

Utah Working Interdisciplinary Network of Guardianship Stakeholders (WINGS)

Thursday, October 15, 2026, 12:00 pm | 2 hours |

AGENDA

	Topic	Presenter	Materials
12:00	Meeting begins		
	- Housekeeping, minutes - Welcome guests	Judge Sanchez	<i>August 2026 – Minutes (draft)</i>
12:10	Stakeholder Updates		
	- GRAMP Updates - New AOC department & GRAMP changes - Court Visitor Program - status	Keri Sargent Shonna Thomas Holly Thorson	
	Judicial Conference recap	Judge Sanchez Keri Sargent	
12:35	WINGS Projects		
	GRAMP Pilot Program - status	Keri Sargent Shonna Thomas	
	Non-GSP guardianship attorneys list	Shonna Thomas	
	Clinical Evaluation Form – draft feedback	Shonna Thomas	<i>Report on Clinical Evaluation (current version - last updated 2019)</i> <i>Report on Clinical Evaluation (draft 8.15.26)</i>
	WINGS workgroups – next steps	Shonna Thomas	<i>WINGS Workgroup Participation</i>
1:45	Other Business		
	Legislative news	Stakeholders	
	Fiduciary Field Census invitation	Shonna Thomas	<i>Fiduciary Field Census invitation for Utah WINGS</i>
2:00	Meeting adjourned		

Next meeting:

December 17, 2026

Evaluator's Name

Address

City, State, Zip

Phone

Email

I am a ☐ Physician ☐ Psychiatrist ☐ Other _____ licensed to practice in the state of _____. My License number is _____

Report on Clinical Evaluation of _____ (patient's name)

To the evaluator: This document may be filed in a court case to appoint a guardian for the patient, and it may be treated as evidence of the patient's incapacity. You may not be able to answer every question within the scope of your evaluation. Answer the questions for which you have information based on your personal observations, based on statements by the patient, or based on a source on which you commonly rely in your professional capacity.

1. Sources of information

I ☐ am ☐ am not aware of the patient's advance healthcare directive.

My answers are based on the following sources of information.

☐ My examination of the patient on _____ (date) for the purpose of assessing capacity. On that date I spent about _____ minutes with the patient.

☐ My general knowledge of the patient, who has been my patient since _____ (date) and who I last saw on _____ (date). On that date I spent approximately _____ minutes with the patient.

☐ Review of the patient's records.

☐ Discussions with the patient.

☐ Discussions with healthcare professionals involved in the patient's care.

☐ Discussions with the patient's family, friends or caregivers.

2. Overall condition

The patient's overall physical health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

The patient's overall physical health will:

☐ Improve ☐ Be stable ☐ Decline ☐ Uncertain

The patient's overall mental health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

The patient's overall mental health will:

☐ Improve ☐ Be stable ☐ Decline ☐ Uncertain

List your diagnoses that affect the patient's functioning.

3. Daily functions (If you check moderate or severe or if you have concerns, explain in the comments.)

	Level of Impairment				
	None	Mild	Moderate	Severe	Not Evaluated
Activities of daily living (ADLs: bathing, grooming, dressing, mobility, toileting, eating, taking medication, etc)	☐	☐	☐	☐	☐
Instrumental Activities of Daily Living (IADLs: medication acquisition and monitoring, food shopping and preparation, transportation, paying bills, protect assets, resist fraud, etc.)	☐	☐	☐	☐	☐
Medical decision making (reason about health, express a choice, and understand, information, etc.)	☐	☐	☐	☐	☐
Care of home and functioning in community (manage home, health, telephone, mail, drive, leisure, etc.)	☐	☐	☐	☐	☐
Ability to protect self from harm, including physical harm, self-neglect, and financial exploitation.	☐	☐	☐	☐	☐
Comments					

4. Behavior (If you check moderate or severe or if you have concerns, explain in the comments.)

	Level of Impairment				
	None	Mild	Moderate	Severe	Not Evaluated
Rambling, nonsensical, or incoherent thinking	☐	☐	☐	☐	☐

4. Behavior (If you check moderate or severe or if you have concerns, explain in the comments.)	Level of Impairment				
	None	Mild	Moderate	Severe	Not Evaluated
Confabulation (fills in memory gaps with honestly believed false information)	[]	[]	[]	[]	[]
Seeing, hearing, smelling things not there	[]	[]	[]	[]	[]
Extreme suspiciousness; believing things that are not true against reason or evidence	[]	[]	[]	[]	[]
Uncontrollable worry, fear, thoughts	[]	[]	[]	[]	[]
Acting without considering consequences	[]	[]	[]	[]	[]
Acting with hostility, anger or violence	[]	[]	[]	[]	[]
Disinhibition, sexual aggression, uncontrollable behavior,	[]	[]	[]	[]	[]
Refuses to accept help or follow directions	[]	[]	[]	[]	[]
Wandering	[]	[]	[]	[]	[]
Comments (Attach additional pages if necessary.)					

