

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, *written as legibly as possible*.

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: _____ Fax: _____
Relationship to the Proposed Protected Person: _____

- Is Proposed Protected Person a **RESIDENT** of Carson City? Yes No *(If NO, the Proposed Protected Person may not qualify for the services of the Carson City 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: _____

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: _____

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
- Correspondence to Family/Significant Others Notified of Petition for Guardianship
- Consultation Reports
- Medication Administration Record (MAR)
- Proof of Payment Source, Application & Guarantee

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 (<i>include year, make, model</i>)			
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, fax or email to:

**Carson City Public Guardian
 201 N. Carson St. Suite 1,
 Carson City, NV 89701
 Fax: (775) 887-2585
 ccpg@carson.org**

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: _____