ADULTS WITH INCAPACITY
(SCOTLAND) ACT 2000

Access to Funds ATF(2) (version 2) Application Form

PLEASE REFER TO THE GUIDANCE NOTES TO ASSIST WITH THE COMPLETION OF THIS FORM

Section 1 - Personal Information

Section 1.1 – Current Details of the Adult

Title:	
Surname:	
Forename:	
Middle Name:	
Date of Birth:	
House Name:	
House Number:	
Street:	
Locality:	
City:	
County:	
Country:	
Post Code:	
Tel No:	
E-Mail Address:	

Ethnic Origin of the Adult

(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 adult and other persons identified in this application. If you consider that a copy of the application should not be sent to the adult as it would pose a serious risk to the adult's health please tick the box. ☐

Simply to indicate that the adult would not understand the application or would be upset by it is not sufficient grounds for non intimation.

If you have ticked the above box the Public Guardian will require you to lodge with this application an additional medical certificate (in the form of SSI No 79) completed by two registered and licensed medical practitioners. One medical practitioner must be a specialist under the terms of the Mental Health Care & Treatment Act. A copy of form SSI No 79 is enclosed.

If you previously submitted a medical certificate (SSI No 79) on a request for bank account information application form and were issued with a letter of authority to contact a bank/building society etc you are not required to complete it again for this application.

Section 1.2 - Details of Applicants (Individuals Only)

	Applicant 1	Applicant 2
Title:		
Surname:		
Forename:		
Middle Name:		
House Name:		
House Number:		
Street:		
Locality:		
City:		
County:		
Country:		
Post Code:		
Tel No:		
E-Mail Address:		

Please identify relationship to the adult: (If family member please state exact relationship)

Applicant 1

Family Member: (i.e. spouse, son etc.) ☐ Friend: ☐ Professional: ☐

Applicant 2

Family Member: (i.e. spouse, son etc.) ☐ Friend: ☐ Professional: ☐

If more than two applicants, please continue on a separate sheet.

Section 1.2 - Details of the Applicant (Organisations Only)

Organisation:	
Department:	
Number:	
Street:	
Locality:	
City:	
County:	
Country:	
Post Code:	
Organisation List Number:	

Nominated Contact for Organisation

Surname:	
Forename:	
Middle Name:	
Contact Person's Designation:	
Street:	
Locality:	
City:	
County:	
Country	
Postcode:	
Tel No:	
E-Mail Address:	

Details of a contact person within the organisation must be supplied and this person should read and complete section 3 on behalf of the organisation. This will be the person who will be sent the Certificate of Authority.

Section 1.3 - Details of the Reserve Withdrawer - (not applicable if joint applicants or an organisation is applying)

Title:	
Surname:	
Forename:	
Middle Name:	
House Name:	
House Number:	
Street:	
Locality:	
City:	
County:	
Country:	
Post Code:	
Tel No:	
E-Mail Address:	

Please identify relationship to the adult: (If family member please state exact relationship)

Family Member: (i.e. spouse, son etc.) ☐ Friend: ☐ Professional: ☐

Section 1.4 - Details of the Nearest Relative

Title:	
Surname:	
Forename:	
Middle Name:	
House Name:	
House Number:	
Street:	
Locality:	
City:	
County:	
Country:	
Post Code:	
Tel No:	
E-Mail Address:	

If there has been a Court Order naming the above as the nearest relative to the adult please tick this box ☐

Relationship to Adult (e.g. spouse, daughter, brother, cousin, grandson etc)	

Section 1.5 – Details of the Primary Carer

Title:	
Surname:	
Forename:	
Middle Name:	
Name of Organisation: (if applicable)	
House Name:	
House Number:	
Street:	
Locality:	
City:	
County:	
Country:	
Post Code:	
Tel No:	
E-Mail Address:	

Please identify relationship to the adult: (If family member please state exact relationship)

Family Member: (i.e. spouse, son etc.) ☐ Friend: ☐ Professional: ☐

Section 1.6 – Details of the Named Person

Title:	
Surname:	
Forename:	
Middle Name:	
House Name:	
House Number:	
Street:	
Locality:	
City:	
County:	
Country:	
Post Code:	
Tel No:	
E-Mail Address:	

Please identify relationship to the adult: (If family member please state exact relationship)

Family Member: (i.e. spouse, son etc.) ☐ Friend: ☐ Professional: ☐

Section 1.7 – Details of any Attorney, Intervener or Guardian

Title:	
Surname:	
Forename:	
Middle Name:	
House Name:	
House Number:	
Street:	
Locality:	
City:	
County:	
Country:	
Post Code:	
Tel No:	
E-Mail Address:	

Please identify relationship to the adult: (If family member please state exact relationship)

Family Member: (i.e. spouse, son etc.) ☐ Friend: ☐ Professional: ☐

Section 1.8 – Details of any other Interested Parties

Details of any other person who has an interest in the adult's affairs e.g. other family members, carer, friend etc.

