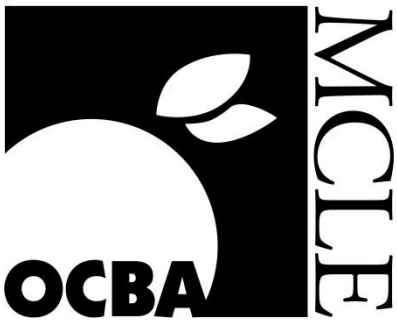
ORANGE COUNTY BAR ASSOCIATION

CONSERVATORSHIP, GUARDIANSHIP & PROTECTIVE PROCEEDINGS SECTION WEBINAR

Declarations of Capacity: How to Navigate the New Capacity Declaration Attachment and How to Compel Compliance



Monday, March 29, 2021

OCBA- CONSERVATORSHIPS & PROTECTIVE PROCEEDINGS SECTION

Meeting March 29, 2021

Probate Code sections 1800

It is the intent of the Legislature in enacting this chapter to do the following:
(a) Protect the rights of persons who are placed under conservatorship.
(b) Provide that an assessment of the needs of the person is performed in order to determine the appropriateness and extent of a conservatorship and to set goals for increasing the conservatee's functional abilities to whatever extent possible.
(c) Provide that the health and psychosocial needs of the proposed conservatee are met.
(d) Provide that community-based services are used to the greatest extent in order to allow the conservatee to remain as independent and in the least restrictive setting as possible.
(e) Provide that the periodic review of the conservatorship by the court investigator shall consider the best interests of the conservatee.
(f) Ensure that the conservatee's basic needs for physical health, food, clothing, and shelter are met.
(g) Provide for the proper management and protection of the conservatee's real and personal property.

Probate Code sections 1801

Subject to Section 1800.3 :
(a) A conservator of the person may be appointed for a person who is unable to provide properly for his or her personal needs for physical health, food, clothing, or shelter, except as provided for the person as described in subdivision (b) or (c) of Section 1828.5 .
(b) A conservator of the estate may be appointed for a person who is substantially unable to manage his or her own financial resources or resist fraud or undue influence, except as provided for that person as described in subdivision (b) or (c) of Section 1828.5 . Substantial inability may not be proved solely by isolated incidents of negligence or improvidence.
(c) A conservator of the person and estate may be appointed for a person described in subdivisions (a) and (b).
(d) A limited conservator of the person or of the estate, or both, may be appointed for a developmentally disabled adult. A limited conservatorship may be utilized only as necessary to promote and protect the well-being of the individual, shall be designed to encourage the development of maximum self-reliance and independence of the individual, and shall be ordered only to the extent necessitated by the individual's proven mental and adaptive limitations. The conservatee of the limited conservator shall not be presumed to be incompetent and shall retain all legal and civil rights except those which by court order have been designated as legal disabilities and have been specifically granted to the limited conservator. The intent of the Legislature, as expressed in Section 4501 of the Welfare and Institutions Code , that developmentally disabled citizens of this state receive services resulting in more independent, productive, and normal lives is the underlying mandate of this division in its application to adults alleged to be developmentally disabled.
(e) The standard of proof for the appointment of a conservator pursuant to this section shall be clear and convincing evidence.

Probate Code Section 1800.3.

(a) If the need therefor is established to the satisfaction of the court and the other requirements of this chapter are satisfied, the court may appoint:

(1) A conservator of the person or estate of an adult, or both.

(2) A conservator of the person of a minor who is married or whose marriage has been dissolved.

(b) No conservatorship of the person or of the estate shall be granted by the court unless the court makes an express finding that the granting of the conservatorship is the least restrictive alternative needed for the protection of the conservatee.

Probate Code section 1828

(a) Except as provided in subdivision (c), before the establishment of a conservatorship of the person or estate, or both, the court shall inform the proposed conservatee of all of the following:
(1) The nature and purpose of the proceeding.
(2) The establishment of a conservatorship is a legal adjudication of the proposed conservatee's inability to properly provide for his or her personal needs or to manage the conservatee's own financial resources, or both, depending on the allegations made and the determinations requested in the petition, and the effect of such an adjudication on the proposed conservatee's basic rights.
(3)(A) The proposed conservatee may be disqualified from voting pursuant to Section 2208 of the Elections Code if he or she is incapable of communicating, with or without reasonable accommodations, a desire to participate in the voting process.
(B) The proposed conservatee shall not be disqualified from voting on the basis that he or she does, or would need to do, any of the following to complete an affidavit of voter registration:
(i) Signs the affidavit of voter registration with a mark or a cross pursuant to subdivision (b) of Section 2150 of the Elections Code .
(ii) Signs the affidavit of voter registration by means of a signature stamp pursuant to Section 354.5 of the Elections Code .
(iii) Completes the affidavit of voter registration with the assistance of another person pursuant to subdivision (d) of Section 2150 of the Elections Code .
(iv) Completes the affidavit of voter registration with reasonable accommodations.
(4) The identity of the proposed conservator.
(5) The nature and effect on the proposed conservatee's basic rights of any order requested under Chapter 4 (commencing with Section 1870), and in the case of an allegedly developmentally disabled adult, the specific effects of each limitation requested in such order.
(6) The proposed conservatee has the right to oppose the proceeding, to have the matter of the establishment of the conservatorship tried by jury, to be represented by legal counsel if the proposed conservatee so chooses, and to have legal counsel appointed by the court if unable to retain legal counsel.
(b) After the court so informs the proposed conservatee and before the establishment of the conservatorship, the court shall consult the proposed conservatee to determine the proposed conservatee's opinion concerning all of the following:
(1) The establishment of the conservatorship.
(2) The appointment of the proposed conservator.

(3) Any order requested under Chapter 4 (commencing with Section 1870), and in the case of an allegedly developmentally disabled adult, of each limitation requested in such order.
(c) This section does not apply where both of the following conditions are satisfied:
(1) The proposed conservatee is absent from the hearing and is not required to attend the hearing under subdivision (a) of Section 1825 .
(2) Any showing required by Section 1825 has been made.

Probate Code sections 1828.5

(a) At the hearing on the petition for appointment of a limited conservator for an allegedly developmentally disabled adult, the court shall do each of the following:
(1) Inquire into the nature and extent of the general intellectual functioning of the individual alleged to be developmentally disabled.
(2) Evaluate the extent of the impairment of his or her adaptive behavior.
(3) Ascertain his or her capacity to care for himself or herself and his or her property.
(4) Inquire into the qualifications, abilities, and capabilities of the person seeking appointment as limited conservator.
(5) If a report by the regional center, in accordance with Section 1827.5 , has not been filed in court because the proposed limited conservatee withheld his or her consent to assessment by the regional center, the court shall determine the reason for withholding such consent.
(b) If the court finds that the proposed limited conservatee possesses the capacity to care for himself or herself and to manage his or her property as a reasonably prudent person, the court shall dismiss the petition for appointment of a limited conservator.
(c) If the court finds that the proposed limited conservatee lacks the capacity to perform some, but not all, of the tasks necessary to provide properly for his or her own personal needs for physical health, food, clothing, or shelter, or to manage his or her own financial resources, the court shall appoint a limited conservator for the person or the estate or the person and the estate.
(d) If the court finds that the proposed limited conservatee lacks the capacity to perform all of the tasks necessary to provide properly for his or her own personal needs for physical health, food, clothing, or shelter, or to manage his or her own financial resources, the court shall appoint either a conservator or a limited conservator for the person or the estate, or the person and the estate.
(e) The court shall define the powers and duties of the limited conservator so as to permit the developmentally disabled adult to care for himself or herself or to manage his or her financial resources commensurate with his or her ability to do so.
(f) Prior to the appointment of a limited conservator for the person or estate or person and estate of a developmentally disabled adult, the court shall inform the proposed limited conservatee of the nature and purpose of the limited conservatorship proceeding, that the appointment of a limited conservator for his or her person or estate or person and estate will result in the transfer of certain rights set forth in the petition and the effect of such transfer, the identity of the person who has been nominated as his or her limited conservator, that he or she has a right to oppose such proceeding, and that he or she has a right to have the matter tried by

jury. After communicating such information to the person and prior to the appointment of a limited conservator, the court shall consult the person to determine his or her opinion concerning the appointment.

Welfare & Institutions Code sections 4501

The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly and having an important impact on the lives of their families, neighbors, and whole communities, developmental disabilities present social, medical, economic, and legal problems of extreme importance.

The complexities of providing services and supports to persons with developmental disabilities requires the coordination of services of many state departments and community agencies to ensure that no gaps occur in communication or provision of services and supports. A consumer of services and supports, and where appropriate, his or her parents, legal guardian, or conservator, shall have a leadership role in service design.

An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community. To the maximum extent feasible, services and supports should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities.

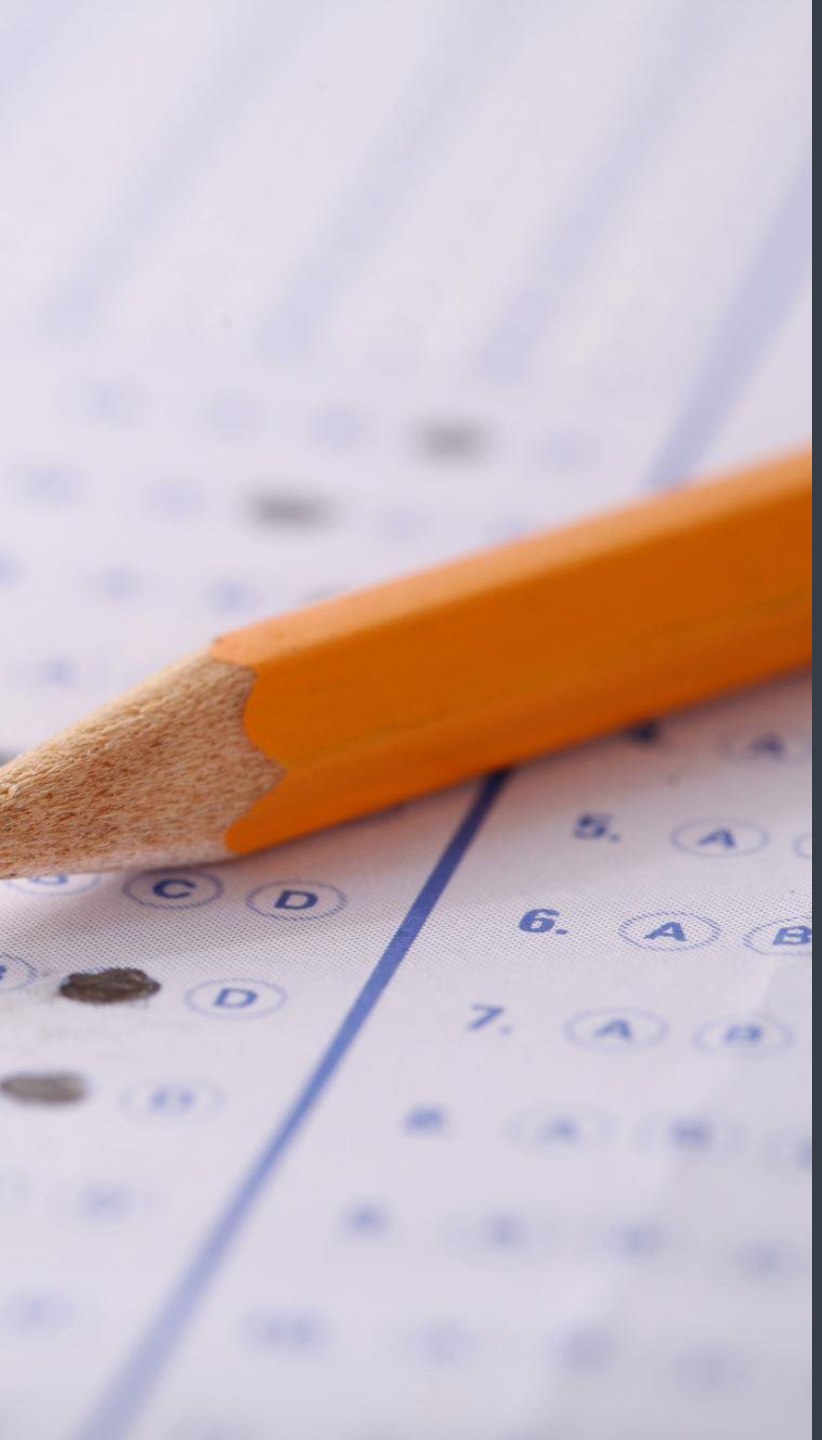
Services and supports should be available to enable persons with developmental disabilities to approximate the pattern of everyday living available to people without disabilities of the same age. Consumers of services and supports, and where appropriate, their parents, legal guardian, or conservator, should be empowered to make choices in all life areas. These include promoting opportunities for individuals with developmental disabilities to be integrated into the mainstream of life in their home communities, including supported living and other appropriate community living arrangements. In providing these services, consumers and their families, when appropriate, should participate in decisions affecting their own lives, including, but not limited to, where and with whom they live, their relationships with people in their community, the way in which they spend their time, including education, employment, and leisure, the pursuit of their own personal future, and program planning and implementation. The contributions made by parents and family members in support of their children and relatives with developmental disabilities are important and those relationships should also be respected and fostered, to the maximum extent feasible, so that consumers and their families can build circles of support within the community.

The Legislature finds that the mere existence or the delivery of services and supports is, in itself, insufficient evidence of program effectiveness. It is the intent of the Legislature that agencies serving persons with developmental disabilities shall produce evidence that their services have resulted in consumer or family empowerment and in more independent, productive, and normal lives for the persons served. It is further the intent of the Legislature that the Department of Developmental Services, through appropriate and regular monitoring activities, ensure that

regional centers meet their statutory, regulatory, and contractual obligations in providing services to persons with developmental disabilities. The Legislature declares its intent to monitor program results through continued legislative oversight and review of requests for appropriations to support developmental disabilities programs.

Welfare & Institutions Code sections 15600

15600. (a) The Legislature recognizes that elders and dependent adults may be subjected to abuse, neglect, or abandonment and that this state has a responsibility to protect these persons.
(b) The Legislature further recognizes that a significant number of these persons are elderly. The Legislature desires to direct special attention to the needs and problems of elderly persons, recognizing that these persons constitute a significant and identifiable segment of the population and that they are more subject to risks of abuse, neglect, and abandonment.
(c) The Legislature further recognizes that a significant number of these persons have developmental disabilities and that mental and verbal limitations often leave them vulnerable to abuse and incapable of asking for help and protection.
(d) The Legislature recognizes that most elders and dependent adults who are at the greatest risk of abuse, neglect, or abandonment by their families or caretakers suffer physical impairments and other poor health that place them in a dependent and vulnerable position.
(e) The Legislature further recognizes that factors which contribute to abuse, neglect, or abandonment of elders and dependent adults are economic instability of the family, resentment of caretaker responsibilities, stress on the caretaker, and abuse by the caretaker of drugs or alcohol.
(f) The Legislature declares that this state shall foster and promote community services for the economic, social, and personal well-being of its citizens in order to protect those persons described in this section.
(g) The Legislature further declares that uniform state guidelines, which specify when county adult protective service agencies are to investigate allegations of abuse of elders and dependent adults and the appropriate role of local law enforcement is necessary in order to ensure that a minimum level of protection is provided to elders and dependent adults in each county.
(h) The Legislature further finds and declares that infirm elderly persons and dependent adults are a disadvantaged class, that cases of abuse of these persons are seldom prosecuted as criminal matters, and few civil cases are brought in connection with this abuse due to problems of proof, court delays, and the lack of incentives to prosecute these suits.
(i) Therefore, it is the intent of the Legislature in enacting this chapter to provide that adult protective services agencies, local long-term care ombudsman programs, and local law enforcement agencies shall receive referrals or complaints from public or private agencies, from any mandated reporter submitting reports pursuant to Section 15630, or from any other source having reasonable cause to know that the welfare of an elder or dependent adult is endangered, and shall take any actions considered necessary to protect the elder or dependent adult and correct the situation and ensure the individual s safety.
(j) It is the further intent of the Legislature in adding Article 8.5 (commencing with Section 15657) to this chapter to enable interested persons to engage attorneys to take up the cause of abused elderly persons and dependent adults.



CAPACITY DECLARATION: ADDENDUM TO FORM GC-335

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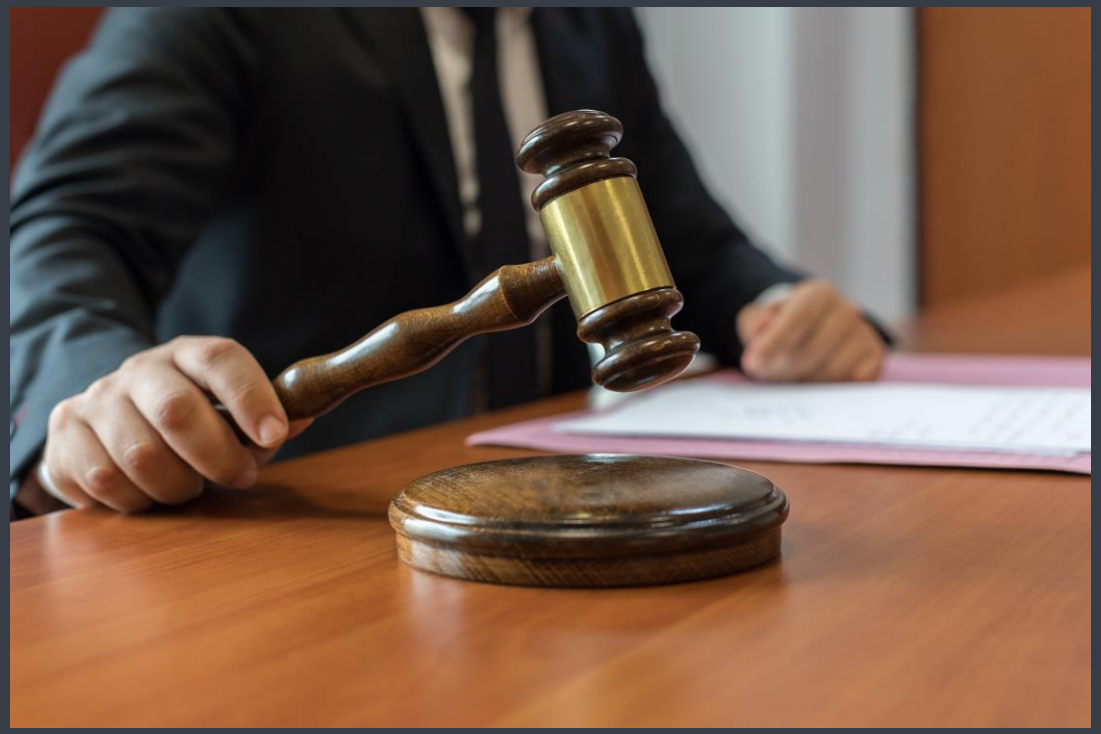

Information from healthcare professionals is necessary for the courts to determine the best life circumstances for persons while preserving as much independence as possible.

HEALTHCARE PERSPECTIVE

- Provide an accurate portrayal of daily life
- Appreciation for **continuum** of decision-making capacity
- Capacity is NOT all or none
- Deficits for patients with dementia are unique to types of dementia and unique from other types of intellectual disabilities

EXISTING FORM

- Lacks information specific for person centered decisions
- Lack of clarity for discerning the impact of deficits on one's well being
- Limits useful information that healthcare providers have to offer

ENHANCED PURPOSE: IT'S NOT JUST DEMENTIA!

