Washoe County Public Guardian
INFORMATION SHEET (Revised 11/2018)

Instructions: If you are petitioning the Washoe County Public Guardian to serve as guardian, please provide the following information, *written as legibly as possible*.

WCPG USE ONLY

Date Received:

Case #: _____

Prior Case #(s): _____

WASHOE COUNTY PUBLIC GUARDIAN
PO Box 12310
Reno, NV 89510-2310
(775) 674-8800 Telephone
(775) 674-8850 Fax

FORM COMPLETED BY:

Name: _____ Date submitted: _____

Agency/Entity: _____ Telephone: _____

Email: _____ Fax: _____

Relationship to the Proposed Protected Person: _____

- **Is Proposed Protected Person a RESIDENT of Washoe County? ☐ Yes ☐ No (*If NO, the Proposed Protected Person may not qualify for the services of the Washoe County Public Guardian.*)**
- **Has this action been Court directed?** ☐ Yes ☐ No

1. **General Information (PLEASE FILL IN *COMPLETELY*):**

   Name of Proposed Protected Person (*last, first middle*) _____

   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 ☐ Widowed ☐ Unknown

2. **Location History:**

   Current physical location of Proposed Protected Person: _____

   Immediately preceding residence, location, or placement: _____

   Any other known residences (home, apartment, et cetera): _____

   Does Proposed Protected Person live alone at residence? ☐ Yes ☐ No

   Residence telephone number: _____

   Cellular 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. **Discharge Plan:** ☐ 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?** ☐ Yes ☐ 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?** ☐ Yes ☐ 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): _____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

12. **If exploitation, abuse, or neglect is suspected, has a Police Report been filed and/or has Elder Protective Service been notified?**
Police Report: ☐ Yes ☐ No If YES, please attach a copy and provide Case # _____
Elder Protective Services notified: ☐ Yes ☐ No

13. **Alternatives to Guardianship:** Guardianship is a serious step and should only be used as a last resort. Please check below the alternatives to guardianship that have already been used, and *include dates of service and outcome*.

☐ Assistance from family and/or friends: _____

☐ Case Management: _____

☐ CHIPS (Division of Aging Services): _____

☐ Day Program: _____

☐ Homemaker Services: _____

☐ Meals on Wheels: _____

☐ Northern Nevada Adult Mental Health Services: _____

☐ Rep Payee and/or money management services: _____

☐ Senior Services: _____

☐ Sierra Regional Center: _____

☐ VA services: _____

14. **Other agencies or professionals/social workers involved or providing services** *(include contact telephone number and email address)***:** _____

_____

_____

15. **Does Proposed Protected Person have a private attorney?** ☐ Yes ☐ No
If YES, provide name, full address, and telephone number: _____

_____

_____

16. **List long-term medical providers:** (e.g. primary care physician, specialists, optometrist, dentist, et cetera ***with contact information***):

Name	Address/Location	Telephone Number	Type of Provider

17. **Is there a history of, or any recent, violent threats or actions noted?** ☐ Yes ☐ No
If YES, describe: _____

_____

_____

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 as Guardian:			
Reason he/she can't serve as Guardian:			
Reason he/she can't serve as Guardian:			
Reason he/she can't serve as Guardian:			
Reason he/she can't serve as Guardian:			
Reason he/she can't serve as Guardian:			

19.

Name of Family Member(s) Notified	**Date**	**Agrees with Guardianship?**
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

20. **Spousal Information *(Current or previous as applicable; LIST EVEN IF DECEASED)*:**

Name of Spouse _____

Address _____

City _____ State _____ Zip _____ Telephone _____

Date of Death (if applicable) _____ Place of Death _____

21. **Hospitals Only -** Copies of the following are required (*please check those you have attached*):

☐ Admit Sheet ☐ Consultation Reports
☐ History & Physical Exam ☐ OT/PT/ST Evaluations
☐ Psychiatric Assessment ☐ Medication Administration Record (MAR)
☐ If Nursing Home Placement sought, copy of Proof of Payment source, application & guarantee

22. **Nursing Homes/Group Care Facilities Only -** Copies of the following are required (*please check those you have attached*):

☐ Admit Sheet
☐ History & Physical Exam
☐ Psycho-Social Assessment
☐ Complete Patient Trust Fund Accounting
☐ Consultation Reports
☐ Medication Administration Record (MAR)
☐ Proof of Payment Source, Application & Guarantee
☐ Correspondence to Family/Significant Others Notified of Petition for Guardianship

23. **Will:** Do you have knowledge of an existing will? ☐ Yes ☐ No (*If YES, attach copy if available)*

Is there an Advance Directive? ☐ Yes ☐ No Date: _____ Location of document: _____

24. **Income Source** (*Attach copies of applications, if applicable*):

Income Source	Amount receiving OR Date of application	Payee? If so, please list
SSA		
SSD		
SSI		
Veterans Benefits		
Pension/Annuity		
Other		

25 **Finances** (*Attach additional sheets, if necessary*):

Accounts	Location (bank, branch, etc.)	Account Number	Approximate Value
Checking Account			
Savings Account			
CD/IRA Trust Fund			
Stocks, Bonds			
Investments			
Patient Trust Account			
Other			

Does anyone else have their name on the above accounts? ☐ Yes ☐ No *If YES, who*? _____

Which account? _____

Asset	Specify Type	Location/Address	Approximate Value
Real Property *(House, Land, etc.)*			
Mobile Home			
Vehicles (*include year, make, model)*			
Burial Plot/Plan Or Insurance			
Safe Deposit Box			
Other			

26 **Health Insurance:**

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			
VA Health			
Private			
Supplemental			

27 **Notes:** Is there anything else you would like us to know for our investigation that is not covered in the previous parts of this information sheet? _____

Once this form is completed, mail or fax to:

Washoe County Public Guardian
PO Box 12310, Reno, NV 89510-2310
Fax: (775) 674-8850

I certify that the information provided is true and accurate to the best of my knowledge, and that I have made every effort to obtain ALL requested information.

Signature: _____ Date: _____