Use separate page if necessary.

	Interested Party 1	Interested Party 2
Title:		
Surname:		
Forename:		
Middle Name:		
House Name:		
House Number:		
Street:		
Locality:		
City:		
County:		
Country:		
Post Code:		
Tel No:		
E-Mail Address:		

	Interested Party 3	Interested Party 4
Title:		
Surname:		
Forename:		
Middle Name:		
House Name:		
House Number:		
Street:		
Locality:		
City:		
County:		
Country:		
Post Code:		
Tel No:		
E-Mail Address:		

Please identify relationship to the adult: (If family member please state exact relationship)

Interested Party 1: Interested Party 2:

Interested Party 3: Interested Party 4:

Section 2 – Financial Information

Does the adult have a current type bank/building society account in their sole name which is suitable for setting up standing orders/direct debits?

Yes – Go to Section 2.1.1 No – Go to Section 2.1.2

Section 2.1.1 - Details of Adult's Existing Account

Please provide full details about the adult's existing bank/building society account which you wish to access.

This account will be referred to as the adult's current account.

Name of Bank/Building Society:	
Branch Name:	
Number:	
Street:	
Locality:	
City:	
County:	
Country:	
Post Code:	
Sort Code:	
Name of Account Holder:	
Account Number:	

Section 2.1.2 - Details of Proposed New Account In Adult's sole name

Name of Bank/Building Society:	
Branch Name:	
Number:	
Street:	
Locality:	
City:	
County:	
Country:	
Post Code:	
Sort Code:	
Name of Account Holder:	

Section 2.1.3 - Details of any Direct Debits/Standing Orders on the adult's current account which you wish to continue or to set up

Name of Company to whom payment is to be made for example, Scottish Power etc.	Amount payable monthly £
Continue:	
Set Up:	

Section 2.1.4 - Department of Work & Pensions (DWP) Appointee

Are you or another person in receipt of the adult's DWP pension, benefits or allowances?

Yes ☐ No ☐

If yes, this application should only be used to access the funds belonging to the adult required in addition to DWP pension, benefits or allowances, e.g. if funds are required from savings and/or an occupational/ private pension or other income the adult is in receipt of.

Section 2.1.5 - Use of Funds

Reason for Expenditure	Monthly Amount £
Gas	
Electricity	
Telephone (including of mobile phones and special telephone services)	
Mortgage	
Rent	
Insurances (building, contents, motor, personal, pets etc.)	
Council Tax	
TV Licence	
Care Charges	
Loan Repayments	
Club or other subscriptions	
Food and household expenses	
Clothing	
Holidays/Outings	
Transport costs	
Personal Allowance	
Other (Please specify)	

TOTAL MONTHLY AMOUNT £ 0.00

Section 2.1.6 - One off Lump Sum

Reason for Expenditure	Amount £
One off payments/lump sums (Please specify)	

TOTAL LUMP SUM £ 0.00

Section 2.1.7 – Account from which Lump Sum will be Transferred

Which account (in the adult's sole name) will the lump sum come from? If it's to come from the adult's current account, please leave this section blank.

Name of Bank/Building Society:	
Branch Name:	
Number:	
Street:	
Locality:	
City:	
County:	
Country:	
Post Code:	
Sort Code:	
Name of Account Holder:	
Account Number:	

Do you wish to apply for authority to carry out other transactions now, i.e. close accounts, transfer funds?

If yes, complete section 2.2.1 and/or 2.2.2

If no, proceed to Section 3.

Part B – Other Financial Transactions

Section 2.2.1 – Second Account

Does the adult already have 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.

Name of Bank/Building Society:	
Branch Name:	
Number:	
Street:	
Locality:	
City:	
County:	
Country:	
Post Code:	
Sort Code:	
Name of Account Holder:	
Account Number:	

If No, do you wish authority to open a second account in the adult's sole name?

Yes ☐ No ☐

If you wish authority to open a second account in the adult's sole name please supply information in the box below.

