KATHLEEN BUCHANAN
CLARK COUNTY PUBLIC GUARDIAN
515 Shadow Lane
Las Vegas, NV 89106
(702) 455-4332
Fax: (702) 455-4797
www.ClarkCountyNV.gov

Please find the attached form to be completed when making a referral to the Office of the Public Guardian. Please note the following general information you may find helpful in making your referral.

1. 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. The Public Guardian's Office requires copies of recent medical records that support what conditions cause a proposed ward to be considered incompetent and /or incapacitated..

2. 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. Please refer family members to us for information on attending our bi-monthly training session, which outlines the responsibilities and duties of a guardian.

3. Temporary Guardianships are appropriate by Nevada Revised Statute 159 only if "the proposed ward faces a substantial and immediate risk of financial loss or physical harm or needs immediate medical attention and the proposed ward lacks capacity to respond to the risk of loss or harm or to obtain the necessary medical attention".

4. Please provide all requested documentation and any other information you may feel pertinent to our investigation. A lack of information will delay the referral process.

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 ward.

Following the evaluation, you will receive written notice of our decision. Thank you for your interest in the welfare of the proposed ward.

If you have any suspicions of elder abuse, neglect, or exploitation, please report to one of the following agencies immediately:

1. State of Nevada Aging and Disability Services Division: 486-3545
2. Nevada State Welfare: 486-5000
3. Any Police Department:
   - Las Vegas Police Department Abuse & Neglect: 828-3364
   - North Las Vegas Police Department: 649-9111
   - Henderson Police Department: 565-8933
   - Boulder City Police Department: 293-9224
4. Office of the Attorney General: 486-3420

GUARDIANSHIP REFERRAL FORM

Date:

Completed By:

Telephone Number:

Agency:

KATHLEEN BUCHANAN
Clark County Public Guardian
515 Shadow Lane
Las Vegas, NV 89106
(702) 455-4332
www.ClarkCountyNV.gov

(PLEASE TYPE)

1. Name of Proposed Ward:
2. AKA: 3. Mother's Maiden Name:
4. Age: 5. D.O.B. 6. Birth Place: 7. Ethnic Origin:
8. Religious Preference: 9. Highest Education:
10. Employment History:
11. Medicaid/CCSS #: 12. Social Security #:
13. Medicare #: 14. VA#: 15. Branch of Service:
16. Home Address: 17. Telephone:
18. Does Proposed Ward Live Alone? 19. Marital Status: 20. U.S. Citizen ___Yes ___No
21. If no, Country of Origin: Naturalized Resident Alien (Attach Immigration Papers)
22. Current Location of Proposed Ward (Independent, group home, hospital, skilled nursing facility, etc.)
23. If there is a Discharge Plan, please describe:
24. Does any person or institution have Legal Guardianship or Power of Attorney for the Proposed Ward?
    ___ Yes ___No If so, who?
25. Other Agencies/Social Workers involved in case:
26. **ATTACH A COPY OF THE CURRENT MEDICAL RECORDS INDICATING CONDITIONS CAUSING INCOMPETENCY/INCAPACITY.**
27. **VIOLENT THREATS OR ACTIONS NOTED: ___Yes ___ No** Describe:
28. Criminal History (Describe):

29. Conditions leading to Referral/Purpose of Guardianship:

30. Relatives/Significant Others (Must include all immediate family members, address and telephone numbers. (Attach additional sheets if necessary)

NAME	ADDRESS	TELEPHONE NUMBER	RELATIONSHIP

31. Name of Family Member(s) Notified | Date | Agree/Disagree with Guardianship Referral (Attach confirmation letter from each relative)

32. SPOUSAL INFORMATION (Attach additional sheets if necessary):

Name, Address & Telephone (include maiden name):

SS#:

Medicare #: Source of Income:

Place of Birth: US Citizen?: Veteran/Branch:

If deceased, Date of Death: Place of Death:

33. **HOSPITALS ONLY, copies of the following information will be required:**

- Admittance Sheet
- History & Physical Exam
- Psychiatric Assessment or Physician documentation of incompetency
- If Nursing Home Placement, copy of proof of payment source, applications & guarantee

34. **NURSING HOMES/GROUP CARE FACILITIES ONLY, copies of the following information will be required:**

- Admittance Sheet
- History & Physical Exam
- Psycho-Social Assessment
- Complete Patient Trust Fund accounting
- Proof of payment source (application and payment guarantee)
- Correspondence sent to family/significant others notifying of referral for Guardianship

35. Will/Trust - Attach Copy

WILL Yes ☐ No ☐ Location:

TRUST Yes ☐ No ☐ Location:

36. Income (attach proof of benefit or copies of applications)

Income Source	Amount Receiving	Or	Date of Application
SSA			
SSI			
VA			
Pension			
Annuities			
Other			

