ADULTS WITH INCAPACITY - (SCOTLAND) ACT 2000

Application form
Access to funds ATF (2) (Version 3)
Individual(s)

Please refer to the guidance notes to assist with completion

Section 1 - Personal information

Section 1.1 - Current details of the adult

Title		House/no	
Forename		Street	
Middle name		Locality	
Surname		City	
Date of birth		County	
Tel no		Country	
E-mail address		Post code	

Ethnic origin
(Please tick as appropriate)

White Scottish	☐	Other White British	☐	White Irish	☐
Other White	☐	Indian	☐	Pakistani	☐
Bangladeshi	☐	Other (South Asian)	☐	Chinese	☐
Caribbean	☐	African	☐	Black Scottish and Other Black	☐
Mixed	☐	Other	☐		

A copy of this application will be sent to the person named above, if you consider this should not be sent as it would pose a serious risk to their health please tick the box. ☐

By ticking this box you are required to lodge the enclosed SSI No 79 medical certificate with the application. This must be completed by two registered and licensed medical practitioners, one of whom must be a specialist under the terms of the Mental Health Care & Treatment Act. If you previously submitted this with an ATF (1) application and were issued with a certificate of authority you are not required to complete again for this application.

SIMPLY TO INDICATE THAT THEY WOULD NOT UNDERSTAND THE APPLICATION OR WOULD BE UPSET BY IT IS NOT SUFFICIENT GROUNDS FOR NON-INTIMATION.

Section 1.2 - Details of applicant(s)

Applicant 1

Title		House/no	
Forename		Street	
Middle name		Locality	
Surname		City	
Tel no		County	
E-mail address		Country	
Relationship (e.g. spouse, son, friend, professional etc.)		Post code	

Applicant 2

Title		House/no	
Forename		Street	
Middle name		Locality	
Surname		City	
Tel no		County	
E-mail address		Country	
Relationship (e.g. spouse, son, friend, professional etc.)		Post code	

if there are more than two applicants, please continue on a separate page

Section 1.3 - Details of the reserve withdrawer
(Not applicable if joint applicants applying)

Title		House/no	
Forename		Street	
Middle name		Locality	
Surname		City	
Tel no		County	
E-mail address		Country	
Relationship (e.g. spouse, son, friend, professional etc.)		Post code	

Section 1.4 - Details of the nearest relative

Title		House/no	
Forename		Street	
Middle name		Locality	
Surname		City	
Tel no		County	
E-mail address		Country	
Relationship (e.g. spouse, son etc.)		Post code	

If there has been a court order naming the above as nearest relative please tick this box. ☐

Section 1.5 - Details of the primary carer

Title		House/no	
Forename		Street	
Middle name		Locality	
Surname		City	
Tel no		County	
E-mail address		Country	
Relationship (e.g. spouse, son, friend, care manager etc.)		Post code	

Section 1.6 - Details of any named person, attorney, intervener or guardian

Title		House/no	
Forename		Street	
Middle name		Locality	
Surname		City	
Organisation		County	
Tel no		Country	
E-mail address		Post code	

Please indicate role

Named person ☐ attorney ☐ intervener ☐ guardian ☐

if more than one role applies please use a separate page

Section 1.7 - Details of any interested parties
e.g. other family members, friend, advocate etc.

Title		House/no	
Forename		Street	
Middle name		Locality	
Surname		City	
Tel no		County	
E-mail address		Country	
Relationship:		Post code	

Title		House/no	
Forename		Street	
Middle name		Locality	
Surname		City	
Tel no		County	
E-mail address		Country	
Relationship:		Post code	

Title		House/no	
Forename		Street	
Middle name		Locality	
Surname		City	
Tel no		County	
E-mail address		Country	
Relationship:		Post code	

Title		House/no	
Forename		Street	
Middle name		Locality	
Surname		City	
Tel no		County	
E-mail address		Country	
Relationship:		Post code	

Please use a separate page if necessary

Section 2 - Financial information

Section 2.1 - Department for Work & Pensions (DWP) appointee

Are you or another person in receipt of their DWP pension, benefits or allowances?

