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 Health, 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 the Ministry of Health, 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:

Alberta Health
Seniors Financial Assistance Branch
PO Box 3100
Edmonton, Alberta, Canada T5J 4W3

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

Fax: 780-422-5954.

0880-10 July 2013

Alberta Government

Certificate of Incapability
Alberta Seniors Benefit Act

For office use only	File No.

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

Information about the senior:

☐ Mr. ☐ Mrs. ☐ Miss ☐ 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 ☐	no ☐
2. Sufficient orientation to time in order to pay bills?	yes ☐	no ☐
3. Sufficient memory to keep track of financial transactions and decisions?	yes ☐	no ☐
4. Sufficient calculating ability to be able to correctly balance accounts and bills?	yes ☐	no ☐
5. Significant impairment of judgment due to altered intellectual function?	yes ☐	no ☐
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 ☐	no ☐
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.)		Phone No. (10 digit) - -	Date
City, Town or Village	Province or Territory	Postal Code	Profession
Are you related to the senior? yes ☐ no ☐ If yes, what is the family relationship? _____		Are you related to the Trustee? yes ☐ no ☐ If yes, what is the family relationship? _____	

Alberta Government

Undertaking to administer benefits under **the Alberta Seniors Benefit Act**

TO BE COMPLETED BY THE PERSON APPLYING TO BE THE TRUSTEE	**For office use only**	**File No.**

Information About the Senior:

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Given name and initial	Family Name
Address (No., Street, P.O. Box, RR. No.)	City, Town or Village

Province or Territory	Postal Code	Personal Health Number
		-

I, the undersigned, do hereby agree to receive benefits under the Alberta Seniors Benefit Act payable to Beneficiary or Applicant described above and undertake, pursuant to the provisions of the Alberta Seniors Benefit Act, as the case may be, and the Regulations made thereunder, without charge:

1. to act on behalf of the said beneficiary and, in accordance with the directions, if any, that may be furnished to me by the Director of the Alberta Seniors Benefit program to administer and expend the benefits in the best interests of the beneficiary;
2. to account in such form and at such time as the Director may indicate, for all benefit payments made therefrom;
3. to notify the Director should the beneficiary change address, become absent from Alberta, die, cease to be incapable of handling his/her own affairs, and to furnish any other information or evidence and to do anything the Alberta Seniors Benefit Act or the Regulations thereunder require the beneficiary to furnish or do;
4. to return uncashed, if the said beneficiary should die, all Alberta Seniors Benefit cheques in favour of the said beneficiary which remains uncashed at the time of his/her death or which may be issued subsequent to the month of death, and to indemnify Her Majesty the Queen in Right of Alberta for any loss sustained by her through the cashing of such cheques.

Please note that the witness' position must be a Commissioner of Oaths, Notary Public, Justice of the Peace or a representative for the Alberta Ministry of Health.

Signature of Witness	Signature of Trustee
Name of Witness (please print)	Name of Trustee (please print)
Address of Witness	Address of Trustee
City, Town or Village Province	City, Town or Village Province
Postal Code Phone No. (10 digit)	Postal Code Phone No. (10 digit)
Date Witness Position	Date Relationship to senior