A. THE CAPACITY TO GIVE INFORMED CONSENT TO MEDICAL TREATMENT AND HAS THE CAPACITY TO HANDLE HIS/HER FINANCIAL AFFAIRS;

B. DEMENTIA AND IF SO, (1) WHETHER HE OR SHE NEEDS TO BE PLACED IN A SECURED-PERIMETER RESIDENTIAL CARE FACILITY FOR THE ELDERLY, AND (2) WHETHER HE OR SHE CAN REMAIN IN HIS/HER HOME WITH FULL-TIME CAREGIVERS IF RESOURCES ARE AVAILABLE, AND (3) WHETHER HE/SHE WOULD BENEFIT FROM DEMENTIA MEDICATIONS;

C. AN ACQUIRED BRAIN INJURY (BRAIN TUMOR, STROKE, SEIZURE DISORDER, TRAUMATIC BRAIN INJURY);

D. AN INTELLECTUAL DISABILITY; AND/OR

E. A PSYCHIATRIC DISABILITY.

OLD VS NEW

- YEARS OF EDUCATION
- LANGUAGE (TESTING OFTEN NORMED ON ENGLISH)

- CLEAR CHOICES FOR IMPAIRMENT/NO IMPAIRMENT

ATTENTION/CONCENTRATION : the foundation of a person's ability to register information

(3) Ability to attend and concentrate (type of attention/concentration impaired)

a ☐	b ☐	c ☐	Focused (1-2 minutes)
a ☐	b ☐	c ☐	Sustained (5 minutes)
a ☐	b ☐	c ☐	Sustained (10-15 minutes)
a ☐	b ☐	c ☐	Sustained (15-30 minutes)
a ☐	b ☐	c ☐	Sustained (30 or more minutes)
a ☐	b ☐	c ☐	Easily Distractible
a ☐	b ☐	c ☐	Alternating/Divided (can multitask; cook, drive)

CHANGES TO INFORMATION PROCESSING

(2) Understand and communicate either verbally or otherwise (deficits reflected by inability to comprehend questions, 3-step command, use words correctly, name objects)
a ☐ b ☐ c ☐

(3) Recognize familiar objects and persons (deficits reflected by inability to recognize familiar faces, objects, family members)
a ☐ b ☐ c ☐

(4) Understand and appreciate quantities (deficits reflected by inability to perform simple calculations)
a ☐ b ☐ c ☐

(5) Understand and appreciate current life circumstances (deficits reflected by inability to acknowledge being dependent on others for life sustaining activities of daily living)
a ☐ b ☐ c ☐

(6) Reason using abstract concepts (deficits reflected by inability to grasp abstract aspects of his/her situation or to interpret idiomatic expressions or proverbs)
a ☐ b ☐ c ☐

(7) Plan, organize and carry out actions (or direct others to if physically unable) in one's own rational self-interest (deficits reflected by inability to break complex tasks down into simple steps and carry them out)

a ☐ b ☐ c ☐

(8) Reason logically by weighing the pros and cons of a given situation to problem-solve or make a decision that is in the best interest of his/her person (deficits reflected by not coming to conclusions that include all information provided in writing, or in an auditory/visual format)

a ☐ b ☐ c ☐

B. **Ability to handle family environment (deficits reflected by inability to identify and/or deal with family dysfunction that is NOT in his/her best interest and/or unduly influences him/her to act in a self-destructive way)**

a ☐ b ☐ c ☐

FAMILY DYNAMICS

NEW SECTION FOR PERSONALITY DISORDERS

D. **Personality Disorder/Character Disorder:** The (proposed) conservatee ☐ has ☐ does NOT have a characterological personality disorder that interferes with his/her ability to make appropriate decisions that are in his/her best interests. If so, complete 6D.

Narcissistic Personality Disorder	a ☐	b ☐	c ☐
Borderline Personality Disorder	a ☐	b ☐	c ☐
Dependent Personality Disorder	a ☐	b ☐	c ☐
Avoidant Personality Disorder	a ☐	b ☐	c ☐
Schizoid Personality Disorder	a ☐	b ☐	c ☐
Schizoaffective Personality Disorder	a ☐	b ☐	c ☐
Paranoid Personality Disorder	a ☐	b ☐	c ☐

ADDED SECTION FOR FUNCTION

Function is the key to independence

The Common Denominator despite the cause of impairment

- ACTIVITIES OF DAILY LIVING
  - BATHING
  - DRESSING
  - TOILETING
  - TRANSFERRING
  - CONTINENCE
  - FEEDING

- INSTRUMENTAL ACTIVITIES OF DAILY LIVING
  - TELEPHONE
  - SHOPPING
  - FOOD PREPARTION
  - HOUSEKEEPING
  - LAUNDRY
  - TRANSPORTATION
  - MEDICATION
  - FINANCES

The (proposed) conservatee is **Independent** in **ALL** ADL functions _____

The (proposed) conservatee is **Dependent** in **ALL** ADL functions _____

. (Optional) Any other information regarding this evaluation of the (proposed) conservatee's Activities of Daily Living function is ☐ stated below ☐ stated in Attachment.

The (proposed) conservatee is **Competent** in **ALL** IADL functions ☐

The (proposed) conservatee is **Moderately Competent/Able to manage** in IADL functions ☐

The (proposed) conservatee is **Not able to maintain self, even with help** in IADL functions ☐

(Optional) Any other information regarding this evaluation of the (proposed) conservatee's Instrumental Activities of Daily Living function is ☐ stated below ☐ stated in Attachment.

PLACEMENT

A. Placement of (proposed) conservatee

(1) ☐ The (proposed) conservatee would benefit from or needs placement in a restricted and secure facility.

(2) ☐ The (proposed) conservatee would benefit from or needs 24-hour caregiver support in their home if resources are provided to the (proposed) conservatee.

(3) ☐ The (proposed) conservatee HAS capacity to give informed consent to this placement.

(4) ☐ The (proposed) conservatee does NOT have capacity to give informed consent to this placement.

(5) A locked or secured-perimeter facility ☐ is ☐ is NOT the least restrictive environment appropriate to the needs of the (proposed) conservatee.

PRESERVING DIGNITY FOR EVERY OLDER AND DEPENDENT ADULT

OCBA Conservatorship, Guardianship & Protective Proceedings Section Webinar
Declarations of Capacity: How to Navigate the New Capacity Declaration Attachment and How to Compel Compliance

March 29, 2021

by
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INTRODUCTION

1. Diverting from paternalism.

2. Granting more freedom for Conservatee.

3. Change in landscape of capacity of Conservatee due to aging population.

   (a) There are many types of disabilities

   (b) There are many ranges of capacity and what Conservatee can do for themselves.

   (c) Consider the Conservatee's particular situation and such person's particular limitations.

CONSIDERATIONS FOR LIMITING CONSERVATOR'S POWERS AND EXPANDING POWERS OF CONSERVATEE IN GENERAL CONSERVATORSHIPS

4. Narrowing the powers of the Conservator and broadening the powers and right sof the Conservatee. Prob. Code §§ 2351-2358.

5. Consider using these seldom-used statutes to request the narrowing of powers of the Conservator and broadening the powers and rights of the Conservatee.

6. Need to think differently and not just request a "general" conservatorship with all of the "general powers."

7. "(b) Where the court determines that it is appropriate in the circumstances of the particular conservatee, the court, in its discretion, may limit the powers and duties that the conservator would otherwise have under subdivision (a) by an order stating either of the following:

   (1) The specific powers that the conservator does not have with respect to the conservatee's person and reserving the powers so specified to the conservatee.

(2) The specific powers and duties the conservator has with respect to the conservatee's person and reserving to the conservatee all other rights with respect to the conservatee's person that the conservator otherwise would have under subdivision (a).

(c) An order under this section (1) may be included in the order appointing a conservator of the person or (2) may be made, modified, or revoked upon a petition subsequently filed, notice of the hearing on the petition having been given for the period and in the manner provided in Chapter 3 (commencing with Section 1460) of Part 1."

8. Goals of narrowing of powers of the Conservator and broadening the powers and rights of the Conservatee.

(a) More freedom for Conservatee.

(b) Less paternalism.

9. In order to consider and determine what specific narrowing of powers of Conservator and broadening powers of Conservatee to request in the petition for appointment, consider reviewing the following.

(a) The powers of a limited conservator. Although these do not apply to a general conservatorship, they can be a guide to evaluating optional powers. See Prob. Code §§ 2351.5(b). These include:

(1) To fix the residence or specific dwelling of the limited conservatee.

(2) Access to the confidential records and papers of the limited conservatee.

(3) To consent or withhold consent to the marriage of, or the entrance into a registered domestic partnership by, the limited conservatee.

(4) The right of the limited conservatee to contract.

(5) The power of the limited conservatee to give or withhold medical consent.

(6) The limited conservatee's right to control his or her own social and sexual contacts and relationships.

(7) Decisions concerning the education of the limited conservatee.

(b) Consider what Conservatee might be empowered to do, based on reviewing the new Capacity Declaration form and consider whether to tailor particular powers with regard to the following, based on the Capacity of the Conservatee with regard to activities of daily life and also by using as a guide the specific powers which can be deleted from the Conservator's powers and granted to the Conservatee as provided in Probate Code sections 2352-2358. These include:

(1) Allowing Conservator to select residence, with the bounds of affordability. Prob. Code § 2352.

(2) Allow Conservatee potential medical powers for certain routine medical treatment if Conservatee has capacity for same. Prob. Code § 2354. Need to make sure this is consistent with and does not conflict with any medical powers which might be granted to the Conservator under Probate Code sections 2355-2357.

(3) Allow Conservator medical powers over only certain specific medical treatment which Conservatee may need and which is known and ongoing. Prob. Code § 2357.

(4) Granting an allowance to the Conservatee which for which there does not need to be an accounting.

(5) Travel allowances and right of Conservatee to designate vacation destinations and allow Conservatee to decide where to go and mode of transportation within a designated fixed budget.

(6) Granting the absolute right to a cell phone for use by Conservatee.

(7) Allowing specific use of a credit card with small limits for purchases by Conservatee for which there does not need to be an accounting.

(8) Allowing Conservatee the power to make/designate gifts within small monetary limits for holidays and birthdays for relatives and friends. This will allow dignity and choice to the Conservatee.

(9) Allowing Conservatee the power to direct the Conservator to pay for meals out with Conservatee's friends and relatives which are paid for from the conservatorship estate, all within a fixed monetary limit.

(10) Allowing Conservatee the right to direct and designate donations

to religious and other charities within a fixed limit.

(11) Allowing the Conservatee the right to direct being transported to religious services on a regular basis.

(12) Allowing the Conservatee the right to direct expenditure of a fixed amount for certain entertainment.

(13) Any other provisions you may consider. Prob. Code § 2358. "When a guardian or conservator is appointed, the court may, with the consent of the guardian or conservator, insert in the order of appointment conditions not otherwise obligatory providing for the care, treatment, education, and welfare of the ward or conservatee. Any such conditions shall be included in the letters. The performance of such conditions is a part of the duties of the guardian or conservator for the faithful performance of which the guardian or conservator and the sureties on the bond are responsible." Prob. Code § 2358.

BENEFITS OF ALTERNATIVE ORDERS

10. Benefits of narrowing of powers of the Conservator and broadening the powers and rights of the Conservatee.

(a) More freedom for Conservatee.

(b) Fewer burdens on Conservator.

(c) Lessened liability of Conservator.

(c) Cost and expenses savings for Conservatee in that anticipated Conservator's fees and attorney's fees will be likely be reduced.

(d) Reduced scrutiny of accounting entries by court.

(e) Easier and quicker approval of accountings by court.

GENERAL OVERALL CONCERNS AND CONSIDERATIONS

11. Conduct thorough interview with proposed Conservator or petitioner as to the status and capacity and abilities of the Conservatee.

12. You may not be requesting medical powers and therefore may not need or may not use a Capacity Declaration. Use it anyway as a guide.

13. Sometimes the petitioner knows the Conservatee's situation very well and can provide very good information.

14. Always consider whether a conservatorship is necessary. Try to avoid one as much as possible. Think about and evaluate possible alternatives.

15. Provide counsel to the petitioner about conservatorship; not just legal services to the petitioner as a "consumer".

16. In thinking about a conservatorship remember most elders never need one during their lifetimes. There are substitutes. However, if a conservatorship is needed, keep it narrowly scoped if possible.

WHAT TO DO IF PHYSICIAN REFUSES TO GIVE OR COMPLETE CAPACITY DECLARATION

When Is Capacity Declaration Required?

1. When petitioner for conservatorship requests that proposed conservatee should be excused from attending the hearing on the petition;
2. When petitioner requests that conservator be given exclusive authority to consent to medical treatment for the proposed conservatee
3. When petitioner requests powers concerning major neurocognitive disorder (dementia medications or placement in secured-perimeter facility)

Scope of HIPAA

4. Who is bound by HIPAA?
5. Health insurers, health plan providers, government aid programs, health care providers (doctors, clinicians, hospitals, psychotherapists, chiropractors, nursing homes, pharmacies, dentists), and individuals or entities that process health information (IT, storage, data analysts, billing providers), and employees, contractors, and subcontractors of the foregoing categories

6. What does HIPAA protect?
7. Civ. Code § 56.05(j)
8. "Medical information" means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment. "Individually identifiable" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

Who does HIPAA protect?

Civ. Code § 56.05(k)

"Patient" means any natural person, **whether or not still living**, who received health care services from a provider of health care and to whom medical information pertains.

HIPAA Exemptions

Mandatory and Voluntary Exemptions

Note that some HIPAA exemptions allow or require disclosure by certain classes of "covered entities," but not others; and to certain classes of recipients, but not others

General exemption: explicit authorization by patient. Civ. Code § 56.10(a).

Statute is not clear if disclosure is required or merely permitted if patient authorizes disclosure.

Civ. Code § 56.10(b) [mandatory]

A provider of health care, a health care service plan, or a contractor **shall** disclose medical information if the disclosure is compelled by any of the following:

(1) By a court pursuant to an order of that court.

MANDATORY Judicial Council Form GC-333: Ex Parte Application for Order Authorizing Completion of Capacity Declaration - HIPAA

Must also submit **MANDATORY Judicial Council Form GC-334: Ex Parte Order Re Completion of Capacity Declaration**

(3) By a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum, notice to appear served pursuant to Section 1987 of the Code of Civil Procedure, or any provision authorizing discovery in a proceeding before a court or administrative agency.

(7) By the patient or the patient's representative pursuant to Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(9) When otherwise specifically required by law.

Civ. Code § 56.10(c) [voluntary]

A provider of health care or a health care service plan **may** disclose medical information as follows:

(1) The information may be disclosed **to providers of health care, health care service plans, contractors, or other health care professionals or facilities**

for purposes of diagnosis or treatment of the patient. This includes, in an emergency situation, the communication of patient information by radio transmission or other means between emergency medical personnel at the scene of an emergency, or in an emergency medical transport vehicle, and emergency medical personnel at a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(12) The information relevant to the patient's condition, care, and treatment provided may be disclosed **to a probate court investigator in the course of an investigation required or authorized in a conservatorship proceeding** under the Guardianship-Conservatorship Law as defined in Section 1400 of the Probate Code, **or to a probate court investigator**, probation officer, or domestic relations investigator engaged in determining the need for an initial guardianship or continuation of an existing guardianship.

(22) Information may be disclosed **pursuant to subdivision (a) of Section 15633.5 of the Welfare and Institutions Code by a person required to make a report pursuant to Section 15630 of the Welfare and Institutions Code [mandatory reporter of suspected Elder Abuse], provided that the disclosure under subdivision (a) of Section 15633.5 concerns a report made by that person**. Covered entities, as they are defined in Section 160.103 of Title 45 of the Code of Federal Regulations, shall comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) privacy rule pursuant to subsection (c) of Section 164.512 of Title 45 of the Code of Federal Regulations if the disclosure is not for the purpose of public health surveillance, investigation, intervention, or reporting an injury or death.

Civ. Code § 1007 [voluntary]

The following disclosures can be made if the patient is present during, or was available prior to, the following circumstances:

limited medical information to "**a family member, other relative, domestic partner, or a close personal friend of the patient, or any other person identified by the patient**, the medical information **directly relevant to that person's involvement with the patient's care or payment related to the patient's health care**."

general medical information "to notify, or assist in the notification of, including identifying or locating, a family member, a personal representative of the patient, a domestic partner, or another person responsible for the care of the patient of the patient's location, general condition, or death."

In either case, the patient must either have been informed of the proposed disclosure, and must have agreed or not expressed an objection to the disclosure being made, or the person disclosing must have reasonably inferred from the circumstances that the patient does not object to the disclosure.

34. Civ. Code § 16 [voluntary]

35. For disclosures not addressed by Section 56.1007, unless there is a specific written request by the patient to the contrary, nothing in this part shall be construed to prevent a general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, upon an inquiry concerning a specific patient, from releasing at its discretion any of the following information: the patient's name, address, age, and sex; a general description of the reason for treatment (whether an injury, a burn, poisoning, or some unrelated condition); the general nature of the injury, burn, poisoning, or other condition; the general condition of the patient; and any information that is not medical information as defined in Section 56.05.

INDEPENDENT MEDICAL EVALUATION

36. There appear to be two primary methods of obtaining a mental evaluation of a person: through a court-appointed expert pursuant to Evidence Code section 730 et seq., or through discovery processes pursuant to Code of Civil Procedure section 2032 et seq.

37. Most of the rules we have are taken from statutes and cases under the Code of Civil Procedure discovery process. The extent to which they apply to the court-appointed expert process under the Evidence Code is unclear.

38. Court-appointed expert process is likely to be more flexible because the statutes may carry an implicit presumption that the Court will be actively involved in the process and prescribe fair rules. On the other hand, the Code of Civil Procedure discovery process is, by definition, adversarial and probably assumes the Court will not be actively involved in the process, and therefore requires more statutory safeguards.

39. In practice, they may be treated similarly. The primary differences and similarities will be highlighted here.

	Court-appointed experts (Evid. Code § 730 et seq.)	Non-Court-appointed experts (Code Civ. Proc. § 2032 et seq.)

