

Decision Making Capacity Assessment Professional Training Program

Class 1 – October 1, 2025

ADDITIONAL SLIDES FROM CLASS



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Elder Education Institute



Capacity definitions

UGCOPPA definitions

- **Cognitive incapacity:** “unable to receive and evaluate information or make or communicate decisions.”
- **Functional incapacity:** “lacks ability to meet essential requirement for physical health, safety, or self-care even with appropriate technological assistance.”
- **Guardianship required when** it is “necessary to provide continuing care and supervision.”
- **Specific conditions** for a declaration of incapacity include: “mental illness, mental deficiency, physical illness or disability, physical or mental infirmities accompanying advanced age, alcoholism, drug addiction, or other cause.”

STATE STATUTES REGARDING CAPACITY IN CHARTS FOLLOWING

Florida	Florida Statutes Title XLIII Chapter 744 Guardianship 744.102(12) lacks capacity to meet at least some of essential health and safety requirements 744.102(12)(b) serious and imminent physical injury or illness more likely than not to occur Fla. Stat. Ann. § 765 medical decision making
Idaho	Idaho Code Title 15 Chapter 5 Guardianship; Title 66 re developmental disabilities. 15-5-101(a) (1) inability to provide for personal needs for food, clothing, shelter, health care or safety; measured by functional limitations 15-5-101(a) lacks sufficient understanding or capacity of make or communicated responsible decisions 15-5-101(a)(1) suffer substantial harm 15-5-101(a)(3) isolated instances of negligence not evidence of inability"
Michigan	Michigan Compiled Laws / Mich. Comp. Laws Ann. Chapter 700 700.1105(a) lacks sufficient understanding or capacity to make or communicate informed decisions

Ohio	Ohio Revised Code Title 21 Chapter 2111 2111.01(D) incapable of taking proper care of self or property or family
Tennessee	Tennessee Code Title 34 Guardianship 34-1-126 court must find respondent is fully or partially disabled and in need of assistance from the court
Washington	RCW 11.130 guardianship (adopted UGCOPPA, mostly) 11.130.265 Lacks ability to meet essential requirements for physical health, safety, or self-care 11.130.360 Unable to manage property or financial affairs 11.130.265 Unable to receive and evaluate information or make or communicate decisions even with support 11.130.360 Limitation in ability to receive and evaluated information or make or communicate even with support 11.130.265 Necessary to prevent significant risk of harm 11.130.360 Avoid harm to adult or significant dissipation of property

Licensure specifics

- State statutes on guardianship and health care decision making are where language is found around licensure qualifications. (*see following charts*)
- In other types of capacity questions, there aren't defined licensure types for who can assess decision making capacity.

Florida	<p>Florida Statutes Title XLIII Chapter 744 Guardianship</p> <p>744.331(3) – Examining committee of 3 professionals: “One member must be a psychiatrist or other physician. The remaining members must be either a psychologist, a gerontologist, a psychiatrist, a physician, an advanced practice registered nurse, a registered nurse, a licensed social worker, a person with an advanced degree in gerontology from an accredited institution of higher education, or any other person who by knowledge, skill, experience, training, or education”</p> <p>744.464 Suggestion of capacity [restoration of rights] – examined by physician</p>
Idaho	<p>Idaho Code Title 15 Chapter 5 Guardianship; Title 66 re developmental disabilities.</p> <p>15-5-101 defines incapacity</p> <p>15-5-303(b) “physician or other qualified person... mental health professional, defined as a psychiatrist, psychologist, gerontologist, licensed social worker, or licensed counselor”</p> <p>Bench Cards (updated in 2018, but may still be helpful): https://isc.idaho.gov/gc/Bench_Card-Guardianship_Conservatorship_FullSet.pdf</p>

Michigan	Michigan Compiled Laws / Mich. Comp. Laws Ann. Chapter 700: 700-5304 – evaluation by physician or mental health professional (under 330.1100b, MHP defined as physician, psychologist, registered professional nurse, licensed masters social worker, licensed professional counselor, marriage and family therapist).
Ohio	Ohio Revised Code Title 21 Chapter 2111: 2111.031 – court “may appoint physicians, clinical nurse specialists, certified nurse practitioners, and other qualified persons”
Tennessee	Tennessee Code Title 34 Guardianship: Tenn. Code Ann. § 34-1: § 34-3-105 (g) “physician, psychologist, or senior psychological examiner”
Washington	RCW 11.130 (adopted UGCOPPA, mostly) 11.130.290 – evaluation by physician, psychologist, advanced registered nurse practitioner, or physician assistant, or “different professional”

	MD/ DO	PsyD/ Phd	Psych- iatrist	PA	NP	RN	SW	Couns /Tx	OT	Geron	LMFT	Other
FL	Y	Y	Y		Y	Y	Y			Y		Y
ID	Y	Y	Y				Y	Y		Y		Y
MI	Y	Y	Y		Y	Y	Y	Y			Y	
OH	Y	Y			Y	Y						Y
TN	Y	Y	Y									?
WA	Y	Y	Y	Y	Y							Y
Uniform Law	Y	Y					Y					Y

Case Study 1: G.T.