Yes ☐ No ☐ Date first payment received

If **yes**, this application should only be used to request funds required in addition to DWP pension, benefits or allowances, e.g. savings, occupational/private pension or other income.

Section 2.2 - Details of existing account in sole name

If there is an existing current type bank/building society account in their sole name which is suitable for setting up standing orders/direct debits please provide full details below. This account will be referred to as the **current acccount**. If this type of account is required please complete section 2.3

Bank/Building Society	
Branch name	
No/building	
Street	
Locality	
City	
County	
Country	
Post code	
Sort code	
Account number	
Account holder	

Section 2.3 - Details of proposed new account in sole name

Once open, this account will be referred to as the **current account**

Bank/Building Society	
Branch name	
No/building	
Street	
Locality	
City	
County	
Country	
Post code	
Sort code	
Account holder	

Section 2.4 - Second account

Is there a bank account in his/her sole name which you would wish to operate as a second account?

Yes ☐ No ☐

If **yes**, please provide details below.

Bank/Building Society	
Branch name	
No/building	
Street	
Locality	
City	
County	
Country	
Post code	
Sort code	
Account number	
Account holder	

If **no**, do you wish authority to open a second account in his/her sole name?

Yes ☐ No ☐

If **yes**, please provide details below.

Bank/Building Society	
Branch name	
No/building	
Street	
Locality	
City	
County	
Country	
Post code	
Sort code	

Section 2.5 - Transfer of funds on existing accounts

Where there are several accounts in his/her sole name it may be that you need to close or transfer funds between these.

Please identify the accounts below and give specific details oif what you want to do.
(If you wish to close an account please indicate "full amount").

	Transfer from	Transfer to	Amount £
Bank/Building Society			
Sort code			
Account number			
Account holder			

Do you wish to close this account? Yes ☐ No ☐

	Transfer from	Transfer to	Amount £
Bank/Building Society			
Sort code			
Account number			
Account holder			

Do you wish to close this account? Yes ☐ No ☐

	Transfer from	Transfer to	Amount £
Bank/Building Society			
Sort code			
Account number			
Account holder			

Do you wish to close this account? Yes ☐ No ☐

If there are more sole accounts, please use an additional page

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Section 2.6 - Details of any direct debits/standing orders on the current account which you wish to continue or set up

Name of company to whom payment is to be made (e.g. Scottish Power, Aviva)		Monthly amount £
Continue:		
Set up:		

Section 2.7 - Use of funds

Reason for expenditure	Monthly amount £
Care charges	
Clothing	
Personal allowance	
Mortgage	
Rent	
Council tax	
Gas	
Electricity	
Telephone (including mobile phones and special telephone services)	
TV licence	
Insurances (building, contents, motor, personal, pets etc.)	
Loan repayments	
Food and household expenses	
Holidays/outings	
Transport costs	
Club or other subscriptions	
Gifts	
Other (Please specify)	
Total monthly amount £	0

Section 2.8 - One off lump sum
One off payments/lump sums
(please specify)

Reason for expenditure	Amount £
Total lump sum £	0

Account from which the lump sum will be transferred

the existing current account in Section 2.2 Yes ☐ No ☐

the existing second account in Section 2.4 Yes ☐ No ☐

Section 2.9 - Additional information

Additional information to support your application e.g. background

Section 3 - Undertaking and declaration by applicant(s)/reserve

Undertaking

I understand that it is my responsibility to keep records of the exercise of my powers as withdrawer and notify the Office of the Public Guardian directly and immediately of any change of circumstances involving myself or the adult, for example, change of address, death of adult etc.

I undertake to:

a) open a designated account solely for the purpose of receiving funds transferred under the authority of any certificate granted and intromitting with those funds; and

b) operate any accounts in the sole name of the adult as directed by my certificate of authority.

