Yukon
Health and Social Services

Form 2 (CCA)
CARE CONSENT ACT
Section 61

CERTIFICATE OF NEED FOR FINANCIAL PROTECTION

INSTRUCTIONS

This form must be filled out by a health care provider. Copies of this form must be provided to the:

- ☐ Public Guardian and Trustee; and
- ☐ care recipient.

Re: _____
Print full name

of _____
Home address

currently residing at _____,
Name of facility or other current place of residence

health insurance number _____, telephone number _____.

I, _____
Print name of health care provider

of _____state that:
Print name of medical clinic or health care facility

1. On _____ I determined that the above-named person is incapable of giving or refusing consent to a care decision regarding _____.
   Date (day/month/year)
   Care decision or treatment decision found incapable of making

2. I observed the following facts indicating incapability to give or refuse consent to the above-named decision (i.e., unable to understand and appreciate the likely consequences of the decision and that it applies to their own situation).

   _____

   _____

   _____

   _____

3. The following facts, if any, indicating incapability to consent to the care decision, were communicated to me by others. *(State facts and source of information.)*

   _____

   _____

   _____

   _____

   _____

4. I understand that the above-named person is required to make the following financial decisions.

☐ pay bills	☐ manage investments	☐ handle large sums
☐ pay debts	☐ do income tax return	☐ balance accounts
☐ handle small currency	☐ pay monthly rent or mortgage	☐ make tax payments
☐ manage a business	☐ write cheques	☐ other _____

5. I observed the following facts indicating incapability to make reasonable judgements or decisions regarding the above financial decisions (i.e., unable to understand and appreciate the likely consequences of their financial decisions and/or unable to carry out decisions).

6. The following facts, if any, indicating incapability to make reasonable financial judgements or decisions were communicated to me by others. *(State facts and source of information.)*

7. Please provide any details of the person's estate that you are aware of (e.g., bank accounts, bills) that will be relevant to the management of the person's estate.

8. Contact information for the substitute decision-maker or other family member or friend who may be able to supply information on the person's financial affairs to the public guardian and trustee:

_____
Print full name of contact person

_____ _____
Address Phone number

9. I believe on reasonable grounds, that because of a health condition, namely,

_____, the above-named person is incapable of making reasonable decisions regarding their financial affairs for these reasons:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DATED at _____,

this_____ day of_____ , _____.
month year

_____
SIGNATURE OF HEALTH CARE PROVIDER

_____
PRINTED NAME OF HEALTH CARE PROVIDER

_____
SIGNATURE OF WITNESS

Information on this form is being collected, pursuant to the *Care Consent Act,* to meet the requirements for a valid Certificate of Need for Financial Protection. For more information, contact the Health and Social Services ATIPP Coordinator (H-1), Box 2703, Whitehorse Yukon Y1A 2C6, (867) 667-3010.