## Carson City Public Guardian INFORMATION SHEET (Revised 8/2023)

Instructions: If you are petitioning the Carson City Public Guardian to serve as guardian, please provide the following information, <u>written as legibly as possible</u>.

CCPG USE ONLY  Date Received:  Case #:  Prior Case #(s):	CARSON CITY PUBLIC GUARDIAN 201 N. Carson St. Suite 1 Carson City, NV 89701  (775) 887-2295 Telephone (775) 887-2585 Fax
FORM COMPLETED BY:	
Name:	Date submitted:
Agency/Entity:	Telephone:
Email:	
Relationship to the Proposed Protected Person:	
General Information (PLEASE FILL IN <u>COMPLETELY</u> ):     Name of Proposed Protected Person ( <i>last, first middle</i> )     Other names used	
Age Date of Birth	Social Security #
Medicare □ A □ B #	Medicaid #
Veteran ☐ Yes ☐ No ☐ Unknown VA Service #	Branch
Marital Status ☐ Single/Never married ☐ Married ☐ [	Divorced D Widowed D Unknown
2. Location History:	
Current physical location of Proposed Protected Person:	
Immediately preceding residence, location, or placemen	it:
Any other known residences (home, apartment, et ceter	ra):
Does Proposed Protected Person live alone at reside	ence? ☐ Yes ☐ No
Residence telephone number:	
Other mailing addresses (post office boxes, et cetera)	
3 Date admitted to current facility, if applicable:	

4.	Date(s) of previous admissions to current facility:
5.	<b>Discharge Plan:</b> ☐ Skilled Nursing ☐ Custodial Long Term Care ☐ Residential Care Facility ☐ Independent Living/Home
6.	List facilities where referrals have been made:
7.	Anticipated discharge date, if applicable:
8.	Identification in Proposed Protected Person's possession at time of admission (verify with facility safekeeping, if applicable): □ Driver's license □ State identification card □ Military identification card □ Medicare card □ Medicaid card □ Private Insurance card □ Other:
9a.	Does any person or institution have Legal Guardianship, Power of Attorney (POA), a supportive decision-making agreement, or custody and control of Proposed Protected Person?   No
	If YES, who?
	(Note: If available, please provide copies of any and all related legal documents, such as POA.)
9b.	Does the Proposed Protected Person have any information stored in the document "Lockbox" maintained by the State of Nevada? $\square$ Yes $\square$ No
	If YES, please provide details:
10.	Purpose of Guardianship: In what way will a guardianship benefit the Proposed Protected Person? What unmet needs exist that cannot be addressed by another agency or service?
11.	Situation leading up to the petition: Briefly describe the chronology of recent events that resulted in the need to petition this individual for guardianship (attach additional sheets, if necessary):
	*
	<del>,</del>

been notified?	glect is suspected, has a Police Report  If YES, please attach a copy and provic  ified: □ Yes □ No		
	o: Guardianship is a serious step and s ardianship that have already been use		
☐ Assistance from family an	od/or friends:		
	ervices):		
	Mental Health Services:		
	management services:		
If YES, provide name, full add	erson have a private attorney?  Yes dress, and telephone number:		
information):			
Name	Address/Location	Telephone Number	Type of Provider
7. Is there a history of, or any If YES, describe:	recent, violent threats or actions not	ed? □ Yes □ No	

18. Relatives/Significant Others, including relationship, full address, and telephone numbers: (This includes immediate family, stepparents, stepchildren, adopted children, adoptive parents, half siblings, etc. -attach additional sheets, if necessary.) Per Nevada Revised Statutes, parents, siblings, and children over 14 years MUST be legally noticed no matter where they are located, so it is critical that this list includes ALL requested

information, if known.

Full Name (First Last)	Full Address Street, City, State Zip	Verified telephone number w/area code	Relationship to Proposed Protected Person
Reason he/she can't serve	e as Guardian:		
Reason he/she can't serve	e as Guardian:		
Reason he/she can't serve	e as Guardian:		
Reason he/she can't serve	e as Guardian:		
Reason he/she can't serve	a as Guardians		
Reason ne/site can't serve	e as Guardiani.		
Reason he/she can't serve	e as Guardian:		
Name of Family Mer	nber(s) Notified	Date Ag	rees with Guardianship?
9			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
O. Spousal Information (Curr	ent or previous as applicable; LIST	EVEN IF DECEASED):	
Name of Spouse			
Address			
	State		ephone
Date of Death (if applicable	e)	Place of Death	
☐ Admit Sheet☐ History & Physical Exam☐ Psychiatric Assessment	☐ Medication Admir ent sought, copy of Proof of Paym	orts ions nistration Record (MAR)	

	Nursing Homes/Grou have attached): ☐ Admit Sheet	p Care Facilities Only -	Copies of the	e following are required ( <i>please</i>	e check	those you
	☐ History & Physical	l Exam		☐ Consultation Reports		
	☐ Psycho-Social Asso			☐ Medication Administration	Record	(MAR)
	☐ Complete Patient	<b>Trust Fund Accounting</b>		☐ Proof of Payment Source, A	pplicati	ion & Guarantee
	☐ Correspondence t	to Family/Significant Ot	hers Notified	of Petition for Guardianship		
				No (If YES, attach copy if ava		
	Is there an Advance D	oirective? ☐ Yes ☐ No	Date:	Location of docume	nt:	
24.	Income Source (Attac	ch copies of application	s, if applicabl	le):		
	Income Source	Amount receivin Date of applicat	-	Payee? If so,	please	list
	SSA					
	SSD					
	SSI					
	Veterans Benefits					
	Pension/Annuity					
	Other					
	o and					
25	Finances (Attach add	itional sheets, if necess	ary):			
	Accounts	Location (bank, bra	nch, etc.)	Account Number		Approximate Value
	Checking Account					
	Savings Account					
	CD/IRA Trust Fund					
	Stocks, Bonds					
	Investments					
	Patient Trust					
	Account					
	Other					
	Does anyone else hav	ve their name on the ah	nove account	s?  Yes  No If YES, who?		
	-	ve their name on the da				
	which accounts					
	Asset	Specify Type		Location/Address		Approximate Value
	Real Property					
	(House, Land, etc	c.)				
	Mobile Home					
	Vehicles (include ye	ear,				
	make, model)					
	Burial Plot/Plan Or Insurance					
	Safe Deposit Box	х				
	Other					

Coverage Type	Name of Company (if applicable) and/or Policy/Member #	Effective Date of Coverage	Copy of Card?
Medicare A			
Medicare B			
Medicare D			
Medicaid			
<b>V</b> A Health			
Private			
Supplemental			
e this form is complete	d, mail, fax or email to:		
e this form is complete	Carson City Public G 201 N. Carson St. S Carson City, NV S Fax: (775) 887-2	Suite 1, 39701 2585	
this form is complete	Carson City Public C 201 N. Carson St. S Carson City, NV S	Suite 1, 39701 2585	
ertify that the inform	Carson City Public G 201 N. Carson St. S Carson City, NV S Fax: (775) 887-2	Suite 1, 39701 2585 org to the best of my kno	owledge, and that