Purpose and Scope	Appoint expert "to investigate, to render a report as may be ordered by the court, and to testify as an expert at the trial of the action relative to the fact or matter as to which the expert evidence is or may be required." Flexible, to resolve matters the Court deems appropriate Permits appointment of non-medical experts to resolve questions that are not related to an interested person's physical or mental health Expert should be impartial 40. However, court may, and often does, appoint the expert proposed by the moving party. Mercury Casualty Co. V. Superior Court (1986) 179 Cal. App. 3d 1027. 41. Demonstrable bias on the part of a court-appointed expert in favor of one party may be grounds for removing the expert. In re Marriage of Adams & Jack A. (2012) 209 Cal. App. 4th 1543, 1567.	Entirely related to discovery Restricted to physical and mental examinations Expert is not required to be impartial 42. "in a sense might be considered an adversary proceeding." Durst v. Superior Court (1963) 222 Cal. App. 2d 447, 451
Who may be evaluated?	Statute does not prescribe limitations	A party, an agent of a party, or a natural person in the custody or under the legal control of a party. Code Civ. Proc. § 2032.020
How does it happen?	Court may move *sua sponte*, or *any* party may move No "meet and confer" prerequisite	Initiated by motion or stipulation "Meet and confer" prerequisite to motion

Burden of Proof	Unspecified; court has wide discretion. Unclear if this form of stipulation would apply in a conservatorship case, as the stipulation seems tailored towards tort litigation.	Default: "Good cause" **or** Heightened "exceptional circumstances" standard if examinee stipulates that "no claim is being made for mental and emotional distress over and above that usually associated with the physical injuries claimed," and that "no expert testimony regarding this usual mental and emotional distress will be presented at trial in support of the claim for damages." The examinee's present mental or physical condition must be "in controversy" in the action. Code Civ. Proc. § 2032.020(a); Doyle v. Sup. Ct. (Caldwell) (1996) 50 Cal. App. 4th 1878, 1886-87. One party's unsubstantiated allegation of a present mental or physical condition cannot put the mental state of another in controversy. Vinson v. Superior Court (1987), 43 Cal. 3d 833, 839.
Generally-applicable privacy principles	The constitutional right of privacy protects access to medical information, but is not absolute, and must be balanced against the need for obtaining the information. 43. "When the constitutional right of privacy is involved, the court must be convinced that the information is essential to determining the truth of the matters in dispute." Britt v. Sup. Ct. (1978) 20 Cal. 3d 844, 859. 44. The more sensitive the information, the greater the need for discovery that must be shown. Hoffman Corp. V. Sup. Ct. (1985) 172 Cal. App. 3d 357, 362. 45. There must be a compelling need for discovery so strong as to outweigh the privacy right when those two competing interests are carefully balanced. Lantz v. Sup. Ct. (1994) 28 Cal. App. 4th 1839, 1853-54.	

Privacy principles that specifically apply to medical examinations	No on-point case law, but principles applicable to non-court-appointed experts likely apply here as well.	Moving party must show specific facts justifying discovery, and that the inquiry is relevant to the subject matter of the action or reasonably calculated to lead to the discovery of admissible evidence. Vinson v. Superior Court (1987) 43 Cal. 3d 833, 840 [Court cites statute that was previously repealed, but affirms that definition of "good cause" is still pertinent]. A plaintiff (or defendant alleging a defense) implicitly waives certain privacy rights related to the action, but such waiver "encompasses only discovery directly relevant to the plaintiff's claim and essential to the fair resolution of the lawsuit." Waiver argument likely does not apply to involuntary conservatorship cases
Specificity of Motion and Order	No on-point case law, but principles applicable to non-court-appointed experts likely apply here as well.	Motion and order must be sufficiently specific Order authorizing "standardized written psychological tests" for the purpose of evaluating "emotional and cognitive functioning" is not sufficiently specific and may be voided on appeal or writ. Carpenter v. Superior Court (2006) 141 Cal. App. 4th 249, 269. 46. Moving party's best practice is to identify all tests that could be administered to diagnose a condition, and allow opposing party to object and court to deny unnecessary tests. Carpenter, supra 141 Cal. App. 4th at 270.

Who may conduct a mental evaluation?	Statute does not specify, but requires expert to be licensed to perform the tests that are ordered to be done. Evid. Code § 730.	"only by a licensed physician or by a licensed clinical psychologist who holds a doctoral degree in psychology and has had at least five years of postgraduate experience in the diagnosis of emotional and mental disorders." Code Civ. Proc. § 2032.020(c)(1). Court may also dictate who the examiner who will be, presumably subject to foregoing licensure requirements. Court is not required to allow examination by moving party's candidate, and may direct evaluation to be made by another expert. Santa Clara Unified School Dist. (1976) 16 Cal. 3d 905, 912-13.
How is the evaluation conducted?	No on-point case law, but principles applicable to non-court-appointed experts likely apply here as well.	Court may dictate time, place, and manner of evaluation, as well as what tests to employ, and specify conditions, scope, and nature of the evaluation. Examiner and examinee both have the right to take audio recording of evaluation.

Right to counsel and cross-examination	No default right to have counsel present during evaluation, but Court can presumably include a provision for counsel in the order appointing the expert	Unless parties stipulate or court orders otherwise, **no** counsel or court reporter should be present during **mental** evaluation. Code Civ. Proc. § 2032.530; Edwards v. Superior Court (1976) 16 Cal. 3d 905, 910. Court may allow counsel attendance of need for observation is shown. Toyota Motor Sales, U.S.A., Inc. V. Sup. Ct. (2010) 189 Cal. App. 4th 1391, 1397. By default, examinee or party producing the examinee has right to have **counsel and stenographer** present during **physical** evaluation, **to observe but not participate**. Code Civ. Proc. § 2032.510(b). Parties may stipulate or seek court order to have other counsel or other persons present. Code Civ. Proc. § 2032.530(b). By default, no right of cross-examination. Examinee's counsel shall have the right to suspend evaluation to seek protective order if evaluation becomes abusive or strays into unauthorized tests or procedures. Sanctions may be awarded against a party who unsuccessfully makes or opposes such a motion unless the unsuccessful party acted with substantial justification or other circumstances make imposition of sanctions unjust. Code Civ. Proc. § 2030.510(d)-(f).

Pretrial access to Expert's report	Court can issue orders for expert to prepare report. Evid. Code § 730. Presumably this includes the possibility that the Court may not order the expert to prepare a report, or the order may be silent on a report, Court **may** be able to make orders granting or limiting access to report	The *party submitting to the evaluation* may issue a written demand for the copy of the expert's "detailed written report setting out the history, examinations, findings, including the results of all tests made, diagnoses, prognoses, and conclusions of the examiner," and "a copy of reports of all earlier examinations of the same condition of the examinee made by that or any other examiner." Code Civ. Proc. § 2032.610(a). Report must be produced by the earlier of 30 days after service of the demand, or 15 days before trial. Work product doctrine is waived with respect to examiner's writing, reports, and testimony. Code Civ. Proc. § 2030.610(c)
Examination at trial	A court-appointed expert may be called and examined by the court or by any party to the action, subject to full rights of cross-examination and objections. Evid. Code § 732. Rules applicable to examining experts at trial apply. Evid. Code § 732.	Subject to rules applicable to examining experts at trial.

Strategies for Moving Party/Proponent

47. Recognize that the mental capacity of a proposed conservatee, or of a testator in a contest of a testamentary instrument, is almost always going to be "in controversy."
48. Establish a strong foundation supporting your arguments for why a medical evaluation is necessary.
49. Allege, in the initial petition, specific facts, including concrete events and overall trends, that tend to show cognitive deficiencies or decline.
50. Reiterate these allegations, preferably in greater detail, in the motion.
51. Ensure that scope of motion and order are "just right."
52. Have the proposed order clearly instruct the expert to examine on matters that are actually relevant to the litigation, e.g., "transactional" capacity (ability to substantially manages finances and resist fraud or undue influence), testamentary

capacity (ability to understand the nature of making an estate plan, to understand the nature and situation of their property, to remember and understand their relations to

53. living family members and persons whose interests are affected by a testamentary document), suffering from delusions or hallucinations, or any other standard of capacity that may be relevant.

54. Speak with proposed expert ahead of time to determine what specific tests can be performed and what conditions they can diagnose.

55. If specific tests have possible side-effects, candidly identify them in motion, but attempt to counter-balance them by identifying their possible benefits.

56. Ensure that motion and proposed order are sufficiently narrow in listing specific tests to be performed, but be over-inclusive in the number of tests you propose to be performed.

57. Anticipate that some tests will be rejected by the court, especially if they are overly-intrusive.

58. Do not waste time, energy, or expense by proposing "useless" tests that are unreliable, or that will only identify a condition that will not help your case.

59. If court permits examinee to have counsel present during evaluation, ensure that the court clarifies (and the order reflects) that counsel may only observe and not cross-examine the expert during the evaluation.

60. If you want a specific test to be performed but you feel it's a close case, be willing to accept conditions and make concessions as to the manner in which it can be performed if you believe it will make a difference.

61. Recall that a diagnosis of a mental disorder alone will not be enough to prevail on your claims.

Strategies for Opponent

62. Has the proponent alleged enough facts to place the examinee's mental or physical capacity in controversy?

63. Argue that proponent has not met the relevant burden of proof

64. Hedge your bets on possible defenses.

65. In conservatorship cases, try to develop "less-restrictive alternative" defenses, and do not rely entirely on resisting claims that the proposed conservatee is incapacitated.

66. Stipulations as to mental or physical condition are risky to make in probate, trust, and conservatorship cases because they tend to be dispositive issues, and should be avoided.

67. Limited stipulations can be effective in some circumstances, e.g., it may be advantageous to stipulate that a person is unable to provide for their personal needs for food, clothing, and shelter in order to limit examination on those issues if you have concerns that a more detailed examination of those issues will reveal

evidence that the examinee is vulnerable to undue influence, especially if no evidence of undue influence has been made.

68. On the other hand, stipulations as to mental or physical conditions in contested conservatorship cases may be less risky if you have strong arguments for less-restrictive alternatives.

69. Attempt to limit the scope of the proposed evaluation.

70. E.g., if no allegations of undue influence are made in the petition, argue that the expert should not evaluate that subject

71. Make other concessions to establish alternative means of discovery.

72. For example, concede that recent medical records may be provided to an expert to review.

73. This should only be proposed if you believe that the examinee will perform poorly in the examination in a manner that does not reflect their actual condition, and you believe that medical records will make a better substitute (e.g., "stage fright" or language barrier).

74. Attempt to have court direct that evaluation be conducted by a "favorable" expert

75. If examinee has a primary care physician who has seen the examinee in good times and in bad, present them to the court as a candidate who can provide a more holistic view of the examinee's health.

76. If language barriers make communication difficult, try to have Court order examination by an expert who speaks the language the examinee is most comfortable speaking.

77. If Court will not appoint expert who speaks that language, ask Court to order that an interpreter be allowed.

78. If you are allowed to be present during the evaluation, listen carefully to the expert's questions and don't hesitate to suspend the evaluation if the expert begins to stray into areas not authorized by the order appointing them or authorizing the evaluation.

79. Bring a copy of the order to the evaluation with you.

80. Familiarize yourself with the procedures of each test that is ordered and note any deviations from protocol.

81. Attempt to minimize the impact of the expert's report and testimony.

82. Carefully read the expert's report in relation to the order appointing the expert or authorizing the evaluation. If the expert's report or testimony appears to stray beyond the scope of the order, make a motion in limine to restrict any testimony as to the extraneous issue.

83. Carefully compare the expert's report with any audio or written record of the evaluation you may have, and note any inconsistencies.

84. Retain your own expert to try to refute unfavorable conclusions of another expert.

85. Ask them to carefully review the report and any audio record of the evaluation.

86. Cross-examination.

87. Do not try to outsmart the expert in their own field of specialty, and do not try to show off. Approach cross-examination of an expert from a standpoint of humility. Leave criticism of an unfavorable expert to your own expert.

88. If expert has opined on capacity to make financial decisions, cross-examine them as to what specific questions they asked, and whether the expert independently verified that the examinee's answers were incorrect or deficient.

89. If expert makes conclusions as to testamentary capacity, ask them what steps they took to verify the examinee's assets, family members, beneficiaries of their estate, etc.

90. Ask if expert made any determinations as to whether the examinee could function with assistance, i.e. from family members, trusted friends, attorney, or financial advisor(s).

91. In conservatorship cases, ask if expert reviewed or made any findings regarding the suitability of less-restrictive alternatives.

92. Attempt to ascertain whether expert spoke with any third parties or other sources of information that may have "tainted" the expert's evaluation.

93. If you have audio record of evaluation and expert's testimony or report is inconsistent with that record, use the audio record to impeach them.

94. However, do not ask them to explain any inconsistencies, as that will give the expert the opportunity to rehabilitate their testimony. Merely point out that inconsistencies exist.

95. Ask the expert what resources they consulted when preparing to evaluate the examinee, or in writing their report and forming their conclusions.

96. Before you have your own expert testify, consult with them as to whether they believe these resources are sound and reliable. If your own expert can credibly criticize these resources, include that in your direct examination of your own expert. If your expert believes the resources are sufficient, do not ask your expert to comment on them.

97. Argument

98. Recall that a diagnosis of a mental disorder alone will not be enough to prove that the examinee lacks the relevant degree of capacity.

Appendix of Statutes

Evid. Code § 730 et seq.

99. Previously Code Civ. Proc. § 1871

100. Section 730

101. When it appears to the court, at any time before or during the trial of an action, that expert evidence is or may be required by the court or by any party to the action, the court on its own motion or on motion of any party may appoint one or more experts to investigate, to render a report as may be ordered by the court, and to testify as an expert at the trial of the action relative to the fact or matter as to which the expert evidence is or may be required.

102. Section 732

103. Any expert appointed by the court under Section 730 may be called and examined by the court or by any party to the action. When such witness is called

and examined by the court, the parties have the same right as is expressed in Section 775 to cross-examine the witness and to object to the questions asked and the evidence adduced. Evid. Code § 732.

Code Civ. Proc. § 2032.310 et seq.

Section 2032.310

(a) If any party desires to obtain discovery by a physical examination other than that described in Article 2 (commencing with Section 2032.210) [physical examination in a personal injury case], or by a mental examination, the party shall obtain leave of court.

(b) A motion for an examination under subdivision (a) shall specify the time, place, manner, conditions, scope, and nature of the examination, as well as the identity and the specialty, if any, of the person or persons who will perform the examination. The motion shall be accompanied by a meet and confer declaration under Section 2016.040.

(c) Notice of the motion shall be served on the person to be examined and on all parties who have appeared in the action.

Section 2032.320

(a) The court shall grant a motion for a physical or mental examination under Section 2032.310 only for good cause shown.

(b) If a party stipulates as provided in subdivision (c), the court shall not order a mental examination of a person for whose personal injuries a recovery is being sought except on a showing of exceptional circumstances.

(c) A stipulation by a party under this subdivision shall include both of the following:

(1) A stipulation that no claim is being made for mental and emotional distress over and above that usually associated with the physical injuries claimed.

(2) A stipulation that no expert testimony regarding this usual mental and emotional distress will be presented at trial in support of the claim for damages.

(d) An order granting a physical or mental examination shall specify the person or persons who may perform the examination, as well as the time, place, manner, diagnostic tests and procedures, conditions, scope, and nature of the examination.

ATTORNEY OR PARTY WITHOUT ATTORNEY	STATE BAR NUMBER:	FOR COURT USE ONLY
NAME:		
FIRM NAME:		
STREET ADDRESS:		
CITY:	STATE: ZIP CODE:	
TELEPHONE NO.:	FAX NO.:	
E-MAIL ADDRESS:		
ATTORNEY FOR *(name)*:		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF		
STREET ADDRESS:		
MAILING ADDRESS:		
CITY AND ZIP CODE:		
BRANCH NAME:		
CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name)*: ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE		
CAPACITY DECLARATION-CONSERVATORSHIP		CASE NUMBER:

TO PHYSICIAN, PSYCHOLOGIST, OR RELIGIOUS HEALING PRACTITIONER

The purpose of this form is to enable the court to determine whether the (proposed) conservatee *(check all that apply)*:

A. ☐ is able to attend a court hearing to determine whether a conservator should be appointed to care for him or her. The court hearing is set for *(date)*: . *(Complete item 5, then sign and file page 1 of this form.)*

B. ☐ has the capacity to give informed consent to medical treatment. *(Complete items 6 through 8, sign page 3, and file pages 1 through 3 of this form.)*

C. ☐ has a major neurocognitive disorder (such as dementia) and, if so, (1) whether he or she needs to be placed in a secured-perimeter residential care facility for the elderly, and (2) whether he or she needs or would benefit from medication for the treatment of major neurocognitive disorders (including dementia). *(Complete items 6 and 8 of this form and complete form GC-335A; sign and attach form GC-335A. File pages 1 through 3 of this form and file form GC-335A.)*

(If more than one item is checked above, sign the last applicable page of this form or, if item C is checked, form GC-335A. File page 1 through the last applicable page of this form; if item C is checked, file form GC-335A as well.)

COMPLETE ITEMS 1–4 OF THIS FORM IN EVERY CASE.

GENERAL INFORMATION

1. *(Name)*:
2. *(Office address and telephone number)*:
3. I am
   a. ☐ a California-licensed ☐ physician ☐ psychologist acting within the scope of my license ☐ with at least two years' experience in diagnosing and treating major neurocognitive disorders (including dementia).
   b. ☐ an accredited practitioner of a religion that calls for reliance on prayer alone for healing. The (proposed) conservatee is an adherent of my religion and is under my care. *(Practitioner may make ONLY the determination in item 5.)*
4. (Proposed) conservatee *(name)*:
   a. I last saw the (proposed) conservatee on *(date)*:
   b. The (proposed) conservatee ☐ is ☐ is NOT a patient under my continuing treatment and care.

ABILITY TO ATTEND COURT HEARING

5. A court hearing on the petition for appointment of a conservator is set for the date indicated in item A above. *(Complete a or b.)*
   a. ☐ The proposed conservatee is able to attend the court hearing.
   b. ☐ Because of medical inability, the proposed conservatee is NOT able to attend the court hearing *(check all items below that apply)*
      (1) ☐ on the date set *(see date in box in item A above)*.
      (2) ☐ for the foreseeable future.
      (3) ☐ until *(date)*:
      (4) **Supporting facts** *(State facts in the space below or check this box ☐ and state the facts in Attachment 5.)*

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT NAME) (SIGNATURE OF DECLARANT)

Form Adopted for Mandatory Use
Judicial Council of California
GC-335 [Rev. January 1, 2019]

Probate Code, §§ 811, 813, 1801, 1825, 1881, 1910, 2356.5
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CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name)*: ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

6. **EVALUATION OF (PROPOSED) CONSERVATEE'S MENTAL FUNCTIONS**

Note to practitioner: This form is ***not*** a rating scale. It is intended to assist you in recording your *impressions* of the (proposed) conservatee's mental abilities. Where appropriate, you may refer to scores on standardized rating instruments.

(Instructions for items 6A–6C): *Check the appropriate designation as follows:* ***a*** *= no apparent impairment;* ***b*** *= moderate impairment;* ***c*** *= major impairment;* ***d*** *= so impaired as to be incapable of being assessed;* ***e*** *= I have no opinion.*

A. **Alertness and attention**

(1) Levels of arousal (lethargic, responds only to vigorous and persistent stimulation, stupor)
a☐ b☐ c☐ d☐ e☐

(2) Orientation (types of orientation impaired)

a☐ b☐ c☐ d☐ e☐ Person

a☐ b☐ c☐ d☐ e☐ Time (day, date, month, season, year)

a☐ b☐ c☐ d☐ e☐ Place (address, town, state)

a☐ b☐ c☐ d☐ e☐ Situation ("Why am I here?")

