EUREKA COUNTY PUBLIC GUARDIAN
Pernecia Johnson

P.O. Box 506
10 South Main Street
Eureka, Nevada 89316
Pjohnson@eurekacountynv.gov

Phone: (775) 237-5664
Fax: (775) 237-6015

Attached is the form to be completed when making a referral to the Eureka County Public Guardian. Please note the following general information which you may find helpful in making this referral. Please be sure to sign this sheet and provide your contact information.

1. It is important to be aware of the seriousness of the matter when making a referral for guardianship. Implementation of a guardianship denies the individual of his or her civil rights. Just because a person uses bad judgment, or lives a lifestyle not acceptable to those around him or her does not necessarily mean that person is incompetent. Guardianship is not used to impose compliance upon any individual who has an awareness of what they are doing and have the right to make bad decisions. A guardianship referral is not warranted unless you feel an individual is incapacitated making him or her unable to manage his or her own financial resources and or is unable to make informed medical decisions thus endangering him or herself. The number of clients the Public Guardian accepts will be based upon the complexity of the Ward's situation and what is deemed to be a reasonable caseload, utilizing all other resources, including but not limited to, services provided by the Division of Aging, attorney's, as well as immediate family members, the County Guardian being the Appointed Guardian of last resort. Because of the seriousness of making a referral to the Public Guardian you may be asked to be present in any court proceedings to determine if Guardianship is warranted. **Copies of recent medical records indicating what condition(s) is causing a proposed ward to be incompetent or incapacitated are required by law in order for guardianship to proceed.**
2. Guardianship is **NOT** an immediate emergency intervention. If you have any suspicions of elder abuse, neglect, or exploitation, please report this to one of the following agencies:

Elder Protective Services	(775) 738-1966
Nevada Division for Aging Services	(775) 738-1966
Eureka County Sheriff's Office	(775) 237-5252

3. Family members or friends, if appropriate, have priority to serve as guardian in lieu of the Eureka Public Guardian. Please contact responsible family members and friends regarding the possibility of serving, prior to contacting the Public Guardians office.
4. Please provide **all** requested documentation and any other information you feel is pertinent to this investigation. **A lack of information will delay action on the case.**
5. Once the referral form has been submitted, please keep the department informed of any significant changes (i.e. medical condition, residence, family involvement, etc.) regarding the proposed ward.

_____ _____
Signature of Referring Party Date

_____ _____
Telephone Number Fax Number

GUARDIANSHIP REFERRAL FORM
This form must be thoroughly completed in order to expedite investigation
Once this form is completed, mail or fax to:

Eureka County Public Guardian
10 South Main Street
P.O. Box 506
Eureka, NV 89316
Phone: 775-237-5664
Fax: 775-237-6015
Email: PJohnson@eurekacountynv.gov

Date: _____

Sent By: _____

Address: _____

Telephone Number: _____

Agency: _____

Signature: _____

1. General Information:
   Name of Proposed Ward_____

   AKA_____ Mother's Maiden Name_____

   Age_____D.O.B._____Birth Place_____Ethnic Origin_____

   Medicaid/CCSS#_____ Social Security #_____

   Medicare # _____VA # _____ Branch_____

   Home Address_____Telephone_____

   Does Proposed Ward Live Alone? _____Marital Status_____

   U.S. Citizen: Yes____ No____ (Note, if not U.S. Citizen, attach immigration papers)

2. Current Location of Proposed Ward (Hospital, Nursing Facility, Family's Residence, etc.)

   _____

3. Date Admitted to Current Facility_____

4. Any Previous Placement?

_____

5. Is there a Discharge Plan? If so, please describe._____

_____

6. Anticipated Discharge Date_____

7. Does any person or institution have Legal Guardianship, Power of Attorney, or Custody or Control of proposed ward? Yes___ No___ If so, who? _____

8. Does Proposed Ward Have a Private Attorney? Yes___ No___ if so, give name, address and telephone number of
attorney._____