5. Cognitive and emotional impairment (If you check moderate or severe or if you have concerns, explain in the comments.)	Level of Impairment				
	None	Mild	Moderate	Severe	Not Evaluated
Alertness/consciousness	[]	[]	[]	[]	[]
Memory and cognitive functioning	[]	[]	[]	[]	[]
Emotional and psychiatric functioning	[]	[]	[]	[]	[]
In what areas are the patient's decision making or thinking impaired and to what extent?					

6. **Risk of harm**

How likely is the risk that the patient may harm self or others?

[] Unlikely [] Possible [] Probable [] Almost Certain

Describe any significant risks the patient faces and note whether these risks are due to the patient's condition and/or due to another person harming or exploiting the patient.

Describe any social factors (persons, supports, environment) that increase or decrease the risk.

7. Level of supervision needed

In your opinion, what level of supervision does the patient need?

☐ No supervision ☐ Some supervision ☐ 24-hr supervision ☐ Locked facility

8. Treatment and accommodation

Describe treatments or accommodations that might enhance the patient's functioning and any that have been tried but are ineffective.

This report is complete and accurate to the best of my information and belief. If directed to do so, I am prepared to present to the court, by affidavit or testimony, my qualifications and my evidence.

Date

Signature ► _____
Printed Name _____

Certificate of Service

I certify that I filed with the court and am serving a copy of this Report on Clinical Evaluation on the following people.

Person's Name	Service Method	Service Address	Service Date
(Petitioner or Attorney)	☐ Mail ☐ Hand Delivery ☐ E-filed ☐ Email ☐ Left at business (With person in charge or in receptacle for deliveries.) ☐ Left at home (With person of suitable age and discretion residing there.)		
(Respondent or Attorney)	☐ Mail ☐ Hand Delivery ☐ E-filed ☐ Email ☐ Left at business (With person in charge or in receptacle for deliveries.) ☐ Left at home (With person of suitable age and discretion residing there.)		
	☐ Mail ☐ Hand Delivery ☐ E-filed ☐ Email ☐ Left at business (With person in charge or in receptacle for deliveries.) ☐ Left at home (With person of suitable age and discretion residing there.)		

 Date

 Signature ►

 Printed Name

Evaluator's Name

Address

City, State, Zip

Phone

Email

I am a health care provider licensed to practice in the state of _____.

My title is: _____. My License number is: _____

Report on Clinical Evaluation of: _____ (patient's name)

To the evaluator: This document may be filed in a court case to appoint a guardian for the patient, and it may be treated as evidence of the patient's capacity. You must assess the patient within the scope of your license and experience, using evidence-based screening tools appropriate for the assessment. You may not be able to answer every question within the scope of your evaluation.

Answers to the assessment questions may also be based on:

- personal observations
- statements by the patient
- sources on which you commonly rely in your professional capacity

You may interview the person seeking appointment as guardian, but you may not base your assessment predominately on the opinion of the person seeking appointment as guardian.

Sources of information

1. My answers are based on the following sources of information: (select all that apply)

☐ Review of the patient's records.

☐ Discussions with the patient.

☐ Discussions with healthcare professionals involved in the patient's care.

☐ Discussions with the patient's family, friends or caregivers.

☐ I examined the patient in person on _____ (date) for the purpose of assessing capacity. I spent about _____ minutes with the patient.

☐ The patient has been under my care since _____ (date).

☐ I last saw the patient on _____ (date). I spent _____ minutes with the patient at that time.

Overall condition

2. Describe the patient's relevant medical and mental health history and current health needs:

Conditions that affect the patient's functioning: (add rows as needed)

Diagnosis: _____ Date: _____ [] by me [] other provider

Diagnosis: _____ Date: _____ [] by me [] other provider

Diagnosis: _____ Date: _____ [] by me [] other provider

Diagnosis: _____ Date: _____ [] by me [] other provider

3. Describe the observed physical condition of the patient at the time of the evaluation: (e.g., hygiene, dress, grooming)

4. Describe any adaptive equipment the patient used during the evaluation: (e.g., visual aids, hearing aids, communication device, leg braces, walker, wheelchair, cane, oxygen, headgear, prosthetic devices)