37. Assets

ASSETS	NAME	ADDRESS	ACCOUNT NUMBER	ACCOUNT BALANCE
Checking Account				
Savings Account				
CD/IRA/Trust Fund				
Deed of Trust				
Stocks/Bonds				
Real Property (House, Land, etc.)				
Mobile Home (Include Year, Make, Model)				
Vehicle (Include Year, Make, Model & Vin #)				
Burial Plot/Plan/ Insurance				
Safe Deposit Box				
Other				
Other				

38. Insurance

INSURANCE	AGENCY/ PROVIDER	ADDRESS OR TELEPHONE NUMBER	POLICY #	MONTHLY PREMIUM.
Health Insurance				
Life Insurance				
Home Insurance				

39. Assistance Programs (**attach proof of benefits and copies of application/redeterminations**)

Medicaid (SAMI) Yes ☐ No ☐ Effective Date: _____ # _____

If No, Pending? Yes ☐ No ☐ Date: _____

CLARK COUNTY SOCIAL SERVICE

Nursing Home Guarantee Yes ☐ No ☐ Effective Date: _____ # _____

Payment for Nursing Home Yes ☐ No ☐ Effective Date: _____ # _____

Medical Card Yes ☐ No ☐ Effective Date: _____ # _____

SSI Yes ☐ No ☐ Amount: $ _____

If no, Pending? Yes ☐ No ☐ Date: _____

Food Stamps Yes ☐ No ☐ Pending ☐ Date of Application: _____

Other: _____

PLEASE ATTACH COPIES OF ANY PERTINENT INFORMATION

Submit by Email

After clicking "Submit by Email" you will receive a message to choose internet service type. If you choose "Internet Email", you will be asked to save the form and attach to Email. Please send to all e-mail addresses indicated. Receipt confirmation will be sent within two business days

OR MAIL TO:

Kathleen Buchanan
Clark County Public Guardian
515 Shadow Lane
Las Vegas, NV 89106

OR FAX TO:

Fax: 702-455-4797

FOR OFFICE USE ONLY:

APPROVED/REJECTED_____ DATE:_____

CERTIFICATE OF INCAPACITY AND REGARDING THE NEED FOR GUARDIANSHIP

In accordance with NRS 159.044(2)(j):

I _____ (your name), am:

- ☐ A physician licensed to practice in the State of Nevada
- ☐ A physician employed by the Department of Veterans Affairs
- ☐ Employed by _____ (name of agency), A government agency who conducts investigations.
- ☐ Employed by _____ (name of agency).

The title of my position is _____ and I qualify to execute this Certificate for the following reasons:

_____

It is my opinion that the adult patient, _____, suffers from a diagnosis of: _____

It is my opinion that this patient ☐ is or ☐ is not a danger to himself/herself or to others.

It is my opinion that:

- ☐ The patient is able to attend and understand the guardianship Court hearing
- ☐ The patient would not comprehend the reason for the Court hearing or be able to contribute to the proceeding
- ☐ Attending the Court hearing would be detrimental to the patient

It is my opinion that this patient:

☐ is or ☐ is not capable of living independently;

☐ with or ☐ without assistance. If patient requires assistance, please explain:

_____

In accordance with NRS 159-052 (1) (a):

It is my opinion that this patient 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
- ☐ None of the above

It is my opinion that this patient:

- ☐ 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:

It is my opinion that this patient needs a guardian of:

- ☐ Person (only)
- ☐ Estate (only)
- ☐ Person and Estate

Dated this _____ day of _____ 20 _____

_____

(Physician's Signature)

_____

(Printed Name)

ADMONISHMENT OF RIGHTS FOR PROPOSED ADULT WARD

The individual signing this Admonishment of Rights for Proposed Adult Ward must advise the proposed Ward of his/her right to be represented by an attorney, to appear at the court hearing in person or via video-conference, and must determine whether the proposed Ward wishes to be represented by an attorney in the guardianship proceedings.

(1)_____ I have informed _____, proposed Ward that Kathleen Buchanan, Clark County Public Guardian is requesting appointment as Guardian of the Ward's ○ Person ○ Estate or ○ Person and Estate.

(2)_____ I have asked the proposed Ward for a response to the Guardianship petition.

(3)_____ I have informed the proposed Ward of his/her right to counsel and have asked the proposed Ward if he/she wishes to be represented by counsel in the guardianship proceedings. He/she does does not wish to represented.

(4)_____ I have asked the proposed Ward who they would prefer be appointed as his/her guardian. He/she has indicated: _____.

(5)_____ I have informed the proposed Ward he/she has a right to appear at the hearing regarding this petition to be held:
on the _____ day of _____, 20____, at _____ a.m./p.m.
at the courthouse located at: _____

He/she has indicated he/she does/does not want to attend this hearing in person via video-conference.

Dated this_____day of_____, 20_____.

_____
(Signature)

_____
(Printed Name)