Office of the Public Guardian
Health and Human Services

Pahrump Office
250 N. Highway 160
Suite 3
Pahrump, NV 89060
24/7 Cell: 775.277.0339
Email: ncpg@nyecountynv.gov

NYE COUNTY
PUBLIC GUARDIANSHIP REFERRAL

Attached, please find the forms to be completed when making a referral for a Public Guardian. Please note the following general information you may find helpful in making your referral.

1. Typically, the Proposed Protected Person will only be considered if they meet the following criteria:
    a. **Person(s) are adults, age 18 and older.**
    b. **Person(s) must be a resident of Nye County.**
    c. **Person(s) must have a psychological and clinical evaluation by a licensed physician or psychiatrist.**
    d. **Person(s) would be placed in a nursing home facility or group home.**

2. A guardianship referral is not warranted unless you feel an individual is incapacitated and unable to manage his or her own financial resources and/or is unable to make informed medical decisions. We will require copies of recent medical records that indicate what conditions caused the Proposed Protected Person to be incompetent or incapacitated.

3. Family members, if appropriate, may have priority to serve as guardian in lieu of the Public Guardian. We ask that you contact responsible family members regarding the possibility of serving, prior to contacting us.

4. Please provide all requested documentation and any other information you may feel pertinent to our investigation. A lack of information may delay action on the case.

5. Once the referral form has been submitted to our office, please keep us informed of any significant changes (i.e., medical condition, residence, family involvement, etc.) regarding the Proposed Protected Person.

Thank you for your interest in the welfare of the Proposed Protected Person.

Nye County Public Guardianship Referral Form

Submitted By: _____ Date:_____

Nye County Public Guardianship Referral Form

Submitted By: _____ Date:_____

Telephone Number: _____

Agency: _____

Signature: _____

1. **Protected Person's Diagnosis**

❖ Attach the completed Psychological and Clinical Evaluation from a licensed physician or psychiatrist.

2. **Protected Person (formerly Ward)**

Name: _____ Birth Date:_____

Other names used: _____

Social Security No.: _____ Medicare/Medicaid #: _____

Is the Protected Person a Veteran? _____ Branch: _____ VA #: _____

Place of Birth (City, State, Country): _____

Father's Name: _____

Mother's Maiden Name: _____

Current Residence: _____

_____

List the last residence of the Protected Person prior to being admitted to a care facility or Institution.

_____

Is the Protected Person a natural born or naturalized US Citizen? _____

Is the Protected Person currently involved in any civil or criminal litigation? _____

Is the Protected Person currently on or scheduled for probate or parole? _____

Is the Protected Person currently on or scheduled incarcerated? _____

❖ Attach a copy of the Protected Person's photo identification (driver's license, Nevada ID card or VA ID card), social security card & Medicare/Medicaid card. Attach a copy of any existing power of attorney executed by the Protected Person. Attach the Protected Person's birth certificate, naturalization papers and/or passport (if available).

3. Elder Protective Services Case

Is there an open Elder Protective Services case involving the Protected Person? _____

Is there a restraining order filed on the Protected Person's behalf? _____ (If YES, attach a copy.)

4. Protected Person's Spouse

Name: _____ Birth Date: _____

Other Names Used: _____

Social Security No.: _____ Medicare/Medicaid #: _____

Is the Protected Person a Veteran? _____ Branch: _____ VA #: _____

Current residence: _____

Is the Protected Person's spouse deceased? _____ Date of Death: _____

Is the Protective Person divorced? _____ Date of Divorce: _____

5. Protected Person's Family

- List of names and current addresses of all children, grandchildren, and siblings (brothers and sisters) of the Protected Person. Use additional pages if necessary.