_____

9. Other Agencies/Social Workers Involved in Case:_____

_____

10. Attach copy of current medical records that indicate the conditions that cause incompetence or incapacity, including a physician's signed letter regarding assessment, diagnosis, prognosis and recommendations._____

_____

11. List Long Term Medical Providers: (i.e., additional physician, optometrist, dentist, etc.)

_____

_____

12. Violent Threat or Actions Noted? Yes___ No___ Describe: _____

_____

13. Criminal History (Describe):_____

_____

14. Conditions Leading to Referral/Purpose of Guardianship: (How would a guardianship improve the quality of life for the proposed ward?)_____

_____

_____

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

Name	*Address & Phone #*	*Relationship*	*Family Member Notified*	*Agree with Guardianship*

16. Spousal Information (Attach additional sheets if necessary):

Name of Spouse_____ Maiden Name_____

Address_____

City_____ State_____ Zip_____ Telephone_____

SS # _____ Medicare # _____

Date of Birth _____ Place of Birth _____

Date of Marriage _____U.S. Citizen _____ Veteran? _____

Source of Income _____

If Deceased, Date of Death _____ Place of Death _____

17. Hospital Only, copies of the following information will be required:

_____ Admit Sheet
_____ History & Physical Exam
_____ Psychiatric Assessment or Physician Documentation of Incompetence
_____ If Nursing Home Placement, Copy of Proof of Payment Source, Application & Guarantee

18. Nursing Homes/Group Care Facilities Only, copies of the following information will be required:

_____ Admit Sheet
_____ History & Physical Exam
_____ Psychic-Social Assessment
_____ Complete Patient Trust Fund Accounting
_____ Proof of payment Source, Application & Guarantee
_____ Correspondence to Family/Significant Others Notified of Referral for Guardianship

19. Will (Attach Copy): Has a Will Been Prepared? _____
Location:_____ _____
Has an advance Directive Been Prepared? _____ Location:
_____

20. INCOME SOURCE (Attach Copies of Applications):

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

21. ASSETS (Attach Additional Sheets if Necessary)

Asset	Name	Location/ Address	Account Number	Account Balance/Value
Checking Account				
Savings Account				
CD/IRA Trust Fund				
Deeds of Trust				
Stock Bonds				
Real Property (House, Land, Etc.)				
Mobile Home				
Vehicles(include year, make, model & VIN)				
Burial Plot/Plan Insurance				
Safe Deposit Box				
Other				
Other				

Does anyone else have their name on the above accounts? _____

Who?_____ Which Account_____

22. INSURANCE

Insurance Type	Name of Company	Address	Policy Number
Life Insurance			
Health Insurance			

23. Has there been two evaluations done by a doctor to determine incompetence? (Required by law) If so, Doctor's names_____ if evaluations are available attach to form.

24. What is the present medical condition of proposed ward? _____

_____

25. Please indicate which of the following services is being/has been utilized. If inappropriate, please explain._____

_____

26. Is there anything else you would like us to know for our investigation that is not mentioned on the previous parts of this referral?

_____

_____

_____

THE "PHYSICIANS REPORT OF INCAPACITATION" MUST BE ATTACHED TO THIS REFERRAL BEFORE AN INVESTIGATION CAN BE STARTED.

Assistance Programs (Attach Copies of Application/Predeterminations):

Social Security/Disability/SSI (775) 777-7738

Services Provided_____

Medicaid (775) 753-1233

Application Date_____ Who Applied? _____
Current Status_____ (Approval/Denial/Pending)
Effective_____
Authorized Representative/Address_____

Elko County Social Services

Social Services (775) 738-4375
Services Provided_____

State of Nevada

Elder Protective Services (775) 738-1966
Services Provided_____

Nevada Division of Aging Services (775) 738-1966
Services Provided_____

Nevada Mental Health Clinic (775) 738-8021
Services Provided_____

Rural Regional Center (775) 753-1100
Services Provided_____

Veteran's Administration 1-800-827-1000
Services Provided_____

*If circumstances have changed since original date of referral, notify guardian as soon as possible with changes. Please indicate if you feel the person being referred could be in immediate danger:

_____

09/27/2016 revised