Washoe County Public Guardian
GUARDIANSHIP REFERRAL FORM (Rev 09/2016)

THIS FORM MUST BE THOROUGHLY COMPLETED IN ORDER FOR WCPG TO REVIEW AND INVESTIGATE.

WCPG USE ONLY
Date Rec'd:

WCGALL #: _____
Re-referral # _____

Susan DeBoer
WASHOE COUNTY PUBLIC GUARDIAN
P.O. Box 12310
Reno, NV 89510-2310
(775) 674-8800 Telephone
(775) 674-8850 Fax

REFERRING SOURCE CONTACT INFORMATION

Name: _____ Date submitted: _____

Agency: _____ Telephone: _____

Email: _____ Fax: _____

- **Is Proposed Ward a RESIDENT of Washoe County? ☐ Yes ☐ No (I*f NO, do NOT complete and submit this form, as the individual does NOT meet basic criteria for WCPG guardianship service*s)**
- **Has this referral been Court directed?** ☐ Yes ☐ No

Attach a copy of current medical records that indicate the conditions that cause incompetence or incapacity (see #21 and #22). A completed *Physician's Certificate With Needs Assessment* MUST be attached. PLEASE *DO NOT* SUBMIT THIS REFERRAL UNTIL THE PHYSICIAN'S CERTIFICATE HAS BEEN OBTAINED.

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

   Name of Proposed Ward (l*ast, first, MI*)_____

   Other names used _____

   Age_____ Date of Birth _____ Social Security # _____

   Medicare #_____ Medicaid # _____

   Veteran ☐ Yes ☐ No ☐ Unknown VA Service #_____ Branch_____

   Home Address_____ City, State, Zip _____

   Does proposed Ward currently live alone? ☐ Yes ☐ No Home Telephone_____

   Marital Status (*check*) ☐ Single/Never married ☐ Married ☐ Divorced ☐ Widowed ☐ Unknown

2. **Current location of Proposed Ward** (if different than above; i.e. *hospital, nursing facility, family's residence)*

   _____

3. **Date admitted to current facility:** _____

4. **Date(s) of previous admissions to current facility:** _____

5. **Discharge Plan:** ☐ Skilled Nursing ☐ Residential Care Facility ☐ Independent Living / Home

6. **List facilities where referrals have been made:** _____

7. **Anticipated discharge date (if applicable):** _____

8. **Identification** in Proposed Ward's possession at time of admission (*verify with facility Safekeeping if applicable)*: ☐ Drivers license ☐ State ID Card ☐ Military ID ☐ Medicare card ☐ Medicaid card ☐ Private Insurance card ☐ Other: _____

9. **Does any person or institution have Legal Guardianship, Power of Attorney, or custody and control of Proposed Ward?** ☐ Yes ☐ No If yes, who?_____
   (Note: if available please provide copies of any and all related legal documents, i.e. POA).

10. **Purpose of Guardianship:** In what way will a guardianship benefit the Proposed Ward? What ***unmet needs*** exist that cannot be addressed by another agency or service? _____

11. **Situation** leading up to the referral**:** Briefly describe the chronology of recent events that resulted in the need to refer this individual for guardianship (attach additional sheets if necessary): _____

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

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*. **Please consider these alternatives before proceeding with this referral.**

    ☐ 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 # and email address)***:** _____

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

_____

_____

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

Name	Address/Location	Phone #	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 Phone # w/area code	Relationship to Proposed Ward
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_____ Phone_____

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- C**opies of the following are required *(please* check those you have attached):

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

Accounts	Location (bank, branch, etc.)	Account Number	Approximate Value
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 appl.) with 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 referral? _____

Please be sure to attach available copies of ALL documentation asked for in questions 9, 12, 21, 22, 23, and 24, as well as a *Physician's Certificate With Needs Assessment.*

Once this form is completed, mail or fax to:

Susan DeBoer, Washoe County Public Guardian
P.O. 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: _____