Declaration

I declare that all information contained in this application is true and correct to the best of my knowledge and I understand that false or misleading information may lead to the rejection of this application or the termination of any authority already granted.

I confirm that the Office of the Public Guardian is authorised to contact appropriate bodies as it sees fit in order to seek such information as they consider reasonable in pursuance of this application.

The Office of the Public Guardian will retain and process the information provided herein on computer. This processing is necessary for the exercise of the statutory functions conferred by the Adults with Incapacity (Scotland) Act 2000. By signing below I understand that I consent to this information being processed, stored and used by the Office of the Public Guardian in the discharge of its function.

Signature of applicant	
Print name	
Date	

Signature of joint/ reserve		Signature of joint/ reserve	
Print name		Print name	
Date		Date	

Section 4 - Countersignatory information

This section does not require to be completed when the information has already been supplied in form ATF(1)

Title	
Forename	
Middle name	
Surname	
House/no	
Street	
Locality	
City	
County	
Country	
Post code	
Tel no	
Email address	
Relationship to applicants(s) (e.g. friend, neighbour, colleague)	

Please note that we may contact the countersignatory in relation to this application

Declaration of countersignatory

I declare that I have known

_____

(insert name(s) above)

for at least one year prior to the signing of the foregoing application and I believe them to be a fit and proper person(s) to intromit with the adult's funds. I further believe that the information contained in this application to be true.

I am not:

a) a relative or person residing with the applicant(s) or the adult; or

b) a director or employee of the fundholder; or

c) a solicitor acting on behalf of the adult or any other person mentioned in this sub paragraph in relation to any matter under this Act; or.

d) the medical practitioner who has signed the medical certificate in connection with this appication; or

e) a guardian of the adult or a welfare or continuing attorney of the adult; or

f) a person who is authorised under an intervention order in relation to the adult.

Please delete below

a) I have no pecuniary interest in this application.

b) I have a pecuniary interest in this application.

The nature and extent of any pecuniary interest is:

The countersignatory must now answer the question below providing as much relevant information as possible.

Please comment below on how you feel that the applicant is a fit and proper person with the ability to carry out the functions of withdrawer

Signature of countersignatory	
Print name	
Date	

THE APPLICATION MUST BE LODGED WITH THIS OFFICE WITHIN 14 DAYS OF THIS DATE.

Checklist for applicant:

- ☐ Have you completed all relevant sections?
- ☐ Has evidence been enclosed to support all requests for funds?
- ☐ Have all applicant(s) and/or reserves signed and dated the form?
- ☐ Has the form been countersigned and dated?
- ☐ Is the application form being submitted within 14 days of the date it was signed by the countersignatory?
- ☐ Where appropriate, have medical certificate(s) been completed and enclosed?
- ☐ Have you included any additional information to support the application?
- ☐ Where appropriate have you enclosed relevant fee? Please see our website for current fees or telephone us. Cheques should be made payable to the 'Scottish Courts & Tribunals Service'. Alternatively you may pay be debit card prior to posting your application.

If you wish to pay by BACS please ensure you quote 'ATF' and the adult's surname as a reference, please also mention the fee is being paid by this method in your cover letter. Our bank account number is 00650476 sort code 83-20-32.

It is advisable to have the application and enclosures weighed at the Post Office to ensure that the correct postage is applied.

Please print, sign and send to:

Office of the Public Guardian (Scotland)
Hadrian House
Callendar Business Park
Callendar Road
FALKIRK
FK1 1XR

DX: 550360 Falkirk 3

Telephone: 01324 677140
Website: www.publicguardian-scotland.gov.uk
Email: OPGATF@scotcourts.gov.uk
Twitter: @OPGScotland

Print Form Reset Form

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Scottish Statutory Instrument 2008 No. 51

Regulation 3

Adults with Incapacity (Scotland) Act 2000 ("the Act")

Certificate of incapacity to accompany an application to the Public Guardian under section 24C, 24D or 25

I ..... (Full Name)

of .....