A. Name: _____

Relationship to Protected Person: _____ Age: _____ Phone #: _____

Mailing Address: _____

B. Name: _____

Relationship to Protected Person: _____ Age: _____ Phone #: _____

Mailing Address: _____

C. Name: _____

Relationship to Protected Person: _____ Age: _____ Phone #: _____

Mailing Address: _____

D. Name: _____

Relationship to Protected Person: _____ Age: _____ Phone #: _____

Mailing Address: _____

6. Income

- List amount and source of all income for the Protected Person and the Protected Person's spouse (if any). Include amount of any automatic deductions, i.e. insurance premiums. Income includes social security payments, pensions, Veterans benefits, disability payments, unemployment benefits, IRA or 401K disbursements, interest payments, alimony payments, money from sale of property, rentals/leases, and money from relatives or others.

Protected Person's Income:	**Monthly:**	**Deductions:**
Social Security Retirement Benefits (FRA)		
Social Security Disability Benefits (SSDI)		
Social Security Supplemental Benefits (SSI)		
PERS		
Veterans Administration Pension		
Other Pension(s)		
Other Pension(s)		
Other Income		
Other Income		

Protected Person's Spouse's Income:	**Monthly:**	**Deductions:**
Social Security Retirement Benefits (FRA)		
Social Security Disability Benefits (SSDI)		
Social Security Supplemental Benefits (SSI)		
PERS		
Veterans Administration Pension		
Other Pension(s)		
Other Pension(s)		
Other Income		
Other Income		

Does the Protected Person have a Will? _____

Does the Protected Person have a Trust (living, revocable, family or irrevocable)? _____

Burial Plan: Prepaid? _____ Provider: _____

Cremation? _____ Full Burial? _____ VA? _____

7. Assets

- Complete as fully as possible. Use additional pages if necessary.

- **Checking or savings account, IRA, annuity, 401K, money market account, CD, brokerage account, stocks or bonds, or other bank or investment account.**

  - Bank or Broker: _____

    Account Number: _____ $ _____

    Names on Account: _____

  - Bank or Broker: _____

    Account Number: _____ $ _____

    Names on Account: _____

- **Real Property**

  - Real Property: _____

    Names on Title: _____

  - Real Property: _____

    Names on Title: _____

- **Tangible Personal Property (clothing, furniture, etc.)**

  - Location: _____

  - Location: _____

- **Vehicle, boat, motor home, mobile home (not part of real property), or travel trailer. Attach a copy of the title or registration.**

  - Vehicle: year: _____ make & model: _____

    Names on Title: _____

  - Vehicle: year: _____ make & model: _____

    Names on Title: _____

  - Vehicle: year: _____ make & model: _____

    Names on Title: _____

- **Life Insurance. Attach a copy of any policies.**

- **Any other assets, including mining claims, water rights, antiques, collectibles, and interests in any partnerships, limited liability corporations or family corporations. Attach copies of ownership documentation, permits, appraisals, articles of incorporation or partnership agreements.**

    - Asset: _____

      Names on Title: _____

      Location: _____

    - Asset: _____

      Names on Title: _____

      Location: _____

The following forms

MUST

be completed and signed by a

licensed physician or **psychiatrist**.

Patient Name: _____

PSYCHOLOGICAL & CLINICAL EVALUATION

1. PHYSICAL AND MENTAL CONDITIONS

A. Mental Diagnoses: _____

_____

Overall Mental Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Overall Mental Health will: ☐ Improve ☐ Be Stable ☐ Decline ☐ Uncertain

B. Mitigating Factors: Are there mitigating factors (e.g., hearing, vision or speech impairment, bereavement, etc.) that cause the person to appear incapacitated and could improve with time, treatment, or assistive devices? ☐ Yes ☐ No ☐ Uncertain

C. Reversible Causes: Have temporary or reversible causes of mental impairment been evaluated and treated? ☐ Yes ☐ No ☐ Uncertain

D. List all Medications: _____

_____

E. Does mental impairment improve or is mental impairment controllable with medication? ☐ Yes ☐ No ☐ Uncertain

F. Physical Diagnoses: _____

_____

Overall Physical Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Overall Physical Health will: ☐ Improve ☐ Be Stable ☐ Decline ☐ Uncertain

2. COGNITIVE FUNCTIONING

A. Motor Activity and Skills (active, agitated, slowed; gross and fine motor skills)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