(3) Ability to attend and concentrate (give detailed answers from memory, mental ability required to thread a needle)
a☐ b☐ c☐ d☐ e☐

B. **Information processing.** Ability to:

(1) Remember (ability to remember a question before answering; to recall names, relatives, past presidents, and events of the past 24 hours)

i. Short-term memory a☐ b☐ c☐ d☐ e☐

ii. Long-term memory a☐ b☐ c☐ d☐ e☐

iii. Immediate recall a☐ b☐ c☐ d☐ e☐

(2) Understand and communicate either verbally or otherwise (deficits reflected by inability to comprehend questions, follow instructions, use words correctly, or name objects; use of nonsense words)
a☐ b☐ c☐ d☐ e☐

(3) Recognize familiar objects and persons (deficits reflected by inability to recognize familiar faces, objects, etc.)
a☐ b☐ c☐ d☐ e☐

(4) Understand and appreciate quantities (deficits reflected by inability to perform simple calculations)
a☐ b☐ c☐ d☐ e☐

(5) Reason using abstract concepts (deficits reflected by inability to grasp abstract aspects of his or her situation or to interpret idiomatic expressions or proverbs)
a☐ b☐ c☐ d☐ e☐

(6) Plan, organize, and carry out actions (assuming physical ability) in one's own rational self-interest (deficits reflected by inability to break complex tasks down into simple steps and carry them out)
a☐ b☐ c☐ d☐ e☐

(7) Reason logically
a☐ b☐ c☐ d☐ e☐

C. **Thought disorders**

(1) Severely disorganized thinking (rambling thoughts; nonsensical, incoherent, or nonlinear thinking)
a☐ b☐ c☐ d☐ e☐

(2) Hallucinations (auditory, visual, olfactory)
a☐ b☐ c☐ d☐ e☐

(3) Delusions (demonstrably false belief maintained without or against reason or evidence)
a☐ b☐ c☐ d☐ e☐

(4) Uncontrollable or intrusive thoughts (unwanted compulsive thoughts, compulsive behavior)
a☐ b☐ c☐ d☐ e☐

(Continued on next page)

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name):* ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

6. *(continued)*

D. **Ability to modulate mood and affect.** The (proposed) conservatee ☐ has ☐ does NOT have a pervasive and persistent or recurrent emotional state that appears inappropriate in degree to his or her circumstances. *(If so, complete remainder of item 6D.)* ☐ I have no opinion.

(Instructions for item 6D): *Check the degree of impairment of each inappropriate mood state (if any) as follows:* ***a*** *= mildly inappropriate;* ***b*** *= moderately inappropriate;* ***c*** *= severely inappropriate.*

Anger	a☐	b☐	c☐	Euphoria	a☐	b☐	c☐	Helplessness	a☐	b☐	c☐
Anxiety	a☐	b☐	c☐	Depression	a☐	b☐	c☐	Apathy	a☐	b☐	c☐
Fear	a☐	b☐	c☐	Hopelessness	a☐	b☐	c☐	Indifference	a☐	b☐	c☐
Panic	a☐	b☐	c☐	Despair	a☐	b☐	c☐				

E. The (proposed) conservatee's periods of impairment from the deficits indicated in items 6A-6D
(1) ☐ do NOT vary substantially in frequency, severity, or duration.
(2) ☐ do vary substantially in frequency, severity, or duration *(explain; continue on Attachment 6E if necessary):*

F. ☐ *(Optional)* Other information regarding my evaluation of the (proposed) conservatee's mental function (e.g., diagnosis, symptomatology, and other impressions) is ☐ stated below ☐ stated in Attachment 6F.

ABILITY TO CONSENT TO MEDICAL TREATMENT

7. Based on the information above, it is my opinion that the (proposed) conservatee
a. ☐ has the capacity to give informed consent to any form of medical treatment. This opinion is limited to medical consent capacity.
b. ☐ lacks the capacity to give informed consent to any form of medical treatment because he or she is ***either*** (1) unable to respond knowingly and intelligently regarding medical treatment ***or*** (2) unable to participate in a treatment decision by means of a rational thought process, ***or both***. The deficits in the mental functions described in item 6 above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of medical decisions. This opinion is limited to medical consent capacity.

(Declarant must initial here if item 7b applies: _____ ***.)***

8. Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

_____ ▶ _____

(TYPE OR PRINT NAME) (SIGNATURE OF DECLARANT)

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name):* ☐ CONSERVATEE ☐ PROPOSED CONSERVATEE	CASE NUMBER:

ATTACHMENT TO FORM GC-335, *CAPACITY DECLARATION-CONSERVATORSHIP,* ONLY FOR (PROPOSED) CONSERVATEE WITH A MAJOR NEUROCOGNITIVE DISORDER

9. It is my opinion that the (proposed) conservatee ☐ HAS ☐ does NOT have a major neurocognitive disorder (such as dementia) as defined in the current edition of *Diagnostic and Statistical Manual of Mental Disorders.*

a. ☐ **Placement of (proposed) conservatee.** *(If the (proposed) conservatee requires placement in a secured-perimeter residential care facility for the elderly, please complete items 9a(1)-9a(5).)*

(1) The (proposed) conservatee needs or would benefit from placement in a restricted and secure facility because *(state reasons; continue on Attachment 9a(1) if necessary):*

(2) The (proposed) conservatee's mental function deficits, based on my assessment in item 6 of form GC-335, include *(describe; continue on Attachment 9a(2) if necessary):*

(3) ☐ The (proposed) conservatee HAS capacity to give informed consent to this placement.

(4) ☐ The (proposed) conservatee does NOT have the capacity to give informed consent to this placement. The deficits in mental function assessed in item 6 of form GC-335 and described in item 9a(2) above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of giving consent to placement in a restricted and secure environment.

(5) A locked or secured-perimeter facility ☐ is ☐ is NOT the least restrictive environment appropriate to the needs of the (proposed) conservatee.

b. ☐ **Administration of medications.** *(If the (proposed) conservatee requires administration of medications appropriate to the care and treatment of major neurocognitive disorders (including dementia), please complete items 9b(1)–9b(5).)*

(1) For the reasons stated in item 9b(5), the (proposed) conservatee needs or would benefit from the following medications appropriate to the care and treatment of major neurocognitive disorders (including dementia) *(list medications; continue on Attachment 9b(1) if necessary):*

(2) The (proposed) conservatee's mental function deficits, based on my assessment in item 6 of form GC-335, include *(describe; continue on Attachment 9b(2) if necessary):*

(3) ☐ The (proposed) conservatee HAS the capacity to give informed consent to the administration of medications appropriate to the care and treatment of major neurocognitive disorders (including dementia).

(4) ☐ The (proposed) conservatee does NOT have the capacity to give informed consent to the administration of medications appropriate to the care and treatment of major neurocognitive disorders (including dementia). The deficits in mental function assessed in item 6 of form GC-335 and described in item 9b(2) above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of giving consent to the administration of medications for the care and treatment of major neurocognitive disorders (including dementia).

(5) The (proposed) conservatee needs or would benefit from the administration of the medications listed in item 9b(1) because *(discuss reasons; continue on Attachment 9b(5) if necessary):*

10. Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Date:

(TYPE OR PRINT NAME) ▶ (SIGNATURE OF DECLARANT)

Form Adopted for Mandatory Use
Judicial Council of California
GC-335A [Rev. January 1, 2019]
CEB ceb.com | Essential Forms

MAJOR NEUROCOGNITIVE DISORDER ATTACHMENT TO CAPACITY DECLARATION—CONSERVATORSHIP

Probate Code, §§ 811, 2356.5
www.courts.ca.gov

(NAME):	CASE NUMBER:

ATTACHMENT TO FORM GC-335,
CAPACITY DECLARATION – CONSERVATORSHIP
ADDITIONAL DETAILED INFORMATION

TO PHYSICIAN, PSYCHOLOGIST, OR PSYCHIATRIST

The purpose of this attachment is to provide additional, more detailed information than is included in the Capacity Declaration - Conservatorship, to enable the court to determine whether the (proposed) conservatee has:

A. The capacity to give informed consent to medical treatment and has the capacity to handle his/her financial affairs;
B. Dementia and if so, (1) whether he or she needs to be placed in a secured-perimeter residential care facility for the elderly, and (2) whether he or she can remain in his/her home with full-time caregivers if resources are available, and (3) whether he/she would benefit from dementia medications;
C. An acquired brain injury (brain tumor, stroke, seizure disorder, traumatic brain injury);
D. An intellectual disability; and/or
E. A psychiatric disability.

This attachment is to be completed only by a physician, psychologist, or psychiatrist. It should be filled out completely, signed and dated on the last page, and filed as an attachment to Judicial Council Form GC-355 (Capacity Declaration - Conservatorship) if ordered by the court or if the petitioner chooses.

GENERAL INFORMATION

1. (Name):
2. (Office address/phone number):
3. I am a California Licensed ☐ Physician ☐ Psychologist ☐ Psychiatrist acting within the scope of my licensure ☐ with at least 2 years' experience diagnosing dementia, acquired brain injury, intellectual disability or psychiatric disability.
4. (Proposed) conservatee (Name):
   a. I last saw the (proposed) conservatee on (date):
   b. The (proposed) conservatee ☐ is ☐ is NOT a patient under my continued treatment.

5. **EVALUATION OF (PROPOSED) CONSERVATEE'S COGNITIVE FUNCTIONS**

   (Proposed) Conservatee's Level of Education:

   Language spoken

Note to practitioner: This form is **not** a rating scale. It is intended to assist you in recording your impressions of the (proposed) conservatee's cognitive abilities. Where appropriate, you may refer to scores on standardized rating instruments.

(Instructions for items 5A and 5B): Check the appropriate designation as follows:

a = No Impairment **b** = Impairment Present **c** = So Impaired as to be incapable of being assessed

A. **Alertness and Attention/Concentration:**

(1) Levels of arousal (alert, lethargic, responds only to constant stimulation, stupor)

a ☐ b ☐ c ☐

(2) Orientation (types of orientation impaired)

a ☐	b ☐	c ☐	Person
a ☐	b ☐	c ☐	Time (day, date, month, year, season)
a ☐	b ☐	c ☐	Place (address, city, state)
a ☐	b ☐	c ☐	Situation (Why, What, How?)

(3) Ability to attend and concentrate (type of attention/concentration impaired)

a ☐	b ☐	c ☐	Focused (1-2 minutes)
a ☐	b ☐	c ☐	Sustained (5 minutes)
a ☐	b ☐	c ☐	Sustained (10-15 minutes)
a ☐	b ☐	c ☐	Sustained (15-30 minutes)
a ☐	b ☐	c ☐	Sustained (30 or more minutes)
a ☐	b ☐	c ☐	Easily Distractible
a ☐	b ☐	c ☐	Alternating/Divided (can multitask; cook, drive)

B. **Information Processing:** Ability to:

(1) Remember (ability to remember a question before answering, recall names, relatives, past presidents, events of the past 24 hours)

I	Immediate recall	a ☐ b ☐	c ☐
II	Short-term memory	a ☐ b ☐	c ☐
III	Long-term memory	a ☐ b ☐	c ☐

(2) Understand and communicate either verbally or otherwise (deficits reflected by inability to comprehend questions, 3-step command, use words correctly, name objects)

a ☐ b ☐ c ☐

(3) Recognize familiar objects and persons (deficits reflected by inability to recognize familiar faces, objects, family members)

a ☐ b ☐ c ☐

(4) Understand and appreciate quantities (deficits reflected by inability to perform simple calculations)

a ☐ b ☐ c ☐

(5) Understand and appreciate current life circumstances (deficits reflected by inability to acknowledge being dependent on others for life sustaining activities of daily living)

a ☐ b ☐ c ☐

(6) Reason using abstract concepts (deficits reflected by inability to grasp abstract aspects of his/her situation or to interpret idiomatic expressions or proverbs)

a ☐ b ☐ c ☐

(7) Plan, organize and carry out actions (or direct others to if physically unable) in one's own rational self-interest (deficits reflected by inability to break complex tasks down into simple steps and carry them out)
a ☐ b ☐ c ☐

(8) Reason logically by weighing the pros and cons of a given situation to problem-solve or make a decision that is in the best interest of his/her person (deficits reflected by not coming to conclusions that include all information provided in writing, or in an auditory/visual format)
a ☐ b ☐ c ☐

6. EVALUATION OF (PROPOSED) CONSERVATEE'S PSYCHIATRIC/PSYCHOLOGICAL FUNCTIONS

Note to practitioner: This form is **not** a rating scale. It is intended to assist you in recording your impressions of the (proposed) conservatee's psychiatric/psychological abilities. Where appropriate, you may refer to scores on standardized rating instruments.

(Instructions for items 6Aand 6B): Check the appropriate designation as follows:

a = No Impairment **b** =Impairment Present **c** = So Impaired as to be incapable of being assessed

A. Thought Disorders

(1) Severely disorganized thinking (rambling thoughts, nonsensical, incoherent or nonlinear thinking)
a ☐ b ☐ c ☐

(2) Hallucinations (auditory, visual, olfactory)
a ☐ b ☐ c ☐

(3) Delusions (demonstrated by false beliefs maintained without or against reason or evidence)
a ☐ b ☐ c ☐

(4) Uncontrollable or intrusive thoughts (unwanted compulsive thoughts, compulsive behaviors)
a ☐ b ☐ c ☐

B. Ability to handle family environment (deficits reflected by inability to identify and/or deal with family dysfunction that is NOT in his/her best interest and/or unduly influences him/her to act in a self-destructive way)

a ☐ b ☐ c ☐

C. **Ability to modulate mood and affect:** The (proposed) conservatee ☐ has ☐ does NOT have a pervasive and persistent or recurrent emotional state that appears inappropriate in degree to his/her circumstances. If so, complete 6C.

Instructions for item 6C & 6D Check the degree of impairment of each appropriate mood state (if any) as follows: **a** = mildly inappropriate **b** = moderately inappropriate **c** = severely inappropriate)

Anger	a ☐	b ☐	c ☐	Euphoria	a ☐	b ☐	c ☐
Anxiety	a ☐	b ☐	c ☐	Depression	a ☐	b ☐	c ☐
Fear	a ☐	b ☐	c ☐	Hopelessness	a ☐	b ☐	c ☐
Panic	a ☐	b ☐	c ☐	Despair	a ☐	b ☐	c ☐
Apathy	a ☐	b ☐	c ☐	Helplessness	a ☐	b ☐	c ☐
Irritability	a ☐	b ☐	c ☐	Indifference	a ☐	b ☐	c ☐

D. **Personality Disorder/Character Disorder:** The (proposed) conservatee ☐ has ☐ does NOT have a characterological personality disorder that interferes with his/her ability to make appropriate decisions that are in his/her best interests. If so, complete 6D.

Narcissistic Personality Disorder	a ☐	b ☐	c ☐
Borderline Personality Disorder	a ☐	b ☐	c ☐
Dependent Personality Disorder	a ☐	b ☐	c ☐
Avoidant Personality Disorder	a ☐	b ☐	c ☐
Schizoid Personality Disorder	a ☐	b ☐	c ☐
Schizoaffective Personality Disorder	a ☐	b ☐	c ☐
Paranoid Personality Disorder	a ☐	b ☐	c ☐

E. The (proposed) conservatee's periods of impairment from the deficits indicated in items 6C & 6D.
(1) ☐ do NOT vary substantially in frequency, severity or duration.
(2) ☐ do vary substantially in frequency, severity, or duration (please explain; continue with an attachment if necessary):

F. (Optional) Any other information regarding this evaluation of the (proposed) conservatee's cognitive or psychiatric/psychological function is ☐ stated below ☐ stated in Attachment.

_____

_____

7. EVALUATION OF (PROPOSED) CONSERVATEE'S EVERYDAY FUNCTIONAL ABILITY

Note to practitioner: This form is **not** a rating scale. It is intended to assist you in recording your impressions of the (proposed) conservatee's daily functional abilities. Where appropriate, you may refer to scores on standardized rating instruments.

(Instructions for items 7A and 7C): Check the appropriate designation as follows:

a = No Impairment **b** =Impairment Present **c** = So Impaired as to be incapable of being assessed

A. **Activities of Daily Living (ADLS)**
Bathing: either sponge, shower or tub
a ☐ b ☐ c ☐

(1) Dressing: includes choosing and obtaining clothing
a ☐ b ☐ c ☐

(2) Toileting: going to toilet, cleaning self, and changing clothes
a ☐ b ☐ c ☐

(3) Transfer: can get in and out of bed / can get on and off chair
a ☐ b ☐ c ☐

(4) Continence: both urine and bowel function completely by self
a ☐ b ☐ c ☐

(5) Feeding:
a ☐ b ☐ c ☐

The (proposed) conservatee is **Independent** in **ALL** ADL functions _____

The (proposed) conservatee is **Dependent** in **ALL** ADL functions _____

B. (Optional) Any other information regarding this evaluation of the (proposed) conservatee's Activities of Daily Living function is ☐ stated below ☐ stated in Attachment.

_____

_____

C. **Instrumental Activities of Daily Living (IADLS)**

(1) Ability to use Telephone/Cellular Phone
a ☐ b ☐ c ☐

(2) Shopping
a ☐ b ☐ c ☐

(3) Food Preparation
a ☐ b ☐ c ☐

(4) Housekeeping
a ☐ b ☐ c ☐

(5) Laundry
a ☐ b ☐ c ☐

(6) Mode of Transportation
a ☐ b ☐ c ☐

(7) Responsible for Medications
a ☐ b ☐ c ☐

(8) Ability to Handle Finances
a ☐ b ☐ c ☐

The (proposed) conservatee is **Competent** in **ALL** IADL functions ☐

The (proposed) conservatee is **Moderately Competent/Able to manage** in IADL functions ☐

The (proposed) conservatee is **Not able to maintain self, even with help** in IADL functions ☐

D. (Optional) Any other information regarding this evaluation of the (proposed) conservatee's Instrumental Activities of Daily Living function is ☐ stated below ☐ stated in Attachment.

_____

_____

_____

8. CAPACITY FOR (PROPOSED) CONSERVATEE TO MAKE PLACEMENT AND MEDICATION DECISIONS

A. Placement of (proposed) conservatee

(1) ☐ The (proposed) conservatee would benefit from or needs placement in a restricted and secure facility.

(2) ☐ The (proposed) conservatee would benefit from or needs 24-hour caregiver support in their home if resources are provided to the (proposed) conservatee.

(3) ☐ The (proposed) conservatee HAS capacity to give informed consent to this placement.

(4) ☐ The (proposed) conservatee does NOT have capacity to give informed consent to this placement.

(5) A locked or secured-perimeter facility ☐ is ☐ is NOT the least restrictive environment appropriate to the needs of the (proposed) conservatee.

B. Administration of Medications to (proposed) conservatee

(1) ☐ The (proposed) conservatee needs or would benefit from the following psychotropic medications appropriate to the care of his/her respective medical/psychiatric disorder:

(2) ☐ The (proposed) conservatee HAS capacity to give informed consent to the administration of psychotropic medications appropriate to the care of his/her respective disorder.

(3) ☐ The (proposed) conservatee does NOT have the capacity to give informed consent to the administration of psychotropic medications appropriate to the care of his/her respective disorder.

