



Certificate of Incapability

Social Insurance Number

Information about the Old Age Security and/or Canada Pension Plan beneficiary

____ - ____ - ____

Mr. Mrs. Usual First Name and Initial
 Ms Miss Last Name

Address - No., Street, Apt., P.O. Box, R.R. and City Province or Territory
Country - If other than Canada Postal Code

Please note that, to be considered incapable of managing his/her own affairs, a person must be suffering from severe mental impairment caused by a mental or a physical illness.

Does the person named above have:

1. Good general knowledge of what is happening to his/her money or investments?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments
2. Sufficient understanding of the concept of time, in order to pay bills promptly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments
3. Sufficient memory to keep track of financial transactions and decisions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments
4. Ability to balance accounts and bills?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments
5. Significant impairment of judgement due to altered intellectual function?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments

In addition:

6A. How long have you known this person?	6B. Please state this person's age
7. Do you consider this person capable of managing his/her own affairs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, when is improvement expected? (Provide date)
8. Diagnosis of impairment	Date impairment started Year Month Day
9. Comments	

Name and signature of professional completing this form

First Name and Initial Last Name	Signature	Date
Address - No., Street, Apt., P.O. Box, R.R. and City	Province or Territory	Telephone (____) ____-____
	Country Postal Code	Profession

FOR OFFICE USE ONLY

Approval <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for disapproval	Reassessment Date	Signature	Date
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