B. Working Memory (attend to verbal or visual material over short time periods; hold > 2 ideas in mind)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

C. Short term/recent memory and Learning (ability to encode, store, and retrieve information)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

D. Long term memory (remember information from the past)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

E. Understanding ("receptive language"; comprehend written, spoken, or visual information)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

F. Communication ("expressive language"; express self in words, writing, signs; indicate choices)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

G. Arithmetic (understand basic quantities; make simple calculations)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

H. Verbal Reasoning (compare two choices and to reason logically about outcomes)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

I. Executive Functioning (plan for the future, demonstrate judgment, inhibit inappropriate responses)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

3. EMOTIONAL AND PSYCHIATRIC FUNCTIONING

A. Disorganized Thinking (rambling thoughts, nonsensical, incoherent thinking)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated
☐ No impairment or mild impairment when on regular/daily psychotropic medications

B. Hallucinations (seeing, hearing, smelling things that are not there) or **Delusions** (extreme suspiciousness; believing things that are not true against reason or evidence)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated
☐ No impairment or mild impairment when on regular/daily psychotropic medications

C. Anxiety (uncontrollable worry, fear, thoughts, or behaviors)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated
☐ No impairment or mild impairment when on regular/daily psychotropic medications

D. Mania (very high mood, disinhibition, sleeplessness, high energy)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated
☐ No impairment or mild impairment when on regular/daily psychotropic medication

E. Depressed Mood (sad or irritable mood)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated
☐ No impairment or mild impairment when on regular/daily psychotropic medication

F. Insight (ability to acknowledge illness and accept help) or **Noncompliance** (refuses to accept help)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated
☐ No impairment or mild impairment when on regular/daily psychotropic medication

G. Impulsivity (acting without considering the consequences of behavior)
Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated
☐ No impairment or mild impairment when on regular/daily psychotropic medication

4. RISK OF HARM AND LEVEL OF SUPERVISION NEEDED

A. How severe is risk of harm to self or others: ☐ None ☐ Mild ☐ Moderate ☐ Severe
☐ No risk when on regular/daily psychotropic medications

B. How likely is it: ☐ Almost Certain ☐ Probable ☐ Possible ☐ Unlikely
☐ No risk when on regular/daily psychotropic medications

C. Level of Supervision Needed (In your clinical opinion):
☐ Locked facility ☐ 24-hr supervision ☐ Some supervision ☐ No supervision
☐ No or limited supervision required when on regular/daily psychotropic medications

5. EVERYDAY FUNCTIONING

1. Independent 2. Needs Support 3. Needs Assistance 4. Total Care

1	2	3	4	
				Care of Self (Activities of Daily Living (ADL's) and related activities)
☐	☐	☐	☐	Maintain adequate hygiene, including bathing, dressing, toileting & dental
☐	☐	☐	☐	Prepare meals and eat for adequate nutrition
☐	☐	☐	☐	Identify abuse or neglect and protect self from harm
				Financial (If appropriate note dollar limits)
☐	☐	☐	☐	Manage and use checks, deposit, withdraw, dispose, invest monetary assets
☐	☐	☐	☐	Enter into a contract, financial commitment, or lease arrangement
☐	☐	☐	☐	Employ persons to advise or assist him/her
☐	☐	☐	☐	Resist exploitation, coercion, undue influence
				Medical
☐	☐	☐	☐	Give/withhold medical consent
☐	☐	☐	☐	Admit self to health facility
☐	☐	☐	☐	Make or change an advance directive
☐	☐	☐	☐	Manage medications
☐	☐	☐	☐	Contact help if ill or in medical emergency
				Home and Community Life
☐	☐	☐	☐	Choose/establish abode
☐	☐	☐	☐	Maintain reasonably safe and clean shelter
☐	☐	☐	☐	Drive or use public transportation
☐	☐	☐	☐	Make and communicate choices about roommates
☐	☐	☐	☐	Avoid environmental dangers such as stove, poisons, and obtain emergency help