(4) ☐ The (proposed) conservatee needs or would benefit from the following psychotropic medications appropriate to the care of his/her respective medical/psychiatric disorder listed in B1 because (state reasons below, continue on Attachment if necessary):

_____

_____

_____

_____

(5) Number of pages attached _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date

_____ _____

Type or Print Name **Signature of Declarant**

ATTORNEY OR PARTY WITHOUT ATTORNEY	STATE BAR NUMBER:	FOR COURT USE ONLY
NAME:		
FIRM NAME:		
STREET ADDRESS:		
CITY:	STATE: ZIP CODE:	
TELEPHONE NO.:	FAX NO.:	
E-MAIL ADDRESS:		
ATTORNEY FOR *(name)*:		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF		
STREET ADDRESS:		
MAILING ADDRESS:		
CITY AND ZIP CODE:		
BRANCH NAME:		
CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name)*: PROPOSED CONSERVATEE		CASE NUMBER:
		CONSERVATORSHIP PETITION HEARING DATE:
EX PARTE APPLICATION FOR ORDER AUTHORIZING COMPLETION OF CAPACITY DECLARATION—HIPAA*		DEPT.: / TIME:

1. Applicant *(name)*:
has filed a petition for the appointment of a conservator for the above-named proposed conservatee. The petition is set for hearing on *(date)*: at *(time)*: in ☐ Dept.: Rm.:

2. The petition requests *(check all that apply)*:
   a. ☐ A finding that the proposed conservatee should be excused from attending the hearing on the petition.
   b. ☐ Exclusive authority to consent to medical treatment for the proposed conservatee.
   c. ☐ Authority to make placement or medication decisions related to a major neurocognitive disorder (such as dementia).
   d. ☐ Appointment of a conservator of the estate.
   e. ☐ Other *(specify)*:

3. Applicant has requested *(name each declarant)*:

to complete, sign, and deliver to applicant, for use to support the petition, a
☐ *Capacity Declaration—Conservatorship* (form GC-335)
☐ and a *Major Neurocognitive Disorder Attachment to Capacity Declaration—Conservatorship* (form GC-335A)
(the Declaration), concerning the medical condition or mental capacity of *(name of proposed conservatee)*:

4. The proposed conservatee has not consented to the disclosure of any private medical information that would be disclosed by the completed Declaration.

5. Applicant requests this court to authorize each declarant named in item 3 to complete, sign, and deliver the Declaration to applicant within 15 days of the declarant's receipt of the court's order.

6. Applicant requests this court to dispense with notice of hearing on this application.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT APPLICANT'S NAME) (APPLICANT'S SIGNATURE)

* The federal Health Insurance Portability and Accountability Act of 1996. Use this form with *Ex Parte Order Re Completion of Capacity Declaration—HIPAA* (form GC-334).

Form Adopted for Mandatory Use
Judicial Council of California
GC-333 [Rev. January 1, 2019]
CEB ceb.com Essential Forms

EX PARTE APPLICATION FOR ORDER AUTHORIZING COMPLETION OF CAPACITY DECLARATION - HIPAA
(Probate-Guardianships and Conservatorships)

Probate Code, §§ 1220, 1825, 1890, 1893, 2356.5;
42 U.S.C. §§ 1177, 1178;
45 C.F.R. §§ 160, 164
www.courts.ca.gov

ATTORNEY OR PARTY WITHOUT ATTORNEY	STATE BAR NUMBER:	FOR COURT USE ONLY
NAME:		
FIRM NAME:		
STREET ADDRESS:		
CITY:	STATE: ZIP CODE:	
TELEPHONE NO.:	FAX NO.:	
E-MAIL ADDRESS:		
ATTORNEY FOR *(name)*:		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF		
STREET ADDRESS:		
MAILING ADDRESS:		
CITY AND ZIP CODE:		
BRANCH NAME:		
CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name)*: PROPOSED CONSERVATEE		CASE NUMBER:
		CONSERVATORSHIP PETITION HEARING DATE:
EX PARTE ORDER RE COMPLETION OF CAPACITY DECLARATION—HIPAA*		DEPT.: TIME:

1. Attached to this order is a *Capacity Declaration—Conservatorship* (form GC-335)
   ☐ and a *Major Neurocognitive Disorder Attachment to Capacity Declaration—Conservatorship* (form GC-335A) (the Declaration).

2. *(Name)*:
   having applied for an order authorizing the declarant(s) named in item 5 to complete, sign, and return the Declaration for the purpose specified in item 6, and good cause appearing:

THE COURT FINDS

3. Notice of the hearing on the application should be dispensed with and the application should be granted.

4. A petition for the appointment of a conservator has been filed in this proceeding by *(name of petitioner)*:

   This petition is set for hearing on *(date)*: at *(time)*: in ☐ Dept.: ☐ Rm.:

5. Declarant *(name each)*:

   has been requested to complete and sign the Declaration for the purpose specified in item 6.

6. Petitioner proposes to use the Declaration to provide evidence to support *(check all that apply)*:
   a. ☐ A finding that the proposed conservatee should be excused from attending the hearing on the petition.
   b. ☐ A request for exclusive authority to consent to medical treatment for the proposed conservatee.
   c. ☐ A request for authority to make placement and medication decisions related to treatment of a major neurocognitive disorder (including dementia).
   d. ☐ The appointment of a conservator of the estate.
   e. ☐ Other *(specify)*:

* The federal Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191).

Form Adopted for Mandatory Use
Judicial Council of California
GC-334 [Rev. January 1, 2019]
CEB ceb.com | Essential Forms

EX PARTE ORDER RE COMPLETION OF CAPACITY DECLARATION - HIPAA
(Probate-Guardianships and Conservatorships)

Probate Code, §§ 1220, 1825, 1890, 1893, 2356.5;
42 U.S.C. §§ 1177, 1178;
45 C.F.R. §§ 160, 164
www.courts.ca.gov

CONSERVATORSHIP OF *(Name)*: PROPOSED CONSERVATEE	CASE NUMBER:

THE COURT ORDERS

7. Notice of hearing on the application is dispensed with.
8. Each declarant named below is authorized to complete, sign, and deliver to the attorney or other person whose address appears at the top of page 1 of this order the original of the Declaration, consisting of:
   a. *Capacity Declaration-Conservatorship* (form GC-335) *(name each authorized declarant):*

   b. ☐ and *Major Neurocognitive Disorder Attachment to Capacity Declaration—Conservatorship* (form GC-335A) *(name each authorized declarant):*

   regarding *(name of proposed conservatee):*
   to enable the Court to determine whether the proposed conservatee should be excused from attending the hearing on the appointment of a conservator or the proposed conservator should be granted certain powers over the person or estate of the proposed conservatee.
9. Use of the Declaration is governed by the disclosure safeguards in the regulations of the federal Department of Health and Human Services (45 C.F.R. §§ 160 & 164) under HIPAA, and no use other than what is permitted in those regulations is permitted by this order.
10. The completed and signed original of the Declaration must be returned to the attorney or other person whose address appears at the top of this order within 15 days after its receipt by the declarant authorized to complete and sign it.
11. Other orders *(specify):*

Date:

_____
JUDICIAL OFFICER

CERTIFICATION

I certify that this document, including any attachments, is a correct copy of the original on file in my office.

Date: Clerk, by _____, Deputy

(SEAL)

STEPHEN M. MAGRO
Law Offices of Stephen M. Magro
14101 Yorba Street, Suite 101
Tustin, California 92780
(714) 832-8456

BAR ADMISSION California 1987; United States Court of Appeals for the Ninth Circuit, 1987; United States District Court, Central District of California, 1987; United States District Court, Northern District of California, 1993; United States Tax Court, 1989.

EDUCATION

Legal — UNIVERSITY OF SOUTHERN CALIFORNIA LAW SCHOOL
J.D., 1987
Top 25% of Class
Major Tax Planning Journal Staff Editor
Computer Law Journal Staff Editor

Graduate — UNIVERSITY OF CALIFORNIA, IRVINE, GRADUATE SCHOOL OF MANAGEMENT
M.B.A., Finance Major, 1983

Undergraduate — UNIVERSITY OF CALIFORNIA, IRVINE
B.A., Political Science Major, 1981

CAREER

June, 1994 - present — LAW OFFICES OF STEPHEN M. MAGRO, Tustin, California
Owner Attorney/Small firm. Engaged in probate and trust litigation, probate, decedent's estate and trust administration, conservatorship and guardianship practice.

February, 1993 - May, 1994 (firm dissolved) — DJANG, LUM & ZIEMBA, Orange, California
Managing Attorney. Engaged in estate planning, probate, trust law, corporate transactions and business litigation practice.
Served as managing attorney/shareholder of this seven-attorney law firm.

May, 1991 - February, 1993 — ADAMS, DUQUE & HAZELTINE, Orange, California
Associate Attorney. Engaged in estate planning and probate and corporate transactional practice. Large national law firm.

October, 1990 - May, 1991 (merged with Adams, Duque & Hazeltine) — DJANG, O'KAIN & JOY, Newport Beach, California
Associate Attorney. Engaged in estate planning and probate and corporate transactional practice.

September, 1987 - October, 1990 — EADINGTON & STUHLEY, Newport Beach, California
Associate Attorney. Engaged in estate planning and probate and corporate transactional and securities practice.

Sandra P. Klein, Ph.D.

Education

1987 - 1992 California School of Professional Psychology
Clinical Psychology San Diego, California
PH.D.

1985 - 1987 California State University
Experimental Psychology Long Beach, California
M.A.

1976 - 1980 University of Delaware
Psychology & Economics Newark, Delaware
B.A.

Licenses

July 29, 1994 Licensed Clinical Psychologist
License # PSY 13918 State of California

Professional Experience

8/94 - Present Dove Psychological Associates Newport Beach, CA

Licensed Clinical Psychologist, Private Practice

- This position involves conducting Psychological/Neuropsychological Assessment, and providing Psychotherapy to Adults, Couples, Adolescents and Families. Testing includes administration, interpretation, report writing, and explanation of test findings to clients and their families, fellow clinical psychologists, educational psychologists, geriatricians, neurologists, and psychiatrists. Neuropsychological Assessments include Medical/Legal evaluations and Capacity evaluations.

10/2014 – Present University of California Irvine (UCI) Orange, CA
Department of Family Medicine
Program in Geriatric Medicine & Gerontology
Health Assessment Program for Seniors (HAPS)

Clinical Psychologist/Consulting Neuropsychologist

- This position involves conducting Brief Neuropsychological Evaluations and reviewing the findings of these assessments with the patient and their family at a Family Conference two weeks later. This is performed as part of the HAPS Consultation Clinic at UCIMC and works with a geriatric population assessing dementia, depression, and cognitive functioning as part of the HAPS team which includes a Geriatrician, Neuropsychologist, Pharmacist, Occupational Therapist and Dietician. Teaching Medical Residents and Fellows, as well as Pharmacy students is also a part of the position. Lecturing Psychiatric residents intermittently.
- As a contributor to the GWEP Grant, I help educate primary care medical staff about cognitive function within the geriatric population differentiating dementia, depression, acquired brain injury and other diagnostic issues.

- Another position included in my part time contract with UCI is working on the Elder Abuse Forensic Center team. This position involves going out in the field to do Brief Neuropsychological Evaluations on a geriatric or dependent adult population and assess cognitive function, write reports and complete Capacity Declarations if needed. This team works with Adult Protective Service, District Attorney's Office in Orange County, Orange County Law Enforcement, Council on Aging and other OC community agencies.

9/00 – 12/12 Coastline Community College Costa Mesa, CA
Acquired Brain Injury Program

Professional Expert/Consulting Neuropsychologist

- This position involves supervising and coordinating neuropsychological interns, conducting student assessments, consulting with staff on individual student cases including direct intervention in crisis situations; reviewing applicant files to verify disabilities, coordinating empirical research on program outcomes. (1/06-12/12)

Counselor

- This position involves conducting groups using a 'Future Planning' workbook and working with students individually to help them transition out of a two-year cognitive retraining program into further educational or career plans. (4/01-3/10)

6/09 – 12/10 Alliant International University/CSPP Irvine, CA
Forensic Program

Professor–Teaching Graduate students Assessment.

- This position involves teaching Psy.D. graduate students Psychological Assessment I, Neuropsychological Assessment, & Projective Tests.

9/00 – 4/01 Coastline Community College Costa Mesa, CA
Acquired Brain Injury Program

Psychosocial Instructor

- This position involves teaching acquired brain injured students psychosocial skills in a group setting using didactic lecture and interactive participation.

8/94 – 3/97 San Pedro Peninsula Hospital San Pedro, CA
Lakewood Regional Medical Center Lakewood, CA

Licensed Clinical Psychologist, Rehabilitation Unit

- This position involved conducting psychological and neuropsychological tests; including administration, interpretation, report writing, and explanation of findings to inpatient and outpatient clients, their families, and other rehabilitation staff. This is as an associate to the main neuropsychologist.

3/94 - 7/94 Michael S. Daniel, Ph.D. Huntington Beach, CA

Registered Psychological Assistant

This position involved conducting psychological and neuropsychological tests; including administration, interpretation, report writing, and explanation of findings to inpatient and outpatient clients, their families, and other rehabilitation staff.

12/90 - 7/94 Douglas E. Harrington, Ph.D. Newport Beach, CA

Registered Psychological Assistant

- This position involved conducting Psychological and Neuropsychological Tests; including administration, interpretation, report writing, and explanation of findings to inpatient and outpatient clients, fellow psychologists, educational psychologists, and psychiatrists. It also involved conducting psychotherapy with adults, couples, adolescents, and families.

2/94 - 6/94 Coastline Community College Costa Mesa, CA
Traumatic Head Injury Program

Instructor for Interact Class

- This position involved teaching a psychoeducational social skills class, including assessing and evaluating students, as well as providing information to their families and other staff regarding their psychosocial strengths and weaknesses.

3/89 - 6/90 Coastline Community College Costa Mesa, CA
Traumatic Head Injury Program

Counselor/Neuroeducational Associate

- This Internship position involved conducting neuropsychological and neuroeducational testing using the Luria-Nebraska Neuropsychological Battery and the Cognitive Assessment System. Counseling students regarding their progress in the program was also part of this internship. Testing included administration, interpretation, report writing, and explanation of findings to staff, students, and their families. I also acted as a substitute instructor and lecturer at orientation.

9/90 - 7/91 West County Counseling Center Huntington Beach, CA

Psychological Intern

- This Internship position involved providing psychotherapy for adults, adolescents, children, and families. It also involved doing Psychological Testing including administration, interpretation, report writing, and explanation of findings to staff, fellow interns, clients and their families.

9/86 - 6/87 California State University Long Beach, CA
Community Psychology Clinic

Graduate Assistant for Practicum Course

- This position involved working closely with staff, other students, and clients; providing counseling, supervision, and treatment planning.

4/85 - 5/88 Newport Harbor Hospital Newport Beach, CA
An Adolescent Acute & Residential Treatment Facility

Psychiatric Assistant/Shift Leader

- This position involved providing supervision and management of floor staff and patients; including individual, group, and family therapy, treatment planning and frequent crisis intervention.

8/82 - 4/85 Greatwest Health Services, Inc. Orange, CA
An Outpatient Alcoholism Treatment Facility

Biofeedback Counselor

This position involved providing individual counseling, didactic lectures, and psychotherapy as a co-leader of a couples group with an adult population.

Research Experience

9/79 - 6/80 University of Delaware Newark, DE

Research Assistant for Florence L. Geis, Ph.D.

- This position involved working on a project dealing with sex-role stereotyping.

6/86 - 12/87 California State University Long Beach, CA

Research Assistant for Kenneth F. Green, Ph.D.

- This position involved working on antihistamines and the analgesia systems, and developing a tolerance to morphine analgesia from a brief exposure to a sweet solution.

6/90 - 6/92 California School of Professional Psychology San Diego, CA
Coastline Community College Costa Mesa, Ca.

Dissertation Mark Sherman, Ph.D. Chairman of Committee

- This research involved working on social skills training with adults with acquired brain injuries.

Publications

Klein, S.P. & Green, K.F. (1988). Tolerance to Morphine Analgesia from Brief Exposure to a Palatable Solution. Brain Research Bulletin, Vol. 21, pp. 963-965.

Chao, L., Klein, S.P. & Duran, R. (2011). Effectiveness of Cognitive Rehabiliation: An Evaluation of Coastline Community College Acquired Brain Injury Program (CCCABI). Archives of Clinical Neuropsychology. Vol. 26, 6 pp. 469.

Professional Memberships

American Psychological Association (1993-2020)

National Academy of Neuropsychology (1995-2020)

References

Philip Oncley, Ph.D., Clinical Psychologist
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Bonnie Olsen, Ph.D., Clinical Psychologist
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CURRICULUM VITAE

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Clinical Professor
Chief, Division of Geriatric Medicine and Gerontology
Reagan Endowed Chair in Geriatric Medicine
Department of Family Medicine

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Email: lgibbs@uci.edu

EDUCATION

Fellowship	Geriatric Medicine, University of California, Davis Sacramento, CA, 2000
Residency	Family Medicine, University of California, Davis, Sacramento, CA, 1999
M.D.	Medicine, Stanford University, School of Medicine, Stanford, CA, 1996
Post-Baccalaureate	Biology/Neuroscience, San Jose State University, San Jose, CA, 1990
B.Music	Piano Performance, College of Notre Dame, Belmont, CA, June 1985

BOARD CERTIFICATION

American Board of Family Practice, 1999, 2005, 2014
Geriatrics Medicine 2000, 2009, 2019

PROFESSIONAL APPOINTMENTS/EMPLOYMENT

2018-present	ACO Medical Director, UCI Health
2015-present	UC Reagan Endowed Chair in Geriatric Medicine
2013-present	Chief, UCI Division of Geriatrics and Gerontology
2012-present	Clinical Professor, UCI Department of Family Medicine
2011-present	Medical Director, UCI Health, SeniorHealth Center
2011-2013	Associate Program Director, UCI Program in Geriatrics
2009-2011	Associate Medical Director, UCI Health, SeniorHealth Center
2008-2014	Director, Geriatric Fellowship, UCI Program in Geriatrics
2008-2012	Associate Clinical Professor, UCI Department of Family Medicine
2007-2015	Director, UCI Geriatric Medical Education
2003-2014	Director, Health Assessment Program for Seniors (HAPS), Senior Health Center
2002-2008	Assistant Clinical Professor, UCI Department of Family Medicine
2000-2002	Adjunct Professor, UC Davis Department of Family Medicine

RESEARCH PUBLICATIONS

1. Jewett BA, Gibbs LM, Tarasiuk A, Kendig JJ: "Propofol and Barbiturate Depression of Spinal Nociceptive Neurons", *Anesthesiology*, December 1992.

2. Gibbs LM, Kendig JJ: "Substance P and NMDA Receptor-Mediated Slow Potentials in Neonatal Rat Spinal Cord: Aged Related Changes", *Brain Research*, Vol. 595, 1992.

3. Kendig JJ, Kodee A, Gibbs LM, Ionescu P, Eger E: "Correlates of Anesthetic Properties in Isolated Spinal Cord: Cyclobutane", *European Journal of Pharmacology*, 264(3):427-36, 1994.

4. Tarasuik A, Gibbs LM, Kendig JJ: "Descending Inhibition in Neonatal Rat Spinal Cord Actions of Pentobarbital and Morphine", *Brain Research Bulletin*, 41:37-45, 1996.

5. Wiglesworth A, Austin R, Corona M, Schneider D, Liao S, Gibbs L, Mosqueda L.: "Bruising as a Marker of Physical Elder Abuse", *Journal American Geriatrics Society*. 2009 July; 57(7):1191-6. Epub June 3, 2009.