- G.T., a 73-yo single Black woman, was referred to a crisis team for possible cognitive and/or mental health issues. She reportedly makes repeated evening calls to 911 for physical distress (e.g., nausea, diarrhea, weakness) but responding providers find her denying any issues or unwilling to talk about the call. However, she has answered the door naked and smelling of urine.
- G.T. lives alone in senior housing but reportedly allows other family members to stay there and has unpaid rent, so she is at risk of eviction. Her unit is very sparse, including no food, but she reportedly has prepared meals onsite. She reported having diabetes type II but otherwise says that her granddaughter takes care of her medical information. When asked about 911 calls, she denies but states that staff come into her unit and mess with the thermostat and her belongings.
- After the visit, you learn there are no meals onsite, the granddaughter denies knowing about 911 calls and medical health, and G.T. has not been seen in clinic for over 2 years. Also a neighbor reports she used to be obese and is now quite thin and frail.

Case Study 2: J.B.

- J.B., 76-yo divorced, veteran White man referred to a crisis team for moderate cognitive decline and wandering behavior at night posing risk to self. In one instance, he called local Senior Center at 2am and left message saying he would be coming to his appointment. He reportedly stood outside the center for six hours in freezing temperatures until it opened.
- Additional report of past financial exploitation by strangers. His out-of-state sister is currently managing finances as POA. No family in the area. He presents with appropriate hygiene and dress. He lives in a shared rental with other housemates, where he sleeps on the floor in his rented basement room. One housemate has been providing him with meals and shopping assistance.
- J.B. reports anxiety about needing to rely on other people to help him.

Case Study 3: D.B.

- D.B., a 94-yo widowed White woman with severe hearing impairment, was referred to APS for safety concerns due to reported functional decline. She has been assisted by a neighbor for nearly a decade -- purchasing groceries, providing transportation to medical appointments, cuing D.B. to do housework, and keeping bills paid -- but the neighbor must step away due to her own health issues.
- D.B.'s 73-yo son moved in with her about a year ago but is bedridden from a medical condition and thus dependent on her for food and waste removal. The neighbor who had been helping expressed grave concern about the situation and stated belief that D.B. herself needs 24/7 care, as well as her son.
- D.B. has stated that she does not want to move out of her home. She has a reported heart condition for which she takes medication independently, but she could not report the name of the meds or her condition.

Case Study 4: D.R.

- D.R., Caucasian woman in her 60's, native English speaker. Lives independently in low-income housing with no family available to assist. Completed high school with IEP and extra support.
- D.R. has a reported history of developmental delays, intellectual disability (no specific diagnosis), history of right partial lobectomy, and anxiety. For many years she has had disorganized thinking and mild memory deficits and difficulty with decision making.
- She has managed healthcare and lived independently for last 20 years, however has always lived on the margins. She takes pride in being independent and not needing a social worker or caregiver.
- D.R. recently has become more confused - forgetting timeline of events, focusing on the past and missing appointments. The professional who manages her trust has expressed concerns about her ability to manage medical and financial decisions and wonders if she needs additional help (that she is currently refusing).

Case Study 5: L.T.

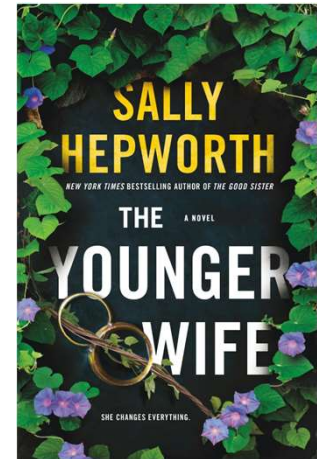
- L.T., 72, female, White, native English speaker. Client and her brother co-own a house. Brother lives separately. L.T. lives with her son, his fiancé, and a tenant who rents a room.
- L.T. was referred to crisis team for concern with different challenges related to her memory: understanding time and the calendar, struggling to eat on time, stay on track with other ADLs. It was reported that L.T. experiences worsening symptoms over time and resists taking medication on time. Family report her functioning is up and down during the day.
- At our visit, L.T. was alert and oriented to person and place, but struggled with situational awareness and time, frequently needing repeated explanations. During the visit, L.T.'s symptoms were notably worse before her scheduled medication at noon. She exhibited slow movement, difficulty speaking, and required help with basic tasks like finding socks and getting water from the kitchen. However, after taking medication, her symptoms improved significantly.

Wrap up

- Resources provided
 - NCEA's [Annual Research Compilation](https://elderjustice.usc.edu/wp-content/uploads/2025/09/NCEA-Elder-Abuse-Annual-Research-Compilation.pdf), a research guide containing articles relating to elder abuse, neglect, and exploitation that were published between September 2024 and August 2025. Available online at <https://elderjustice.usc.edu/wp-content/uploads/2025/09/NCEA-Elder-Abuse-Annual-Research-Compilation.pdf>
- CEUs
- How did today feel, in terms of timing / breaks?

Elder Justice Book Club

- Members of the Elder Justice Community are welcome! Join virtually to discuss books and share ideas 3-4 times yearly.
- Co-presented by National Center on Elder Abuse and NAPSA Research to Practice (R2P) Interest Group
- NEXT MEETING: Thursday December 4, 2025 12pm PT/ 3pm ET via Zoom
- TO SIGN UP: Let us know your contact info to receive meeting invitations and vote on new reads, using <https://forms.gle/dAwYt97PRw2TiD56A>
- Please email elaine.chen@med.usc.edu if help is needed.



[The Younger Wife](#)
by Sally Hepworth

Our next classes

October 15	Cognition and mental health in capacity
October 29	Cognitive testing and other assessment tools
November 12	Case studies and discussion, next steps