Name of Bank/Building Society:	
Branch Name:	
Number:	
Street:	
Locality:	
City:	
County:	
Country:	
Post Code:	
Sort Code:	

Section 2.2.2 – Transfer of Funds on Existing Accounts

Where the adult has several accounts it may be that you need to transfer funds between accounts, close accounts.

You should identify the accounts below and thereafter give specific details of what you want to do with each as allowed for above:

	Transfer From:	Transfer To:	Amount £
Bank/Building Society:			
Sort Code:			
Account Holder:			
Account Number:			

Do you wish to close the above account? Yes ☐ No ☐

	Transfer From:	Transfer To:	Amount £
Bank/Building Society:			
Sort Code:			
Account Holder:			
Account Number:			

Do you wish to close the above account? Yes ☐ No ☐

	Transfer From:	Transfer To:	Amount £
Bank/Building Society:			
Sort Code:			
Account Holder:			
Account Number:			

Do you wish to close the above account? Yes ☐ No ☐

If there are more accounts identified please use an additional sheet.

All applicants must now complete Section 3

Section 3 – Undertaking and Declaration

Section 3.1 - Undertaking

I understand that it is my responsibility to keep records of the exercise of my powers as withdrawer and to 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 or death of the 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.

Section 3.2 – 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 on the Public Guardian 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 OR RESERVE APPLICANT:		
PRINT NAME:		
DATE:		

This application must be lodged with the Office of the Public Guardian no later than 14 days after the date the form is signed by the applicant if no countersignatory is required.

Section 4 – Countersignatory Information

See Guidance Notes

Section 4.1 - Details of Countersignatory

Title:	
Surname:	
Forename:	
Middle Name:	
House Name:	
House Number:	
Street:	
Locality:	
City:	
County:	
Country:	
Post Code:	
Tel No:	
E-Mail Address:	
Relationship to Applicant/s:	

Please note that the Public Guardian may at some time during this process contact the countersignatory in relation to the application.

Section 4.2 - Declaration of Countersignatory

I DECLARE THAT
(Applicant's name)

I have known the applicant/s

- I have known the applicant/s for at least one year prior to the signing of the foregoing application and I believe the applicant(s) 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 application; 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.

Delete (a) or (b) below

(a) I have no pecuniary interest in this application.

(b) I have a pecuniary interest in this application.

The nature and extent of that interest is:

The countersignatory must now complete this question providing as much relevant information as possible.

However, this part does not require to be completed where the information has already been supplied in form ATF(1). The countersignatory should simply sign and date the form below.

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

SIGNATURE OF COUNTERSIGNATORY:

PRINT NAME:

DATE:

This application form must be lodged with the Office of the Public Guardian no later than 14 days after the date the form is countersigned.

Checklist For Applicant

- ☐ Have you completed all the relevant sections?
- ☐ Have all persons signed and dated the form?
- ☐ Where appropriate, have medical certificate(s) been completed and enclosed?
- ☐ Where appropriate has the form been countersigned and dated?
- ☐ Has evidence been enclosed to support your request for funds?
- ☐ Where appropriate have you enclosed the relevant fee. Your cheque should be made payable to the "Scottish Court Service"?
- ☐ Is the application form being submitted to the Public Guardian within 14 days of the date it is signed by the countersignatory, or within 14 days of the date it is signed by the applicant, where no countersignatory has been required?

The form is now complete, please print and send to:

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

Telephone 01324 678300
Email opg@scotcourts.gov.uk
Website www.publicguardian-scotland.gov.uk

Save Form | Print Form | Reset Form

Scottish Statutory Instrument 2008 No. 51
(Previously SSI No. 76)

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, eg 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 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.

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

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 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 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, eg GP, specialist in mental disorder

NOTES (For completion of SSI 79)

* Insert as appropriate, e.g. GP, specialist in mental disorder

Under section 11(2) of the Act, the Public Guardian may dispense with any intimation or notification by her to an adult under the Act, if she considers that the intimation or notification would be likely to pose a serious risk to the health of the adult. Under section 7(1)(d) of the Act, the Scottish Ministers may prescribe the evidence which the Public Guardian shall take into account when deciding under section 11(2) whether to dispense with intimation or notification to the adult.

This certificate (SSI 79) should be used to provide such evidence to the Public Guardian when it is necessary. It should be attached to the certificate of capacity (SSI 51) and accompany an application to the Public Guardian 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 by the Public Guardian to an adult may be dispensed with on production of certificates from two medical practitioners that such intimation or notification would pose a serious risk to the health of the adult. 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.

Sections A and B of this certificate (SSI 79) must therefore both be completed, and the two doctors signing the document must fulfil the requirements above.