6. Wiglesworth A, Mosqueda L, Mulnard R, Liao S, Gibbs L, Fitzgerald W: "Screening for Abuse and Neglect of People with Dementia", *Journal American Geriatrics Society.* 58(3), 493-500 (2010).

7. Mosqueda L, Wiglesworth A, Gibbs L: "The Ability of People with Dementia to Recall Emotional Life Events" Abstract, International Conference on Alzheimer's Disease, Honolulu, HI, July 13, 2010.

8. Mosqueda, M, Wiglesworth, A, Moore, AA, Nguyen, AL, Gironda, MW, Gibbs, L. Variability in Findings from Adult Protective Services Investigations of Elder Abuse in California. Journal of Evidence Based Social Work, 2016;13(1):34-44.

9. Lee DR, Kawas CH, Gibbs L, Corrada MM., Prevalence of Frailty and Factors Associated with Frailty in Individuals Aged 90 and Older: The 90+ Study, J Am Geriatric Soc. 64:2257- 2262, 2016.

10. Kim HJ, Kehoe P, Gibbs LM, Lee JA: "Caregiving Experience of Dementia among Korean American Family Caregivers", Issues Mental Health Nursing 2019 Feb; 40(2): 158-165, doi: 10.1080/01612840.2018.1534909. Epub 2019 Jan 8.

11. Nguyen H, Lee JA, Sorkin DH, Gibbs L: "Living happily despite having an illness", Perceptions of healthy aging among Korean American, Vietnamese American, and Latino older adults; App. Nurse Res. 2019 Aug; 48:30-36. doi: 10.1016/j.apnr.2019.04.002. Epub 2019 May 10.

12. Lee JA, Kim HJ, Nguyen H, Le K, Sorkin D, Gibbs L. (April, 2019). Asian older immigrants' perceptions on depression, dementia, and elder abuse. Western Institute of Nursing annual meeting, San Diego, CA. (Best Research Poster Award)

13. Walling AM, Sudore RL, Bell D, Tseng C, Ritchie C, Hays RD, Gibbs L, Rahimi M, Sanz J, Wenger NS: "Population-Based Pragmatic Trial of Advance Care Planning in Primary Care in the University of California Health System", Journal of Palliative Medicine,Vol. 22, No. S1 | Advance Care Planning Studies; https://doi.org/10.1089/jpm.2019.0142. Epub 2019 August 22 PMID: 31486723

14. Lee JA, Campbell S, Rousseau J, Di Sano A, Gibbs L. (2020, April). Geriatric in-home caregivers' support: a community and academic partnership for cultural and linguistic tailored education. Journal of American Geriatrics of Society, Supplement Page 8. https://doi.org/10.1111/jgs.16432. (Presidential Best Paper Award).

15. Burton C, Lee JA, Waalen A, Gibbs L. (2019). "Things are Different Now But": Older LGBT adults' experiences and unmet needs in health care. Journal of Transcultural Nursing, 19;1043659619895099. https://doi.org/10.1177/1043659619895099. PMID: 31854263

PUBLICATIONS

1. Jerant AF, Gibbs L: "Development of a Distance and Computer Technologies in Medicine Elective", *The Journal of Information Technology in Medicine*, January 2000, Vol. 2, #1, htttp://www.-itm.com/articles/tmedelrv/index/html.

2. Hixon A, Gibbs L: "Osteochondritis Dissecans: A Diagnosis Not to Miss", *American Family Physician*, January 1, 2000.

3. Neyhart B, Gibbs L: "Osteoporosis," *Primary Care Geriatrics*, Ham, Sloan and Warshaw eds., Mosby Publishing, 2002.

4. Gibbs L, Mosqueda L: "Confronting Elder Mistreatment in Long-Term Care", *Annals in Long-term Care*, 12(4), April 2004.

5. Gibbs L, Mosqueda L and Morrison E: "Primary Care of Adults with Disabilities", AAFP Home Study Monograph, November 2006.

6. Gibbs L, Mosqueda L: "The Importance of Reporting Mistreatment of the Elderly", Editorial for the *American Family Physician*, 75(5), March 2007.

7. Gibbs L, Young L: "The Medical Director's Role: Neglect in Long-Term Care" *Journal of the American Medical Director's Association*, 8:3, March 2007.

8. Gibbs L, Mosqueda L, Chen E, Williams B, Martinez R: Geriatric Pocket Doc, August 2007. (A resource for allied professionals in the field of Elder Abuse).

9. Gibbs L: "Assessing Self-Neglect in Older Patients", Ethics Forum, http://www.ama-assn.org/amednews/2008/08/04/prca0804.htm, August 4, 2008, Accessed August 12, Amednews.com, 2008.

10. Gibbs L, Mosqueda L, Elder Abuse: A Medical Perspective, *Aging Health*. 2010 6:6, 739- 747.

11. Gibbs L, Mosqueda L, Chen E, Williams B, Martinez R: Geriatric Pocket Doc. (A resource for allied professionals in the field of Elder Abuse). 2nd edition, 2012 Expanded version available through Amazon, 2020.)

12. Vognar L, Gibbs L, Care of the Victim. *Clinics in Geriatric Medicine*, 30:4, Pgs. 869- 880, Nov 2014.

13. Gibbs, L. Understanding the Medical Markers of Elder Abuse and Neglect: Physical Examination Findings. *Clinics in Geriatric Medicine*, 30:4, Pgs. 687-712, Nov 2014.

14. Gibbs LM, Mosqueda L. Editors: Medical Implications of Elder Abuse and Neglect. Clinics in Geriatric Medicine, 30:4. November 2014.

15. Gibbs LM, Carico C, Walden L: The (Folstein) Mini-Mental State Exam: Just how useful is it for assessing capacity?, Trust and Estates Quarterly, California Bar Association, Vol 24, Issue 2, 2018.

16. A Practical Guide to Addressing the Social Needs of Older Adults by West Health Institute and University of California, Irvine, https://www.westhealth.org/resource/addressing-the-social-needs-of-older-adults-a-practical-guide-to-implementing-a-screening-and-referral-program-in-clinical-settings/, 2020. This guide was the output from a collaborative research project with the Gary and Mary West Health Institute and the University of California, Irvine SeniorHealth Center, funded and supported by the Gary and Mary West Health Institute. (Gibbs UCI site PI).

ONLINE CURRICULUM PUBLICATIONS

1. Akasheh, A, Gibbs, L, Mosqueda, L, Taheri, N, Chakravarthy, B, Fox, J and Lotfipour, S. Geriatric Emergency Medicine Online Curriculum (GEM-OC) 1 - Advance Directives. POGOe - Portal of Geriatric Online Education; 2010 http://www.pogoe.org/productid/20800

2. Gibbs, L, Sehgal, S and Abrams, A. Student/Senior Partner Program (SSPP)-Medical Student Handbook. POGOe - Portal of Geriatric Online Education; 2011 http://www.pogoe.org/productid/20785

3. Gibbs, L. Syllabus for an Internal Medicine Residency Program Rotation in Geriatrics. POGOe - Portal of Geriatric Online Education; 2011 http://www.pogoe.org/productid/20786

4. Lisa Gibbs, MD, University of California, Irvine, John Halphen, MD and Sabrina Pickens, PhD, University of Texas Houston. Elder Abuse (Mrs. James). POGOe - Portal of Geriatrics Online Education; 2013 Available from: http://www.pogoe.org/webgem/9499

5. Gibbs L, Sehgal S, Austin R. "Elder Abuse Simulation", University of California, Irvine, http://www.pogoe.org/productid/21718, June 2014.

6. Geri Team Communication: Gibbs L, Olsen B, Youm J, O'Toole E. University of California, Irvine, 2014; www.pogoe.org/productid/21764, October 2014.

7. "Responding to Physical Elder Abuse and Neglect" 2 hour eLearning course, UC Irvine Center on Elder Abuse & Neglect, California Geriatric Education Center and the Academy for Professional Excellence. academylms@projects.sdsu.edu.

8. Geriatric Workforce Enhancement Project (HRSA) Podcast Series: PI, overseeing development of Podcast presentations for the care of older adults. 259 total views.
   a. 33 International Views from: Saudi Arabia, England, India, Bulgaria, Russia, Spain, Newfoundland, Indonesia 220 USA Views from: VA, SC, NC, AK, TX, GA, OR, UT, MO, FL, NM, MA

BOOKS

1. Gibbs L. Mosqueda L. Clinics Review Articles: Clinics in Geriatric Medicine; Medical Implications of Elder Abuse and Neglect. McCool J, editor. Philadelphia (PA): 2014 November. Available from http://www.theclinics.com

BOOK REVIEW

1. Shapiro J, Gibbs L: Souls on a Walk: An Enduring Love Story Unbroken by Alzheimer's, Book Review, Family Medicine, 6:2, February 2014.

INVITED TALKS

1. Grand Rounds: "Elder Mistreatment", Los Alamitos Medical Center, Los Alamitos, CA, August 2004.

2. "Confronting Elder Mistreatment", SCAN/CHW Geriatric Symposium, Long Beach, CA, October 2004.

3. "Elder Abuse", Continued Learning Experience, California State University Fullerton, September 2004.

4. "Common Medical Illnesses Faced by Elders", Elder Abuse Symposium, California District Attorneys Association, San Francisco, CA, December 2004.

5. "Confronting Elder Mistreatment", Improving the Health of Older Women of Color Conference, Stanford University School of Medicine, Stanford, CA, December 2004.

6. Co-Presenter: "Practice and Policy Implications of Elder Abuse Multidisciplinary Teams Workshop", American Society on Aging/National Council on the Aging Annual Conference, Philadelphia, PA, March 2005.

7. Grand Rounds: "Elder Abuse", South Coast Medical Center, Laguna Beach, CA, April 2005.

8. "Confronting Elder Mistreatment", Saddleback College Emeritus Institute, Laguna Woods, CA, April 2005.

9. Developer/Moderator/Co-Presenter: "Elder Mistreatment in Long-Term Care", workshop, American Geriatric Society Annual Conference, Orlando, FL, May 2005.

10. "Psychosis in the Elderly", Annual Family Medicine Update Course, Newport Beach, CA, June 2005.

11. "Elder Abuse, Detection and Prevention", SCAN/CHW Geriatric Symposium Rancho Mirage, CA, October 2005.

12. Training Grant Focus Group, Office on Violence Against Women, US DOJ, Dallas, Texas, January 2006.

13. Co-Presenter: "Elder Abuse Forensic Center", Panel Discussion/Workshop, American Society on Aging/National Council on the Aging Annual Conference, Anaheim, CA, March, 2006.

14. Developer/Moderator: "Difficult Elder Abuse Cases", Panel Discussion/Workshop, American Society on Aging/National Council on the Aging Annual Conference, Anaheim, CA, March, 2006.

15. "Identification and Screening" and "Interviewing Vulnerable Adults", Idaho Elder Abuse Conference, Nampa, ID, May 2006.

16. "Psychosis in the Older Patient," and "Depression in the Older Patient," UC Irvine Family Medicine Update Course, Irvine, CA, June 2006.

17. "Elder Abuse and the Geriatric Emergency", Paramedic Training Institute, Lakeside, CA, July 2006.

18. "Dementia as a Risk Factor for Elder Abuse", Alzheimer's Disease Conference, Institute for Brain Aging and Dementia/Alzheimer's Association, Newport Beach, CA, September 2006.

19. Speaker/Panelist: "Elder Abuse," ASCP's Annual Meeting; Senior Care Pharmacy conference panel, Phoenix, AZ, November 2006.

20. POST Training for Law Enforcement: "Psychological Issues in Elder Abuse: Capacity Assessment and CASTLE", December 2006.

21. "Forensic Markers of Elder Abuse", Annual Conference for Legal Assistance for Seniors/HICAP conference, Oakland, CA, April 2007.

22. Moderator: "Ethical Issues in Elder Abuse", Archstone Foundation Elder Abuse and Neglect Initiative Convening, San Jose, CA, April 2007.

23. "Markers of Elder Abuse and Neglect" and Breakout Session, "Interviewing", King County Annual Elder Abuse Conference, Keynote presentation, Bellevue, WA, September 2007.

24. Developer/Moderator: "Death by Elder Neglect", Symposium, American Geriatric Society, Washington D.C., May 2008.

25. "Starting an Elder Abuse Forensic Center", National Adult Protective Services Association conference, Chicago, IL, August 2008.

26. "Elder Abuse", 10th Annual Educational Conference, Monterey County Domestic Violence Coordinating Council, Seaside, CA, October 2008.

27. Speaker and Course Director: Coroner Elder Death Investigation Course, California Coroner Training Center, Santa Ana, CA, October 28-30, 2008.

28. "Reporting Elder Abuse", Redlands Community Hospital, Redlands, CA, December 2008.

29. Grand Rounds: "Reporting Elder Abuse", Anaheim Memorial Hospital, Anaheim, CA, January 6, 2009.

30. Grand Rounds: "Managing Complex Geriatric Patients", JFK Memorial Hospital, Indio, CA, February 2009.

31. "Dementia and Capacity", Probate and Mental Health Institute Annual Conference, San Diego, CA, February 2009.

32. "Forensic Marker of Elder Abuse", New Mexico's District Attorney's Conference, Albuquerque, NM, March 2009.

33. "Forensic Markers of Elder Abuse" "Dementia and Capacity" California Association of Superior Court Investigators Annual Conference, San Diego, CA, May 2009.

34. "Treating Complex Geriatric Patients", UC Irvine Family Medicine Update Course, Garden Grove, CA, June 2009.

35. Grand Rounds: "Dementia Related Psychosis", Valley Presbyterian Hospital, Van Nuys, CA, July 2009.

36. Grand Rounds: "Forensic Markers of Elder Abuse", Los Alamitos Medical Center, Los Alamitos, CA, July 2009.

37. "Recognizing Elder Abuse in Primary Care: Making the Call", American Academy of Family Physicians conference, Boston, MA, October 2009.

38. "Forensic Markers of Elder Abuse", Alaska AAVA Conference, Anchorage, AK, May 2010.

39. "Medical Aspects of Elder Abuse", Silverado Conference, Los Angeles, CA, October 2010.

40. "What's Geriatrics Got To Do With It?", Department of Urology Grand Rounds, UC Irvine Medical Center, June 2011.

41. Advanced Detective Training in Elder Abuse, Anaheim Family Justice Center, Anaheim, CA, August 2011.

42. Invited Speaker: UC Irvine Obstetrics and Gynecology Grand Rounds, "What's Geriatrics Got To Do With It: Ob/Gyn?", UC Irvine Medical Center, December 2011.

43. "Responding to Physical Elder Abuse and Neglect", 4-hour seminar: Orange County Social Services, Riverside Social Services, 20xx, (California Geriatric Education Center HRSA grant product).

44. "Geriatrics for Urogynecology", International Urogynecological Association, UC Irvine Medical Center, March 9, 2012.

45. "Medical Aspects of Elder Abuse" Community Hospital Lecture, Placentia, CA, July 2, 2012.
46. Host/Moderator: Geri West – Western Regional Reynolds Meeting, Newport Beach, July 12, 2012

47. "Medical Markers of Elder Abuse" Los Alamitos Hospital, Los Alamitos, CA, September 10, 2012.

48. Conference Presentation: "Applying Motivational Interviewing to Geriatric Medicine", Lisa Gibbs, MD, Carla Herman, MD, and Keri Oetzel, PhD, 2012 Reynolds Grantee 10th Annual Meeting, St. Louis, MO, October 2012.

49. Conference Presentation: "Developing Regional Reynolds Awardees Consortia" Hal Atkinson, MD, MS,; Lisa Gibbs, MD,; Jan Busby-Whitehead, MD,; Mindy Fain, MD,; Mitchell Heflin, MD, MHS; Victor Hirth, MD; Mark Supiano, MD, 2012 Reynolds Grantee 10th Annual Meeting, St. Louis, MO., October 2012.

50. "Neglect and Capacity" Los Angeles District Attorney's Office, Los Angeles, CA. October 30, 2012.

51. "Elder Abuse: A Perfect Storm Rising", Citrus Valley Medical Center, West Covina, CA, January 15, 2013.

52. Invited Speaker: "Elder Abuse: A Perfect Storm Rising", St. Jude Medical Center, West Fullerton, CA, March 13, 2013.

53. Invited Speaker: UC Irvine Surgery Grand Rounds: "The Role of Geriatric Assessment in Perioperative Care", UC Irvine Medical Center, April 2013.

54. "Elder Abuse", Riverside Community Hospital, Riverside, CA, June 5, 2013.

55. "Pressure Ulcers", California Department of Social Services, Legal Division, Monterey Park, CA, June 28, 2013.

56. Gibbs, L, Austin R. Innovations in the Healthcare of Older Patents – The use of remote monitoring technology, University of California, Irvine, SeniorHealth Center, HASC. 2013 HASC Conference on Aging, October 2013.

57. "Medical Aspects of Elder Abuse", California Judges Association, Monterey, CA, October 2013.

58. "Dementia" for CalOptima, Orange, CA, January 30, 2014.

59. So. California Readmissions Update Summit 2014 – Focus On Case Management: So Cal Case Managers Share What It Takes To Be A Provider Of Choice, "Care Transitions/Remote Monitoring/SNF Track Innovative SNF Partnerships: iPad Self-Management and Tele- health: Seeking SNF's in Search of Increased Medicare Volume Readmissions" Anaheim, CA, October 16, 2014.

60. So. California Readmissions Update Summit 2014 – Focus On Case Management: So Cal Case Managers Share What It Takes To Be A Provider Of Choice Care Transitions/IT/Remote Monitoring/SNF Track – Moderated Panel: "Proven Technology Solutions in Reducing Readmissions", Anaheim, CA, October 16, 2014.

61. "Senior Health Center: Patient Centered Medical Home": UCOP Primary Care Collaborative: October 2014.

62. “Geriatric Depression”, Placentia Linda Hospital, Placentia, CA, April 2015.

63. Invited Expert, “Elder Abuse”, Police Officer Training (Post) Course Video, San Diego, CA, April 2015.

64. “Elder Abuse in the Building Industry” (2 hour program), Renovate America HERO program, San Diego, July 2015.

65. Invited: California Commission on Aging, “Elder Abuse Innovations in OC”, Costa Mesa, CA, October 2015.

66. “Elder Abuse”, Program for the All-Inclusive Care of the Elderly (PACE) staff, Garden Grove, CA, December 2015.

67. “Annual Wellness Exam”, Elder Abuse”, for Geriatric Workforce Enhancement Program (GWEP), for primary care providers and staff of OC FQHCs, Santa Ana, CA May 2015, Commerce, CA October 2016.

68. Invited: “Mental Illness and Elder Abuse and Neglect”, for World Elder Abuse Awareness Day (WEAAD), Santa Barbara, CA, June 2016.

69. Invited Panelist: ICTS Conference, UC Irvine, June 2016.

70. Panelist; Women’s Health Association, Alzheimer’s OC, Irvine, CA August 2016.

71. Panelist, “Elder Abuse”, Orange County Family Violence Council, 2016 Conference, Costa Mesa, CA, November 2016.

72. “Intimate Partner Violence”, OC Healthcare Agency, Orange, CA, Nov 2016

73. “Intimate Partner Violence”, Cal State Fullerton health professionals, April 2017

74. “Medical Aspects of Elder Abuse”, Grand Rounds, Orange Coast Memorial, Fountain Valley, Ca, April 2017.

