [ ] No [ ] Unknown [ ]]
   - inpatient or outpatient surgery [Yes [ ] No [ ] Unknown [ ]]
   - major medical test(s) [Yes [ ] No [ ] Unknown [ ]]
   - psychological or psychiatric testing [Yes [ ] No [ ] Unknown [ ]]

6. In your opinion, does this person have the mental or physical capacity to effectively manage his/her property and financial affairs
   Yes [ ] No [ ]
   and/or make necessary daily living and health care decisions
   Yes [ ] No [ ]
7. To your knowledge does this person have:

<table>
<thead>
<tr>
<th>Protection</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>a power of attorney</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a health care power of attorney or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a &quot;living will&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Does the above person have any of the following coverages?

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>health insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medicare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medicaid</td>
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<td></td>
<td></td>
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<tr>
<td>veteran’s health care</td>
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</tr>
</tbody>
</table>

9. Does this person have a primary caretaker?

<table>
<thead>
<tr>
<th>Primary Caretaker</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
</table>

If yes, please give available information on name, address, and relationship to above person.

SWORN to before me this ______ day of __________________________

_________________________, 20 _____

______________________________

Examiner’s Signature

Notary Public for South Carolina

Examiner’s Name

My Commission Expires: __________________________

Use this space for explanations or additional comments.

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