(Professional Address) in my capacity as ..... (1)

have examined the following patient on ..... (Date),

..... (Patient's Name)

of .....

..... (Address) ..... (Date of Birth)

I am of the opinion that he/she is incapable in relation to decisions about, or incapable of acting to safeguard or promote his/her interests in, the funds.

I am of the opinion that the patient named above is incapable in terms of section 27B of the Act because of:

mental disorder(2) and/or

inability to communicate because of physical disability(3)

Brief description of mental disorder/inability to communicate .....

.....

.....

(Signed) .....

(Date) .....

(1) the person signing the certificate must be a registered and licenced medical practitioner; insert as appropriate, e.g. GP, specialist in mental disorder

(2) mental disorder has the meaning given to it in section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003, namely that it means any mental illness; personality disorder or learning disability however caused or manifested, but an adult is not mentally disordered by reason only of sexual orientation; sexual deviancy; transsexualism; transvestism; dependence

(3) on,or use of, alcohol or drugs; behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person; or acting as no prudent person would act.

(4) one of these **must** be deleted unless both apply.

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Scottish Statutory Instrument 2001 No 79

Adults with Incapacity (Scotland) Act 2000 ("the Act")

Evidence to inform decision to dispense with notification to adult with incapacity in terms of Sections 7(1)(d) and 11(2) of the Act.

IMPORTANT: This form is to be completed by two medical practitioners.

A: First Medical Practitioner

I ..... (Full Name)

of ..... (Professional Address)

have examined the following patient on ..... (Date), in my capacity as

..... *

to ..... (Patient's Name)

..... (Date of Birth), of .....

..... (Patient's Address)

I am of the opinion that it would pose a serious risk to the health of the patient named above for the Public Guardian to notify him/her of an application under Section 26 of the Act for the authority to intromit with funds.

the reason for this opinion is .....

.....

..... (Signed) ..... (Date)

B: Second Medical Practitioner

I ..... (Full Name)

of ..... (Professional Address)

have examined the following patient on ..... (Date), in my capacity as

..... *

I am of the opinion that it would pose a serious risk to the health of the patient named above for the Public Guardian to notify him/her of an application under Section 26 of the Act for the authority to intromit with funds.

the reason for this opinion is .....

.....

..... (Signed) ..... (Date)

* the person signing the certificate must be a medical practitioner; insert as appropriate, e.g. GP, specialist in mental disorder - insert as appropriate

NOTES (FOR COMPLETION OF SSI 79)

Under section 11(2) of the Act, we may dispense with intimation or notification to an adult under the Act, if it is considered that this would be likely pose a serious risk to their health. Under section 7(1)(d) of the Act, the Scottish Ministers prescribe the evidence which we shall take into account when deciding under section 11(2) whether to dispense with intimation or notification.

This certificate (SSI 79) should be used to provide such evidence when it is necessary. It should be attached to the certificate of capacity (SSI 51) and accompany an application made under section 26 of the Act for authority to intromit with funds.

The Adults with Incapacity (Evidence in Relation to Dispensing with Intimation or Notification) (Scotland) Regulations 2001 prescribe that intimation or notification may be dispensed with on production of certificates from two medical practitioners that such intimation or notification would pose a serious risk to their health. The regulations also prescribe that:

- The two medical practitioners **must** be independent of each other

- In any case where the incapacity of the adult is by reason of mental disorder, one of the two medical practitioners **must** be a medical practitioner approved for the purposes of Section 22 of the Mental Health (Care and Treatment)(Scotland) Act 2003 as having special experience in the diagnosis or treatment of mental disorder.

BOTH SECTIONS OF THIS CERTIFICATE (SSI 79) MUST BE COMPLETED AND THE TWO DOCTORS SIGNING MUST FULFIL THE REQUIREMENTS ABOVE.