6. CAPACITY AND ATTENDANCE AT HEARINGS

A. Legal Documents: Does patient have the capacity necessary to understand and execute testamentary or legal documents? (i.e. will or trust)? ☐ Yes ☐ No ☐ Uncertain

B. Informed Medical Decisions: Does patient have the capacity necessary to make an informed decision concerning medical care? ☐ Yes ☐ No ☐ Uncertain

C. Voting: Does patient have the capacity necessary to understand and complete voter registration forms and to vote? ☐ Yes ☐ No ☐ Uncertain

D. Driving: Is patient capable of driving? ☐ Yes ☐ No ☐ Uncertain

E. Owning or purchasing a firearm: Would patient present a risk or threat to self or others if patient were to own or purchase a firearm? ☐ Yes ☐ No ☐ Uncertain

F. Attendance at hearing regarding guardianship

☐ Patient would not comprehend the reason for attendance at the hearing and could not contribute to the proceedings.

☐ Attendance at a hearing would be detrimental to patient's mental and/or physical health.

☐ Patient suffers from an illness or disease which requires isolation or prevents transport of the patient to the courthouse.

☐ Patient can attend the hearing.

G. Guardianship

☐ Patient is capable or living independently and does not require a guardian.

☐ Patient is capable of living independently or in a minimal supervision facility but requires oversight to take medications and/or assistance with medical and financial matters (limited guardianship or case manager).

☐ Patient cannot live independently and requires a guardian for all medical and financial decisions (full guardianship).

☐ Discussing need for guardianship with patient would be detrimental to patient's mental health.

☐ Patient has requested that _____ be appointed as patient's guardian.

Form must be signed by a physician or psychiatrist licensed to practice in Nevada, or a physician or psychiatrist employed by the Veterans Administration

_____

Dated

_____

Signature of physician or psychiatrist

_____

Printed name and title of physician or psychiatrist

A psychologist, nurse, nurse practitioner, physician's assistant, social worker or case manager may assist in completion of this form, but cannot complete the form without the signature of a physician or psychiatrist.

_____

Dated

_____

Signature

_____

Printed name and title

CERTIFICATE OF NEED FOR GUARDIANSHIP, ABILITY TO APPEAR AT HEARING, AND ADMONISHMENT OF RIGHTS

CERTIFICATE OF NEED FOR GUARDIANSHIP

In accordance with NRS 159.044(2)(j), NRS 159.044(3) and NRS 159.0535:

1. I, _____ (your name), am:
   - ☐ A physician licensed to practice in the State of Nevada
   - ☐ A physician employed by the Department of Veterans Affairs
   - ☐ A physician or non-physician employed by the following governmental agency in the State of Nevada which conducts investigations _____(name of agency)
   - ☐ None of the above, but I am qualified to execute this Certificate for the following reasons (I understand the court will have to determine for itself if I am qualified to execute all or any part of this Certification): _____
     _____
     _____

2. It is my opinion that the adult proposed Protected Person, _____
   _____ (name of Proposed Protected Person), suffers from: _____
   _____
   _____,
   which limits his/her ability to maintain his/her safety and basic needs as follows: _____
   _____
   _____
   _____
   _____

3. It is my opinion that this proposed Protected Person:
   - ☐ Is a danger to himself/herself or to others
   - ☐ Is NOT a danger to himself/herself or to others

4. It is my opinion that this proposed Protected Person:
   - ☐ Would comprehend the reason for a guardianship court hearing or be able to contribute to the proceeding
   - ☐ Would NOT comprehend the reason for a guardianship court hearing or be able to contribute to the proceeding

5. It is my opinion that this proposed Protected Person:
   - ☐ Is capable of living independently
   - ☐ Is capable of living independently with assistance as follows: _____
     _____
     _____
   - ☐ Is NOT capable of living independently

In accordance with NRS 159.0523 and NRS 159.0525:

6. It is my opinion that this proposed Protected Person is unable to respond (check all that apply):
   - ☐ To a substantial and immediate risk of physical harm
   - ☐ To an immediate need for medical attention
   - ☐ To a substantial and immediate risk of financial loss
   - ☐ Proposed Protected Person is able to respond to all of the above