5. List the patient's medications:

6. The patient's overall physical health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

7. The patient's physical health is expected to:

☐ Improve ☐ Stabilize ☐ Decline ☐ Uncertain

8. If the patient's physical health is expected to improve, under what conditions, treatments, or accommodations?

9. The patient's overall mental health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

10. The patient's mental health is expected to:

☐ Improve ☐ Stabilize ☐ Decline ☐ Uncertain

11. If the patient's mental health is expected to improve, under what conditions, treatments, or accommodations?

12. Comments:

Functional Abilities and Limitations

13. Daily Functions

Mark (X) the patient's average functional ability for each item listed below:

(I) = Independently - patient performs the activity without any assistance.

(A) = Assisted - patient performs the activity with assistance or prompting.

(D) = Dependent - patient is unable to perform it with or without assistance.

	I	A	D
Take a shower or bath			
Brush teeth			
Put clothes on			
Put shoes on			
Get in and out of bed			
Control bladder/bowels			
Clean after toilet use			
Plan and cook meals			
Use utensils, feed self			
Clean living spaces			
Wash, put away laundry			
Yard care, snow removal			
Pay bills			
Manage a Budget			
Read			
Write			

	I	A	D
Go up and down steps			
Get in and out of a vehicle			
Drive a vehicle			
Use public transportation			
Get up from a prone position			
Navigate through stores			
Choose and purchase items			
Ask questions about health			
Make medical appointments			
Express health choices			
Take medications as prescribed			
Use email			
Navigate the internet			
Use a phone (cell or landline)			
Communicate			
Other:			

14. Additional notes on the patient's **Daily Functions**:

15. Behavior and Risks

- a. Mark the behaviors the patient experiences on a regular basis (e.g., daily, weekly), without a supported environment:

- ☐ Rambling, nonsensical, or incoherent thinking
- ☐ Fills in memory gaps with honestly believed false information
- ☐ Seeing, hearing, smelling things not there
- ☐ Suspiciousness; believing things that are not true against reason or evidence
- ☐ Uncontrollable worry, fear, thoughts
- ☐ Acting without considering consequences, uncontrollable behavior
- ☐ Acting with hostility, anger or violence
- ☐ Disinhibition, inappropriate sexual expression
- ☐ Wandering

- b. Mark the impairments the patient is currently experiencing:

- | | | | |
|--|-------------------------------|-----------------------------------|---------------------------------|
| ☐ Alertness | ☐ Mild | ☐ Moderate | ☐ Severe |
| ☐ Awareness | ☐ Mild | ☐ Moderate | ☐ Severe |
| ☐ Memory | ☐ Mild | ☐ Moderate | ☐ Severe |
| ☐ Cognitive functioning | ☐ Mild | ☐ Moderate | ☐ Severe |
| ☐ Emotional functioning | ☐ Mild | ☐ Moderate | ☐ Severe |
| ☐ Psychiatric functioning | ☐ Mild | ☐ Moderate | ☐ Severe |

- c. In what areas are the patient's decision making or thinking impaired and to what extent?

- d. Mark the risks the patient may experience or is currently experiencing, without a supported environment:

- ☐ Risk of harm to self
- ☐ Risk of harm to others
- ☐ Risk of self-neglect
- ☐ Risk for fraud
- ☐ Risk of coercion or undue influence
- ☐ Risk of financial exploitation

- e. Are the above risks due to the patient's condition and/or due to another person harming or exploiting the patient? (describe)

- f. Describe any social factors - persons, supports, environment - that increase or decrease the risk:

16. Additional notes on the patient's Behavior and Risks:

Treatment and Accommodations

17. Describe treatments that might enhance the patient's functioning:

18. Describe treatments that have been tried but have been ineffective:

19. Describe accommodations that might enhance the patient's functioning:

20. Describe accommodations that have been tried but have been ineffective:

21. In your professional opinion, does the patient require some level of supervision, and if so, what level of supervision does the patient need? (e.g., no supervision, some, 24-hr, locked facility)

22. Does the patient have an advance healthcare directive?

☐ Yes ☐ No ☐ Unknown

This report is complete and accurate to the best of my information and belief. If directed to do so, I am prepared to present to the court, by affidavit or testimony, my qualifications and my evidence.

Signature ►

Date

Printed Name

Certificate of Service

I certify that I filed with the court and am serving a copy of this Report on Clinical Evaluation on the following people.

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Signature ►

Date

Printed Name

WINGS Workgroup Participation

The foundation of WINGS is built on the diverse representation of the agency and individual stakeholders that comprise the committee. The broad scope and reach of the committee allows us to tackle initiatives and projects with full consideration of the different perspectives and interests each committee member brings to the table.

