File No:_____
Matter No:_____
Date: _____

Mental Health
Review Tribunal

Application to Revoke a Financial Management Order

under s88 of the NSW Trustee and Guardian Act 2009

The Mental Health Review Tribunal can only revoke a financial management order if:

- **the original order was made by the Mental Health Review Tribunal or a Magistrate;**
- **the person whose affairs are under management (the protected person) is or was**
  - **a patient under the *Mental Health Act 2007*, or**
  - **a forensic patient under the *Mental Health (Forensic Provisions Act) 1990*, and**
- **the Tribunal is satisfied that:**
  - **the protected person is now capable of managing their own financial affairs, or**
  - **it is in the best interests of the protected person to have the order revoked.**

Only the protected person is able to apply to have the order revoked.

YOUR DETAILS (THE PERSON WHOSE AFFAIRS ARE UNDER MANAGEMENT)

NAME: Mr/Mrs/Ms/Miss/Dr _____ _____
Given names *Family name*

ADDRESS: _____

_____
Postcode

TELEPHONE: (___) _____ (___) _____ (___)_____
Daytime *After hours* *Fax*

DATE OF BIRTH: _____

When the financial management order was made, the Magistrate or Tribunal were satisfied you were incapable of managing your own affairs. **Please state why you believe that you are now capable of managing your financial affairs or that it is in your best interests to have the order revoked**.

_____

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NAME OF YOUR ESTATE MANAGER, CASE MANAGER, DOCTOR, PSYCIATRIST OR OTHER PROFESSIONALS INVOLVED WITH YOU:

Your application should be accompanied by information in support of your case. This may be from a professional person involved in your care and/or other persons involved in your life e.g. family, friends, designated carer or principal care provider. Reports should address why it is thought you are capable of managing your affairs and/or whether it is in your best interests to have the order revoked and the evidence for these opinions. The report should also detail the qualifications and experience of its author and the nature of their contact with you.

Please indicate the details of the people who will be providing reports.

NAME: Mr/Mrs/Ms/Miss/Dr _____ _____
Given names *Family name*
ADDRESS: _____

_____
Postcode
TELEPHONE: (___) _____ (___) _____ (___)_____
Daytime *After hours* *Fax*
Relationship (eg Case Worker, Psychiatrist etc): _____ Report attached ☐

NAME: Mr/Mrs/Ms/Miss/Dr _____ _____
Given names *Family name*
ADDRESS: _____

_____
Postcode
TELEPHONE: (___) _____ (___) _____ (___)_____
Daytime *After hours* *Fax*
Relationship (eg Case Worker, Psychiatrist etc): _____ Report attached ☐

If you would like to add more names please attach an extra sheet

OTHER PEOPLE INVOLVED

Please provide the details of any other people who may be able to give information to the Tribunal about the application eg. your spouse, designated carer or principal care provider, close friends, relatives etc.

NAME: Mr/Mrs/Ms/Miss/Dr _____ _____
Given names *Family name*
ADDRESS: _____

_____
Postcode
TELEPHONE: (___) _____ (___) _____ (___)_____
Daytime *After hours* *Fax*

Likely attitude to this application? ☐ Support ☐ Oppose ☐Don't know

NAME: Mr/Mrs/Ms/Miss/Dr _____ _____
Given names *Family name*

ADDRESS: _____

_____
Postcode

TELEPHONE: (___) _____ (___) _____ (___)_____
Daytime *After hours* *Fax*

RELATIONSHIP:_____

Likely attitude to this application? ☐ Support ☐ Oppose ☐ Don't know

If you would like to add more names please attach an extra sheet

SPECIAL NEEDS AT HEARING:

Does anyone associated with the application need a language interpreter?_____

If so, which language? _____

Does anyone associated with the application have a hearing impairment? _____

If so, what would assist them at the hearing? (e.g signing interpreter) _____

Is any other type of help needed at the hearing? (eg wheelchair) _____

If so, what help is needed? _____

DECLARATION :

I have read this completed application and believe that to the best of my knowledge all of the information provided is true, complete and accurate.

Signature of applicant: _____

Signature of witness: _____Date:_____

Name of witness (please print): _____

Address of witness: _____

Please return the completed application and the required supporting evidence to the Tribunal at the following address:

Mental Health Review Tribunal
PO Box 247, GLADESVILLE NSW 1675

For further information or assistance please contact the Tribunal on the following numbers:

Phone: (02) 9816 5955 Toll Free: 1800 815 511 Fax: (02) 9817 4543