



North Carolina Department of Health and Human Services  
Division of Aging and Adult Services

2101 Mail Service Center • Raleigh, North Carolina 27699-2101  
Courier 56-20-02 Phone 919-733-3818 Fax 919-715-0023

Michael F. Easley, Governor  
Carmen Hooker Odom, Secretary

Karen E. Gottovi, Director

August 4, 2005

DEAR COUNTY DIRECTOR OF SOCIAL SERVICES:

ATTENTION: Adult Protective Services Supervisors

**SUBJECT: ASSESSING AN ADULT'S CAPACITY TO CONSENT**

The Division of Aging and Adult Services is pleased to announce the availability of a one-day workshop entitled, *Assessing An Adult's Capacity To Consent*. It will be offered in two locations across the state this year.

The workshop will provide participants an excellent opportunity to learn about and discuss mental capacity as it relates to Adult Protective Services (APS). Mental capacity will be defined and the differences and similarities between mental capacity and mental competence will be discussed. Lecture and small group discussion will be used to examine the degrees and components of mental capacity. Principles for determining whether an adult has or lacks capacity to consent to protective services will be explored, including using APS evaluation data to assist with making a decision about capacity to consent. Participants will learn the importance of obtaining help, when necessary, in making a capacity decision, and the importance of accurately and thoroughly documenting how the decision was reached.

Social workers and supervisors with responsibility for evaluating and planning service interventions in APS cases will benefit from attending this workshop. The workshop is being offered as an advanced level training (beyond the APS Basic Skills Training) for APS staff. **All participants should have completed both Modules I and II of the *Adult Protective Services Basic Skills Training* before attending this workshop.**

A maximum of thirty participants will be accepted at each of the training sites and registration will be accepted on a first come, first served basis. There is no cost for this training, however, **you must pre-register**. A registration form is attached. Please make copies as needed. Participants can expect to receive a confirmation letter and specific information about the

training site after registering. Each workshop **starts at 9:30 a.m.** and will **end by 4:00 p.m.** There will be no on-site registration.

**November 18, 2005**

Pitt County Mental Health Building  
203 Government Circle  
Greenville, NC

**April 21, 2006**

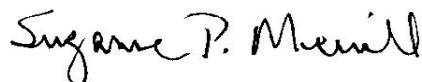
Iredell County Health Department  
318 Turnersburg Highway  
Statesville, NC

Please choose one of the workshops listed above and complete the attached registration form. If the site you request is full, you will be notified and offered another site, if available. Refreshments will not be provided, however, participants may bring their own drinks and snacks.

If you need additional information or have questions regarding the content of the workshops, please contact Laura Cockman, APS Program Consultant at (919) 733-3818, or your Adult Programs Representative. For all questions regarding registration, please contact Monica Nealous, Program Assistant, at the number referenced above.

To **assure registration** at the selected location, send your registration as soon as possible. A completed registration form may be **mailed or faxed** to Ms. Nealous at NC Division of Aging and Adult Services, 693 Palmer Drive, 2101 MSC, Raleigh, North Carolina 27699-2101. FAX: (919) 715-0023. **On-line registration** is also available at <http://www.ncswtrain.org/>.

Sincerely,



Suzanne P. Merrill, Chief  
Adult Services Section

SPM/lsc

AFS 10-2005

Attachment

## Adult Services, NC Division of Aging and Adult Services Registration Form

**Have you attended the prerequisites for this training event?**       Yes    No  
 (For prerequisite information please refer to the training description)       Not Applicable for this Training

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

If you have ever registered for a training under a different name, what is that name? \_\_\_\_\_

"Goes By" Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Gender:  Female    Male  
 (SSN requested for internal record keeping purposes only)

Race/Ethnicity (Optional):

Caucasian    African American    Latino/Hispanic    Asian/Pacific Islander    Native American/Eskimo    Mixed Race

Home Phone (please include area code): \_\_\_\_\_ Work Phone & Extension (please include area code): \_\_\_\_\_  
 ( ) ( )

Home phone requested in event of last minute postponement due to severe weather.

Your Work E-mail Address: \_\_\_\_\_ Fax #: ( ) \_\_\_\_\_

Agency Name: \_\_\_\_\_

Mailing Address (PO Box, Drawer #, or Street Name and Suite #): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

State Courier #: \_\_\_\_\_ County: \_\_\_\_\_

Supervisor's Full Name: \_\_\_\_\_ Supervisor's Phone (please include area code): ( ) \_\_\_\_\_

**Employment Type:**

Not applicable

County DSS - Permanent

County DSS - Temporary

County Non-DSS

Federal Agencies

State Agency/Public University

Private University/College

Private Agency/Business

**Work Type:**

Direct Client Service

Line Supervisor

Trainer/Staff Development

Program Manager

Program/Admin. Support

Director

Other

Not Applicable

**Program Responsibilities:**

If you are **NOT** a county DSS worker, please skip to the next box (Check all that apply)

Adult Care Home CMS

Adult Day Care

Adult Home Specialist

Adult Protective Services

Adult Services Intake

At-Risk Case Management

Attorney

Guardianship

In-Home Aide Services

Special Assistance

Trainer

Other

**Other Roles:**

Complete this box if you are **NOT** a county DSS worker

Aging Services

Attorney/Judicial

Developmental Disabilities

Health/Medical

Law Enforcement

Long Term Care

Mental Health

Student/Student Intern

Substance Abuse

Vocational Rehabilitation

Other

<b>Highest Degree</b>		<b>Highest Social Work Degree</b>
<input type="checkbox"/> HS	<input type="checkbox"/> Masters	<input type="checkbox"/> BSW/BSSW
<input type="checkbox"/> Associate	<input type="checkbox"/> Doctorate	<input type="checkbox"/> MSW/MSSW
<input type="checkbox"/> Bachelor		<input type="checkbox"/> PhD/DSW

**Training Event**

To ensure this registration form is faxed/mailed to the appropriate person please refer to the Dear Director letter to which this was attached

Training Event you are registering for: \_\_\_\_\_

Date(s) of Training Event: \_\_\_\_\_

Location of Training Event: \_\_\_\_\_

If you are replacing a registered co-worker, what is his/her name: \_\_\_\_\_

If you are making up a missed training day, which day are you making up? \_\_\_\_\_