75. “Mental Health Issues in Older Adults”, Kaiser Permanente Mental Health Convening, Fullerton, Ca, Nov 2017.

76. “Mental Health in Older Adults”, Kaiser Permanente Mental health TEDx presentation, Garden Grove, CA March 2018.

77. “Trauma Informed Care in the Field of Elder Abuse”, CWDA Protective Services Operations Committee (PSOC), Sacramento, CA, April 2018.

78. “Senior-Centered Care: A Discussion with Leaders from Healthcare, Community and Senior-Focused Organizations, Panelist for West Health’s 2018 American Geriatric Society Pre-Conference, May 2018.

79. "Frailty and Healthy Aging", Newport Beach Library series, Newport Beach CA October 2018.

80. "Train the Champion" for Mission Conference Center, Mission Hospital, Mission Viejo, March 2019.

81. "Aging With Dignity", South OC Senior Day (sponsored by Sen. Bates), April 2019.

82. Stem Cell Community Lecture "Aging, Alzheimer's & Frailty—Can we find the fountain of youth?" Gross Hall, UCI, 4/19.

83. "Elder Abuse and Trauma Informed Care" World Elder Abuse Awareness Day Guest Speaker, Buena Park, CA, June 2019.

84. "Reducing Harm: Trauma informed care and case management", Presentation, National Adult Protective Services Association, Colorado, August 2019.

85. OC Bar Association- OC Harm Reduction, Orange, CA, September 2019.

86. Initiative to End Family Violence, Elder Abuse and Trauma Informed Care study, September 2019. UCI School of Law

87. UCI MIND: 30th Annual SoCal Alzheimer's Disease Research Conference, "30 Years of Discovery: Hope on the Horizon,": "Dementia research from a clinical perspective." October 2019

88. Panelist: Laguna Beach Community Clinic 4th Annual Health Symposium on Longevity, Laguna Beach, CA, January 2020.

89. Panelist: Senator Tom Umberg Virtual Town Hall (COVID) , April 2020

LECTURES/CLINICAL TEACHING

1. Orange County Social Services - "Dementia" 2006-2007, quarterly

2. Community lectures series (2 hours each): CLE Spring 2003, Fall 2004; OLLI Spring 2007

3. Family Medicine Resident Precepting, UC Irvine Family Health Center, Santa Ana, CA. 1 session/week, 2003-June 2007

4. Clinical Teaching - Geriatric Fellows: Geriatric Assessment consultation clinic, 1 session/week: 2003-2010

5. Clinical Teaching - Medical Students, Residents: Geriatric Ambulatory Care, 3-4 sessions weekly: 2005-2016; average 1 session weekly 2017-present.

6. Clinical Teaching- Continuity Clinic for Fellows, 1session weekly, 2008-present

7. Clinical Teaching – Longitudinal Year Long Geriatric clinic, weekly, for Psychiatry residents, 2011-2013

8. Clinical Teaching- Preceptorship for Clinical Foundations student, 5 sessions, 2012

9. UC Irvine Family Medicine Resident Conferences: "What's Geriatrics Got to do With It?; Family Medicine", August 2011, Psychosis in the Elderly, June 2004, Elder Abuse, March 2005, Flying with Medical Conditions, May 2005, Adults with Disabilities, April 2009, September 2011, The Use of Anticholinergics in Urinary Incontinence, 2012; Annual Wellness Exam, 2019.

10. Geriatric Clinical Pharmacology, Pharmacology Course, UC Irvine School of Medicine: February 2004, March 2005, March 2006, March 2007, March 2008, March 2009, March 2010

11. Coordinator: Fellowship Lecture Series: 2005-2006

12. Diversity in Medicine Undergraduate lectures, "Diversity in Geriatric Medicine", UC Irvine, 2008, 2010

13. Residency Lecturer: "Forensic Markers of Elder Abuse", Long Beach Memorial Family Medicine Residency Program, July 2009

14. Functional Assessment Seminar (2 hours): UC Irvine Medical Student Clinical Foundations II course: 2009-2016

15. UC Irvine Pediatric Residency Conference, Millers Hospital, Long Beach, CA "What's Geriatric Got To Do With It?": Pediatrics", July 2011

16. Speaker/Moderator: UC Irvine Medical Student Clinical Foundations I, Geriatric Medicine through Theater: "Patient-Doctor Relationship", November 29, 2011, 2012, 2013, 2014

17. Speaker/Moderator: UC Irvine Medical Student Clinical Foundations II, Geriatric Medicine through Theater, 2011- 2014

18. Speaker/Moderator: Elder Mistreatment Panel, UC Irvine Medical Student Clinical Foundations I, March 2012-2015

19. UC Irvine Department of Urology Residency Section, "Geriatric Urology", June 2012, "What's Geriatrics Got To Do With It: Understanding Anticholinergics", June 2013; "The Role of Geriatric Assessment in Perioperative Care", UC Irvine Medical Center, April 2013.

20. "Introduction to Geriatrics", UC Irvine First Year Medical Students, Clinical Foundations I, August 2012

21. Internal Medicine Resident Core Lecture Series: "Functional Assessment", 2013; "Dementia", 2015

22. "Elder Abuse", Hospitalist Geriatric Medicine Series, UC Irvine, August 2014

23. Schwartz Rounds panelist, UC Irvine Medical Center, June 2015

24. Urology Grand Rounds, "Geriatrics", October 2015; "Communication with Older Adults", October 2015; "Urinary Incontinence", March 2016.

25. "Elder Abuse", Undergraduate Public Health Policy course, UC Irvine, 2014, 2015, 2016, 2019, 2020. (Instructor: Dana Mukamel, PhD)

26. Psychiatry Residents lecture, "Dementia" December 2015, September 2016.

27. Doctoring Course, 4th Year medical students, "Establishing Trust in the Patient Doctor Relationship", October 2016, October 2017, September 2018.

28. Functional Exam lecture to combined MS1 and MS2, nursing students, Feb 2017, Feb 2018

29. Geriatric Multidisciplinary Session with an Elder Abuse Panel for combined medical student and nursing student classes, April 3, 2017.

30. Human Kindness course seminar: Breaking bad news, UCI SOM, Sept 2018.

31. "Caring for LGBT Older Adults", for Gender and Sexual Diversity in Healthcare lecture series, UCI SOM, Dec 2019.

MENTORSHIP

2010- 2012	FM Scholars Summer Humanities Research, "Changes in Medical Care from Then to Now: Exploring the Life Story Narratives of Patients Ages 65 and Older" (Laura Doan)
2013-present	External LOR for promotions: Jernberg –Univ of Arizona 2020, Chodos-UCSF 2019, Morton- U of Louisville 2017, Aggarwal –Univ of Hawaii, 2017, Tan- UCLA 2016, Halphen- U of Texas 2014, Ahmed- U of Texas 2013
2012, 2016	Medical Student Training in Aging Research (MSTAR) Program-Advisor, UCI SOM (David Lee) (Thomas Trieu)
2014	Dean's Summer Research Stipends, UCI SOM, "MyFive App+" (Risha Bera)
2016-2017	PRESTIGE (Program in Research: Elevating Standards in Graduate Education): (Sarah Khalaf – international MD from Saudia Arabia)
2016-2018	Research and Independent Study on HRSA Geriatric Award, UCI SOM (Roxanne Talmaya-Pascual)
2017	Arizona State University (ASU) student internship at SeniorHealth (Rebecca Perley)_
2018	Master's Practicum, "Elder Death Review in OC", UCI Public Health, UCI (Sophie Chen)

2019 Pre-med volunteer at SeniorHealth Center, (Kati Duddridge- matriculated to Med school, 2019)

2019-2020 Research and Independent Study 699F, UCI SOM (Anders Waalen)

5/20-present ICTS Incubation Project submission, "Health enhancing outreach to at-risk seniors during a pandemic", Marian Ryan- PI from Institute for Healthcare Advancement, mentoring Geriatric faculty Sonia Sehgal as co-PI.

1/20-present "Effect of nighttime dosing of blood pressure medication on nocturia in elderly patients", Lead researcher Dena Moskowitz, MD, Asst Clinical Professor in Urology; mentoring and co-investigator.

CURRICULUM DEVELOPMENT

1. Co-Course Director: Clinical Foundations Faculty Development Course (12 hours), UC Irvine School of Medicine, Irvine, CA, June 2009.

2. Internal Medicine Rotation: 2 week rotation in Geriatric Ambulatory Care for 22 Internal Medicine interns/year, (Clinical experience, didactics, pre/post testing) 2009-2013.

3. Developer/Presenter: "Physical Elder Abuse", (1 day training for social services/law enforcement), Santa Ana, CA, April 2010. Riverside County Adult Protective Services, October 2010.

4. Coordinator/Developer: Medical Student Geriatric Ambulatory Rotation: One week required rotation for 100+ third year students/year, (Clinical experience, didactics, pre/post testing) 2010-2013.

5. Coordinator/Developer: Elder Abuse Elective for medical students/residents: 2 or 4 week experience concentrating on the medical expertise in elder abuse investigation, 2009- Present.

6. CME Course Advisor
   - Ethics and Spiritual Care at the End of Life, (UC Irvine symposium) May 2011.
   - Motivational Interviewing (Keri Bolton) (UC Irvine /University of New Mexico Donald W. Reynolds grant collaboration) June 2011-December 2012.
   - Clinical Teaching Workshop, Stanford University faculty, 2012.
   - Scholarship Workshop, University of So. Carolina visiting faculty, 2013.
   - Medication Utilization for Older Adults (Grand Rounds), August 2011-June, 2013.

7. CME Course Director/Moderator: Treating the Older Adult Across Cultures, (UC Irvine Symposium) November 5, 2011.

8. CME Course Director/Moderator: Ethnogeriatrics and Dementia, (UC Irvine Symposium), l September 2012.

9. Developer/Presenter: "Elder Abuse", 4 hour training for New Orleans Police Department, Domestic Abuse Unit, New Orleans, LA, November 2011.

10. Advisor/Mentor: As PI on educational grant, assisted UC Irvine faculty members in the development and submission of 56 curricular products (9,900 unique page views) for medical student/resident education to Portal of Geriatrics Online Education, POGOe, 2009- 2014.

11. Co-hosting Visiting Professorship: George Drach, MD, Geriatric Urologist, University of Pennsylvania: Grand Rounds, faculty, resident and student seminars, June 2012.

12. Coordinator: Visiting Professorship: Louise Aronson, Humanities and Medicine, January 2012.

13. Simulations-"Elder Abuse", "Code, No Code" for Medical Students, 3rd year clerkship experience.

14. Student Senior Partner Program, Co-leader, 2009-2014.

15. Course Director: MBTI Workshop (Patrick Kerwin) for Faculty/staff development at SeniorHealth Center 2012.

16. CME Course Director: Motivational Interviewing Seminars (Keri Bolton) for Practicing Physicians, 2012

PROFESSIONAL ACTIVITY

AWARDS AND HONORS

2020 Best Hospital by U.S. News & World Report; Ranked #45 for Geriatrics

2019 UCI Engage Faculty Great Partner Award
Recognition for excellence, innovation, and effectiveness in teaching/research that demonstrates community collaboration, institutional impact, and deeply engaged, high quality learning and research

Orange County Medical Association Physicians of Excellence Award

Best Hospital by U.S. News & World Report; Ranked #42 for Geriatrics.

2017 Physician of the Year, Orange County Medical Association

Orange County Medical Association Physicians of Excellence Award ARIISE finalist for Innovation, UC Irvine

Best Hospital by U.S. News & World Report; Ranked #49 for Geriatrics.

2016 Orange County Medical Association Physicians of Excellence Award

2015 Orange County Medical Association Physicians of Excellence Award

Best Doctor® in America in Geriatric Medicine Best Doctors, Inc.

	Best Hospital by U.S. News & World Report; Nationally Ranked 43rd for Geriatrics
2014	Orange County Medical Association Physicians of Excellence Award
	Outstanding EduProjects 2013-2014 Project: GeriTeam iPhone app – an Interprofessional Health Education App for Geriatrics Care Teams (launched in the Apple App Store)
	Best Doctor® in America in Geriatric Medicine Best Doctors, Inc.
	America's Best Hospital by U.S. News & World Report; Nationally Ranked 39th for Geriatrics
2013	Orange County Medical Association Physicians of Excellence Award
	Best Doctor® in America in Geriatric Medicine Best Doctors, Inc.
	America's Best Hospital by U.S. News & World Report; Ranked 30th for Geriatrics.
	Fellow of the American Geriatrics Society, awarded May 2012, Baltimore, MD.
2012	The UCOP University of California's Center for Quality and Innovation Fellowship Program Award recipient
	Office of Educational Affairs MVP Outstanding Service Award, UC Irvine School of Medicine
2007-2009	Orange County Medical Association Physicians of Excellence Award
2005	Primary Care Physician of the Month, Primary Care Medical Group, UC Irvine Medical Center
	SAGE Program of the Year Recipient: UCI Medical Center Health Assessment Program for Seniors
	Director of Health Assessment Program for Seniors (HAPS).
2003	Primary Care Physician of the Month, Primary Care Medical Group, UC Irvine Medical Center
1996	Dean's Award for Outstanding Community Service Stanford University School of Medicine

PROFESSIONAL MEMBERSHIPS

1997-present	American Association of Family Practice
1999-present	American Geriatrics Society
2002-present	Vulnerable Adult Specialist Team/Orange County Forensic Center
2004-present	Elder Death Review Team, Orange County
2005	Society for Teachers in Family Medicine
2009-present	Association of the Directors of Geriatric Academic Programs (ADGAP)
2014, 2017-present	Orange County Medical Association
2015-present	Member: NAGE (National Association for Geriatric Education)
2015-present	Orange County Aging Services Collaborative (OCASC)
2015-present	Orange County Healthy Aging Initiative (OCHAI)

ORGANIZATIONAL/LEADERSHIP

2006-present	Co-Chair with Chief Coroner: Elder Death Review Team, Orange County CA
2008-2013	Chair: Elder Abuse Special Interest Group, American Geriatrics Society
2011-2013, 2015	American Geriatric Society Annual Conference Submissions Reviewer
2012-2019	National Geriatric Certification Exam Committee, American Board of Internal Medicine (ABIM)
2012	Implemented Schwarz Center Rounds at UCI Health (DW Reynolds award)
2012-2014	Judge: Academy of Leaders of the 2012 Senior Care Hero Awards for SeniorServe, a community based organization serving older adults in Orange County
2012-2016	Founder, Geri-West, a consortium of Geriatric Medicine programs on the West Coast, 7 member universities: 1st Conference, Newport Beach, July 2012.
2016, 2018	Organizer/Moderator for UCOP Primary Care Collaborative UC wide, UC Irvine site meeting, May 2016, November 2018
2014-present	Director, UC Irvine Center for Excellence in Elder Abuse and Neglect
2017-present	Director, OC Elder Abuse Forensic Center
2017	Organizer/Lead for Geriatric Workforce Enhancement Program, Western Regional Conference, Anaheim, CA, December 2017
2019	Consultant to OC Family Court Judge on Limited Conservatorship form revision for proposal to California judicial committee
2019	Organizer, Lead for multi-site PCORI UC meeting at UCI, Dec 2019
2020	Community Suicide Prevention Initiative Leadership Group, Be Well OC member
2014-present	UCI Member of the UCOP Primary Care Collaborative
2019-present	UCI Member of the UCOP Population Health Steering Committee (Meets monthly and biannual strategic retreat)
2019-present	UCI Member for the UCOP Diabetes Initiative
2019-present	UCI Member for UCOP Population Health Pharmacy Workgroup
2020-present	UCI Future Health https://futurehealth.ics.uci.edu/ (To transform health systems away from hospitals and into the hands of each individual)
2017-present	OCSPA (Orange County Strategic Plan for Aging) Leadership Council-

	representing UC Irvine for county-wide approach to planning for an elder-friendly environment
2020-present	Chair, Data Taskforce Committee for OCSPA

UC Irvine School of Medicine/UC Irvine Health

2009-2014	Clerkship Course Directors Committee-Member
2009-2014	Geriatric Medicine: Undergraduate/Graduate Medical Education-Chair
2010-2014	Graduate Medical Education Committee Member
2002-present	UC Irvine Speakers Bureau
2012-2016	Interviewer: School of Medicine Admissions Committee
2012	Simulation Certified Instructor Training
2013, 2015	Psychiatry Chair Search Committee Member
2014-2016	Ambulatory Transformational Journey committee member
2014	Academy for Innovation in Medical Education (AIME), member
2014-present	UC Irvine Interdisciplinary Center on Family Violence, Steering Committee Member
2016-present	Chair, UC Irvine Health, Primary Care Collaborative
2017-present	ACO Medical Director for Health Net Blue and Gold: High Risk Patient Management
2016-2017	Family Medicine Chair Search Committee Member
2016-2018	Post-Acute Care Preferred Provider Network Steering Committee
2017-present	OCSPA (Orange County Strategic Plan for Aging) Leadership Council- representing UC Irvine for county-wide approach to planning for an elder-friendly environment
2017-present	Readmission Reduction Committee
2018-present	All of Us Research Program, Clinical Collaborator (PI- Dr. Anton-Culver)
2018-present	ACO MSSP Board Member
2018, 2019	UC Telehealth Summit attendee for UCI, 2018- UCSD, 2019-UCD
2019-present	Telehealth Implementation Committee
2019-present	Interviewer for new School of Pharmacy faculty
2019	Hospital at Home Committee member
2019	West Health Geriatric ED UCI rep from Geriatric Medicine/partnering with UCI ED for implementation

UC Irvine Department of Family Medicine/Division of Geriatric Medicine and Gerontology

2020	Archstone Endowed Chair of Geriatric Medicine designation; as Chief of Geriatrics, established Chair supported by Archstone Foundation
2014	Developed Normal Pressure Hydrocephalus (NPH) Geriatric assessment Program
2015-present	Department Family Medicine Executive Committee
2014-present	CCC member, Geriatric Fellowship
2014-present	Developed TeleHealth Program, iPAD pharmacy consults for community and telemedicine consults for nursing home care.
2013-2019	Developed collaboration between UC Irvine and CalOptima's Program for the All Inclusive Care of the Elderly (PACE), UC Irvine Health, Geriatric consultation, contract negotiations
2009-2014	Student Senior Partner Program, Co-leader
2013-2016	Chair, Merits and Promotions Committee
2012-present	Merits and Promotions Committee Member
2012-2016	Delivery System Reform Incentive Payment (DSRIP) Program: Project Leader - Increase Training of Primary Care Workforce, Expand Primary Care Capacity, Introduce Telemedicine, Expand Medical Homes, and Redesign of Primary Care
2012	MBTI Workshop Coordinator for Faculty/staff development at SeniorHealth Center
2006-present	Interviewer, Geriatric Medicine fellowship