7. From what I have observed, it is my opinion that this proposed Protected Person:
   - ☐ Is or has been subject to abuse, neglect or exploitation
   - ☐ Has not been subject to abuse, neglect or exploitation

In accordance with NRS 159.044:

8. It is my opinion that this proposed Protected Person needs a guardian of:
   - ☐ The person only (healthcare decisions)
   - ☐ The estate (financial matters)
   - ☐ Person and estate

_____
Dated

_____
Signature

_____
Printed name

CERTIFICATION OF ABILITY TO APPEAR AT HEARING

In accordance with NRS 159.0535:

1. I, _____ (your name), am:
   - ☐ A physician licensed to practice in the State of Nevada
   - ☐ A physician employed by the Department of Veterans Affairs
   - ☐ A physician or non-physician employed by the following governmental agency in the State of Nevada which conducts investigations _____(name of agency)
   - ☐ None of the above, but I am qualified to execute this Certificate for the following reasons (I understand the court will have to determine for itself if I am qualified to execute all or any part of this Certification): _____

     _____

     _____

2. It is my opinion that this proposed protected person:
   - ☐ Is able to appear at the guardianship court hearing, **and the proposed Protected Person should be transported by the hospital/facility to the courthouse for the hearing**
   - ☐ Is NOT able to appear at the guardianship court hearing because transporting the proposed Protected Person to the courthouse for a hearing would be detrimental, and pose an undue burden on the Protected Person's mental or physical health for the following reasons (please print legibly for the Court's consideration):

     _____

     _____

     _____

     _____

     _____

     _____

_____

Dated

_____

Signature

_____

Printed name

CERTIFICATION OF RIGHTS FOR PROTECTED PERSON
(only if proposed Protected Person will not be attending the hearing)

☐ TEMPORARY GUARDIANSHIP
- ☐ Person
- ☐ Estate
- ☐ Person and Estate

☐ GENERAL GUARDIANSHIP
- ☐ Person
- ☐ Estate ☐ Summary Admin.
- ☐ Person and Estate

☐ SPECIAL GUARDIANSHIP
- ☐ Person
- ☐ Estate ☐ Summary Admin.
- ☐ Person and Estate

☐ NOTICES/SAFEGUARD
- ☐ Blocked Account
- ☐ Bond Posted
- ☐ Public Guardian Bond

1. _____ (Print Name).
   - ☐ I am a physician licensed to practice medicine in the State of Nevada; or
   - ☐ I am a _____ (title) with _____, (facility at which you are employed). I am qualified to execute this certificate and state the conditions of the Protected Person.

In accordance with NRS 159.0535

2. I have informed the Protected Person that the Nye County Public Guardian's Office is requesting appointment as Guardian(s) of the Protected Person. I have asked the Protected Person for a response to the Guardianship petition.
   - ☐ The Protected Person's response was:
     _____
     _____
   - ☐ The Protected Person was unresponsive.

3. I have informed the Protected Person of his/her right to counsel and ask the Protected Person if he/she wishes to be represented by counsel in the guardianship proceedings.
   - ☐ The Protected Person's response was:
     _____
     _____
   - ☐ The Protected Person was unresponsive.

4. I have asked the Protected Person who he/she would prefer to be appointed as his/her guardian.

   ☐ The Protected Person's response was:

   _____

   _____

   ☐ The Protected Person was unresponsive.

5. Are there any conditions of the Protected Person that would limit his/her responses to the above questions?

   _____

   _____

   _____

_____

Dated

_____

Signature

_____

Printed name

PHYSICIAN'S ASSESSMENT
(only necessary if a Nevada licensed physician did NOT complete the certifications above, which should contain the following findings)

In accordance with NRS 159.044(3):

1. I am a physician licensed to practice medicine in the State of Nevada.

2. The proposed Protected Person _____ (name) suffers from the following limitations of capacity that affect his/her ability to maintain his/her safety and basic needs as follows: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
Dated

_____
Signature

_____
Printed name

The foregoing packet of certifications is submitted by:

_____
Signature