One of the primary ways WINGS achieves its goals is through workgroups that take on the tasks of researching topics, identifying solutions, and developing recommendations for the full committee and beyond. The purpose of this survey is to give WINGS members the opportunity to express interest in participating in one or more of the ongoing and proposed WINGS workgroups.

CURRENT AND NEW WORKGROUPS:

- **Guardianship Forms Workgroup.** Purpose: updating guardianship and conservatorship forms to make them more accessible and easy to understand. Developing new forms as needed.
- **Background Disclosure Workgroup.** Purpose: exploring and developing strategies to recommend and enact universal background checks for prospective guardians and conservators.
- **Manual & Exam Workgroup.** Purpose: updating the manuals and exams required for guardians and conservators as a condition of their appointment. Developing interactive modules to address guardianship and conservatorship standards and responsibilities over time.
- **Community Education Workgroup.** Purpose: developing resources and tools to assist the public with understanding guardianship and conservatorship, including alternatives and the least restrictive options.
- **Judicial Education Workgroup.** Purpose: developing resources and practical tools for judges in guardianship and conservatorship cases, such as bench cards and training for new judges. This workgroup could be expanded to include support staff training as well.

WORKGROUP	VOLUNTEERS
Guardianship Forms Workgroup	• Shonna Thomas - Chair • Tanya Schmidt • Natasha Burningham • Leslie Francis • Katie Cox • Katie Thomson • Carrie Poor + 4 non-WINGS participants
Background Disclosure Workgroup	• Kaye Lynn Wootton - Chair • Shonna Thomas • Natasha Burningham • Katie Thomson • Wendy Naylor • Carrie Poor
Manual & Exam Workgroup	• Shonna Thomas – Chair • Ann Humpherys • Rob Denton • Brant Christiansen • Andrew Riggle • Carrie Poor
Community Education Workgroup	• Natasha Burningham – Chair? • Deborah Brown • Ann Humpherys • Tanya Schmidt • Eve Larsen • Katie Cox • Brant Christiansen • Andrew Riggle • Holly Thorson
Judicial Education Workgroup	• Keri Sargent – Chair? • Leslie Francis • Deborah Brown • Rob Denton • Katie Cox • Katie Thomson • Brant Christiansen • Carrie Poor

Fiduciary Field Census invitation for Utah WINGS

1 message

Junel Unrein <junel@thefiduciaryinstitute.com>
To: shonnat@utcourts.gov

Fri, Oct 2, 2026 at 1:41 PM

Hi Shonna,

I'm writing on behalf of The Fiduciary Institute to invite you and eligible Utah WINGS participants to take the Fiduciary Field Census 2026. I'm also asking whether the committee would review the survey and, if useful and appropriate, share it with relevant members and partner networks.

Your work with both WINGS and the Guardianship Reporting and Monitoring Program offers a valuable view across guardianship practice, court administration, monitoring, and system improvement. Those perspectives can help the census describe who does fiduciary work and what support the field needs.

The census is an open, voluntary national field survey for professional and public fiduciaries, fiduciary-practice staff, prospective professionals, and family members or friends serving in fiduciary roles, including guardians, conservators, trustees, personal representatives or executors, agents under power of attorney, representative payees, and VA fiduciaries. Staff members may participate even if they do not personally hold an appointment or professional credential.

It asks about roles, workloads, entry pathways, practice conditions, barriers, and support needs. Because no complete national list of people performing fiduciary work exists, recruitment uses broad outreach rather than probability sampling. Findings will describe participating respondents and will not be presented as national population estimates.

The survey takes about 5 minutes and is open through November 15th. It does not ask for a respondent's name, email address, employer, or license number. Findings will be reported only in aggregate, with additional protections for very small groups.

Participation is entirely voluntary and unrelated to any appointment, proceeding, approval, compliance obligation, monitoring, or oversight.

The Fiduciary Institute is a commercial education company. The survey is separate from course marketing and does not promote or ask about its products. The questionnaire, methodology, aggregate findings, and study limitations will be published free and open to everyone.

If the survey is appropriate for the committee's network, please share it through suitable channels. We are requesting review and distribution, not endorsement.

Survey link: <https://www.thefiduciaryinstitute.com/census>

If a brief conversation would be useful, you are welcome to schedule time here: [Calendar Link](#)

Thank you for considering it.

Warmly,

Junel Unrein, MBA, NCG
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Let's Connect: [Schedule a Meeting](#)