FACULTY/PROFESSIONAL DEVELOPMENT

2020	Certificate for Leadership in Healthcare Transformation, UCI Merage School of Business
2019	Project ECHO Immersion Training, ECHO Institute, 3 days, Albuquerque, New Mexico, Nov 2019.
2019	Moxie Virtual Speaker Coaching series
2013-2014	Coaching for Physician Leadership
2012	The University of California's Center for Quality and Innovation Fellowship Program
January-June 2010	UC Irvine Leadership in Medicine Course - Prescription for Healthcare Lean Workshop, Johns Hopkins Medicine
2012	UC Irvine Leadership in Medicine Course - Prescription for Healthcare Lean Workshop, John Hopkins Medicine
February-May 2009	AMIA 10X10 Online Informatics Course, Oregon Health Sciences University
March 2007	Geriatric Medicine Leadership Training: California Geriatric Education Center/UCLA, Long Beach, CA
1999-2000	Family Medicine Faculty Development Fellowship, UC San Francisco
September 2001	Stanford University School of Medicine Faculty Development Program: Geriatrics in Primary Care (1 month)

SUPPORT

Support Cycle	Sponsor	Project Title	Role
2020-2021	US Department of Health and Human Services - Health Resources & Services Administration (Coronavirus Aid, Relief and Economic Security Act)	Assisting and Supporting Socially Isolated Seniors through Telehealth in the COVID-19 Pandemic: ASSIST ($90,000)	PI
2020 - 2021	UCI Office of the Vice Chancellor for Research	CRAFT Award for COVID-19. Basic, Translational and Clinical Research Funding Opportunity. ($60,000)	PI
2019 - 2024	US Department of Health and Human Services - Health Resources & Services Administration	Geriatric Workforce Enhancement Program: Technology Advanced Geriatrics: Together Educating, Advocating, and Mentoring (TAG- TEAM) ($3.75M)	PI
2019 - 2022	UniHealth Foundation	Social Work Intervention for Transforming Dementia Health Care: SWIFT-DC ($375,000)	Co-PI/Mentor
2019 - 2020	Altarum Institute	OC Community Eldercare Project ($30,000)	PI
2017 - 2021	Administration for Community Living	Orange County Harm Reduction Initiative: Combination of Trauma Informed Care & Case Management ($992,500)	PI
2017 - 2019	Longeveron, LLC	A Phase 2b, Randomized, Blinded and Placebo-controlled Trial to Evaluate the Safety and Efficacy of Longeveron Allogenic Human Mesenchymal Stem Cells Infusion in Patients with Aging	PI

2017 - 2019	West Health Institute	The 360 degree Caregiving Solution: Linking UC Irvine Health's PCMH Services and Community Based Services ($1.8M)	PI
2018 - 2023	Patient Center Outcomes Research Institute	Population-Based Comparison of Evidence-Based, Patient Centered Advanced Care Planning Interventions ($2.1M) UCLA Primary Site	UCI PI
2017- 2022	County of Orange	Elder Abuse Forensic Center ($571,127)	UCI PI
2018 - 2021	BlueShield of California Foundation	Women's Health Project- Orange County Health and Domestic Violence System Integration Project	Director
2016 - 2019	US Department of Health and Human Services - Health Resources & Services Administration	Geriatric Workforce Enhancement Program: Cultivating a Culture of Caring for Older Adults C^3OA ($3.3M)	PI
2017 – 2018	Institute for Clinical and Translational Science Campus-Community Research Incubator (CCRI)	Dementia Care for Underserved Asian American Communities in Orange County: A Pilot Education Intervention and Qualitative Needs Assessment ($7,600)	Co-PI
2016 - 2017	UniHealth Foundation	A Comprehensive Agile Response Team for Dementia Care: CART-DC ($150,000)	PI
2016 - 2017	University of Southern California (USC)	The Physician Handbook for Medical Assessment of Elder Abuse & A Guide for Elder Abuse Response (368/GEAR)	Subcontractor PI
2014 - 2015	Institute for Clinical and Translational Science	Crime and Personal Safety: Ethnic Differences in Senior Living Needs in Orange County" Campus Community Research Incubator Grant Institute for Clinical and Translational Science ($10,000)	PI

2011 - 2012	Center for Future Health Care Professionals, UC Irvine	Developing High School Interest Group in Primary Care ($1,750 grant)	Co-PI
2008 - 2011	United States Department of Justice and The National Institute of Justice	Coroners' Investigations of Suspicious Deaths	Co-PI
2010 - 2011	Center for Future Health Care Professionals, UC Irvine	Developing High School Interest Group in Geriatrics ($1,000 grant)	PI
2009 - 2011	National Multiple Sclerosis Society	The Challenge of Giving Care to People with Multiple Sclerosis	Co-PI
2009 - 2010	US Department of Health and Human Services-Health Resources & Services Administration	Subcontract UCLA Geriatric Education Center, Physical Abuse of Elders: Medical Aspects and Psychosocial Dynamics	PI
2009 - 2013	Donald W. Reynolds Foundation	Communication: The Art of Geriatric Medicine (Physicians Training in Geriatrics) 4 years/$2,000,000 grant	PI (2011-2013) Co-PI (2009-2010)
2006 - 2008	National Institute on Aging	Development and Validation of a Criterion Standard for Elder Mistreatment	Co-PI
2006 - 2007	National Institute of Justice	Bruising as a Forensic Marker of Physical Elder Abuse	Co-PI
2006 - 2007	Los Feliz Foundation	Elder Abuse Education	Co-PI
2006 - 2007	Archstone Foundation	The Center of Excellence on Elder Abuse and Neglect	Co-PI
2005 - 2008	UniHealth Foundation	Elder Abuse Training Institute	Co-PI
2004-2006	US Department of Health and Human Services-Health Resources & Services Administration	Geriatric Academic Career Award	PI

2004-2007	State of California Department of Health Services, California Alzheimer's Disease Program	Abuse of Elders with Dementia: Toward a Model of Prediction	Co-PI
2004 - 2005	US Department of Health and Human Services-Health Resources & Services Administration	Training in Primary Care Medicine and Dentistry: Research Mentoring Program Role: Program Participant Principal Investigator: Kathryn Larsen, MD	Program Participant
2003 - 2006	Archstone Foundation	Medical Forensic Center on Elder Abuse and Neglect	Clinical Evaluator

MEDIA

1. Forensic Skills Seek to Uncover Hidden Patterns of Elder Abuse, The New York Times September 27, 2006.

2. Interview: Satellite radio station and web portal Reach MD (XM Radio XM157), "Elder Abuse: Neglect", October 2008.

3. Teaching Doctors What Older Patients Need, Orange County Business Journal, July 27-August 2, 2009 Vol. 32 No. 30.

4. Panelist: Expert Chat Webinar: Forensic Markers and Elder Abuse March 2011, http://innovations.harvard.edu/event/elder-abuse-series-forensic-markers.

5. Guest speaker: REAL ORANGE at PBS SoCal. Topic: UCI Medical Center Geriatrics Program Recognized In *US News & World Report*, July 2012.

6. Lisa Gibbs Innovation Profile, October 31, 2012, health.universityofcalifornia.edu/2012/10/31/innovationprofile-lisa-gibbs/.

7. UCI Implementing New Model for Patient-Centered Senior Care – Physicians News Network: OC County, December 1, 2013.

8. UC Irvine Ageless Lessons in Doctoring – Senior partners offer first-year medical students an Education in caring for older adults, Orange County Register, January 6, 2014.

9. GERiteam Mobile App, designed to promote communication and collaboration within outpatient Geriatric health care teams. February 14, 2014. Published in the Apple Store for learners in Interdisciplinary Team Training and Geriatrics, Olsen B, Youm J, Gibbs L and O'Toole E. University of California, Irvine, 2014.

10. SeniorHealth Center is designated as patient-centered medical home. October 7, 2014. Published in UC HEALTH.

11. Interviewed for, 'Where was I supposed to go?' Pilot program helps elder abuse victims, whose O.C. numbers are on the rise. The Orange County Register, March 23, 2015.

12. "How to Detect Elder Abuse" Warnings Signs to detect Elder Abuse. U.S. News & World Report, September 28, 2015.

13. "Grant to fund training for geriatric healthcare workers", California Health Report September 28, 2015.

14. "Holidays a time for celebration with older relatives, friends and to recognize their needs", UC Irvine Health, November 16, 2015

15. "Big money in nursing home therapy, but is all the treatment necessary?" OC Register, February 29, 2016.

16. "Clashes at nursing homes not uncommon", HealthDay, June 13, 2016, and Arizona Daily Star, Associated Press, June 2016.

17. Living Well, UC Irvine, Summer 2017.

18. Orange Coast Magazine feature for Physician of the Year, June 2017

19. NPR Radio, Larry Mantel show: Mental Health of Older Adults during COVID, March 2020

20. NPR Radio: Food program: Shopping Hours for Seniors, March 2020

21. "Phone pals? For UC Irvine med and nursing students students, and older people dodging the virus, a call can be a lifeline." OC Register, June 2020

22. "Delaying medical care can be harmful to older adults", Advertorial, Orange Coast magazine, Sept 2020.

CONFERENCE PROCEEDINGS, PAPERS, OTHER

1. Zanin N, Oakes O, Wiglesworth A, Austin R, Gibbs L, Mosqueda L. Poster on Suspicious elder deaths: a thematic analysis of factors influencing investigation, The American Geriatrics Society (AGS) 2013 Annual Scientific Meeting, Grapevine, TX, May 2-May 5, 2013.

2. Gibbs L, Austin R, Boicey C, Hoppe J. Poster on Innovations in the Healthcare of Older Patients – Remote Home Monitoring Pilot Study, American Nursing Informatics Association (ANIA) national meeting in Las Vegas, NV, March 27 – 29, 2014.

3. Lee JA, Nguyen H, Sorkin D, Rousseau J, Milbury B, Gibbs L. Poster on Perceptions of health in Underserved Seniors: Needs Assessment, Western Institute of Nursing's Annual Communicating Nursing Research Conference in Denver, Colorado, April 19-22, 2017.

4. Lee JA, Nguyen H, Rousseau J, Gibbs L, Sorkin D, Zaragoza M, Nyamathi A. Perceived Experiences and Unmet Needs of Asian American Dementia Family Caregivers. (2017, May). American Geriatric Society Conference, Orlando, FL.

5. Behnawa S, Gibbs L, Vo B, Tran Chinh TA, Lau H, Tran LH. Poster on UC Irvine Residents Get Up and Go! Integrating Geriatric Specialty Care into Continuity Panels, Society of Teachers of Family Medicine (STFM) Annual Spring Conference in San Diego, CA, May 5-9, 2017.

6. Lee JA, Nguyen H, Sorkin D, Rousseau J, Milbury B, Gibbs, L. Poster on The Health Needs of Diverse Older Adults Being Served by the HRSA Geriatric Workforce Enhancement Program (GWEP) in Orange County, CA, American Geriatrics Society (AGS) 2017 Annual Scientific Meeting in San Antonio, TX, May 18-20, 2017.

7. Kivlanhan C, Pellegrino K, Grumbach K, Skootsky S, Raja N, Gupta R, Clark R, Balsbaugh T, Ikeda T, Friedman L, Gibbs L, Todoki E. Presented on Calculating Primary Care Panel Size, Primary Care Collaborative, Oakland, CA, January 2017.

8. Lee JA, Milbury B, Nguyen T, Kim J, Rousseau J, Fitzpatrick C, Evangelista L, Guo Y, Sorkin D, Gibbs L. Training of In-home Supportive Service Caregivers on Older Adult Care Western Institute of Nursing Annual Meeting, Spokane, WA, April 2018.

9. Lee JA, Nguyen H, Park J, Tran L, Nguyen T, Huynh Y, Sorkin D, Gibbs L. Smartphone APP-Based Education for Asian-American Dementia Family Caregivers. Spokane, WA, April 2019.

10. Fitzpatrick C, Di Sano A, Sehgal S, Sorkin D, Wen A, Chodos A, Watanabe JH, Chau D, Gibbs L. Poster on GWEP Coordinating Center Networking Meeting: American Geriatrics Society (AGS) 2018 Annual Scientific Conference in Orlando, Florida, May 3-5, 2018.

11. Burton C, Lee JA, Waalen A, Sorkin D, Fitzpatrick C, Gibbs L. Poster on Asian Older Immigrants' Perceptions on Depression, Dementia and Elder Abuse: American Geriatrics Society (AGS) 2018 Annual Scientific Conference in Orlando, Florida, May 3-5, 2018.

12. Fitzpatrick C, Talamayan-Pascua R, Behnawa S, Gibbs L. Poster on Impact of educational level on the performance of the Clock Draw Test: A preliminary study: American Geriatrics Society (AGS) 2018 Annual Scientific Conference in Orlando, Florida, May 3-5, 2018.

13. Morris AM, Engelberg JK, Pashaee S, Vincent M, Corzo G, Sehgal S, St-Onge F, Gibbs L. Poster on Improving care for seniors: Understanding processes to address unmet social needs, American Geriatrics Society (AGS) 2018 Annual Scientific Conference in Orlando, Florida, May 3-5, 2018.

14. Burton C, Lee JA, Waalen A, Sorkin D, Fitzpatrick C, Gibbs L. Poster presented at Presidential Poster Session: LGBT elders and US health care systems: experiences and unmet needs. American Geriatrics Society (AGS) 2018 Annual Scientific Conference in Orlando, Florida, May 3-5, 2018.

15. Lee JA, Rousseau J, Kang K, Diep H, You SY, Lee JW, Le C, Hong KJ, Sorkin D, Gibbs L. Community-based dementia care education for underserved Asian Americans. Western Institute of Nursing annual meeting, San Diego, CA, April 2019.

16. Engelberg JK, Morris, AM, St-Onge F, Pashaee S, Seghal S, Sorkin D, Gibbs L. Poster on Developing a Senior-Specific Screener: Identifying and Addressing Social Determinants of Health for Seniors: WestHealth Institute, AGS, Portland, Oregon, March 2019.

17. Di Sano A, Lee JA, Evangelista L, Milbury B, Tiso S, Gibbs L. Poster on Educating Nursing and Caregiver Workforces through a unique Pilot Program: American Geriatrics Society (AGS) 2019 Annual Scientific Conference in Portland, Oregon, May 2-4, 2019.

18. Dolouei RT, Di Sano A, McGuire C, Gibbs L. Poster on Transitions of Care in a FQHC: Addressing unique needs with a post-hospitalization clinic: American Geriatrics Society (AGS) 2019 Annual Scientific Conference in Portland, Oregon, May 2-4, 2019.

19. Sehgal S, Sauval M, Fitzpatrick C, Sorkin D, Di Sano A, Gibbs L. Poster on Cultivating a Culture of Caring for Older Adults within a Large Health System in O.C.: American Geriatrics Society (AGS) 2019 Annual Scientific Conference in Portland, Oregon, May 2-4, 2019.

20. Chen S, Rodriquez L, Sole J, Reynaga R, Gibbs L. Poster on The Orange County Elder Death Review Team County Report: American Geriatrics Society (AGS) 2019 Annual Scientific Conference in Portland, Oregon, May 2-4, 2019.

21. Gibbs L, St.-Onge F, Engelberg JK, Pashaee S, Sehgal S, Mukamel D, Sorkin D, Schmitthenner B, Corzo G, Morris AM. Poster on Improving Care for Senior Patients: Developing the 360* Caregiving Solution to Identify and Address Unmet Social Needs: American Geriatrics Society (AGS) 2019 Annual Conference in Portland, Oregon, May 2-4, 2019.

22. Gibbs L. UC Health Care Planning Study Team. Three Health System Efforts to Semi-Automate Targeted Advance Care Planning Among Seriously Ill Primary Care Patients. Presented at: EPIC's 2019 Users Group Meeting, August 24-27, 2019; Verona, WI.

23. Lee JA, Kehoe P, Gibbs L. A Home-Visit Pilot Intervention to Promote Communication Skills and Well-Being for Dementia Family Caregivers. Paper presented at Gerontological Society of America 2019 Annual Scientific Meeting: Innovation in Aging. November 2019

24. Lee J, Campbell S, Rousseau J, Di Sano A, Gibbs, L. Geriatric in-home caregivers' support: a community and academic partnership for cultural and linguistic tailored education. Paper accepted for American Geriatric Society (AGS) 2020 Annual Conference: Session on Improving Communication with Diverse Older Adults. Long Beach, CA, May 8, 2020. Winner of an AGS 2020 Best Paper Award.

25. Lowerson Bredow V, Gibbs L, Robles B, Fowler, C. Poster on OC Harm Reduction Initiative: accepted for the American Geriatrics Society (AGS) 2020 Annual Conference in Long Beach, CA, May 6-8, 2020. (published due to COVID)

26. Kompala T, Cabrera M, Christian MJ, Lambrechts S, Mowers R, Sak R. For the UC Diabetes Initiative Group (L. Gibbs, member). University of California Diabetes Initiative: A Multi-Institution Collaboration to Improve Diabetes Care. Presented at American Diabetes Association Virtual Scientific Sessions June 13-16, 2020.

27. Walling AM, Sudore R, Ritchie C, Gibbs L, Rahimi M, Sanz J, Bell D, Lee JA, Thomas J, Wenger N. Poster on Getting Everyone on the Same Page: Key Components of an Implementation Process for a Large Pragmatic Randomized Trial Across Three Health Systems. Accepted for RAPiD Poster at AAHPM State of the Science (presentation delayed due to COVID).

28. Walling AM, Sanz J, Bell D, Sudore R, Ritchie C, Gibbs L, Rahimi M, Patel K, Pickell K, Wenger N. Using the Electronic Health Record to Identify a Cohort of Seriously Ill Patients from a Primary Care Population Across Three Academic Health Systems. Accepted for Presentation at AAHPM State of the Science (presentation delayed due to COVID).

29. Lee JA, Rousseau J, Saville N, Brown S, Nguyen H, Gibbs L. Nursing Student Led Online COVID-19 Education for In-Home Supportive Service Caregivers. Innovations in Workforce Education for Family Caregiving Virtual Summit, Accepted for Presentation at UC Davis, September 2020.

30. Tam S, Bredow V, Robles B, Odom M, Conger L, Barrett N, Gibbs L, Social Work Interventions for Transforming Dementia Care (SWIFT-DC). Innovations in Workforce Education for Family Caregiving Virtual Summit, Accepted for Presentation at UC Davis, September 2020.

31. .

REVIEWER

1. Primary Care Monograph Series: "Medical Management of Renal Stones", Urinary Tract Infections", Hematuria", Incontinence", American Urological Association, 2012.

2. Annual Wellness Toolkit for Orange County Healthcare Agency (OCHA), 2013.

3. "Preoperative risk factors of postoperative delirium after transurethral prostatectomy for benign prostatic hyperplasia" Manuscript ID END-2014-0831-OR for the Journal of Endourology, December 2014.

4. Institute of Clinical and Translational Science, NIH activity

    a. ICTS Pilot Funding 2016
    b. Community-Campus Research Incubator, UCI 2016
    c. Clinical and Translational Science Awards (CTSA) Program of the NIH National Center for Advancing Translational Sciences (NCATS) reviewer, 2020

5. California Department of Public Health, Alzheimer's Disease Program (1.6M funding) March 2016.

6. Human Resources and Services Administration (HRSA), U.S. Department of Health and Human Services: Geriatric Academic Career Award review, 7/10-11, 2019.

7. "Lesbian, Gay and Bisexual Older Adults: What Predicts Adjustment to Aging?" SRSP-D-20-00065, for Sexuality Research and Social Policy, 5/20.

8. Journal of Geriatric Emergency Medicine, 2020- present.