

Churchill County Social Services Attn: Public Guardian 485 West B Street, Suite #105 Fallon, Nevada 89406

Churchill County Guardianship Referral Form

This form must be thoroughly completed in order to expedite investigation. (Please type or print)

Date:			
Sent by:			
Agency:	· ————		
Phone Number:	·		
Address:Signature:			
	1. General Info	rmation	
Name of Proposed Ward:			
Also Known as:			
Home Address:			How Long:
Mailing Address:			 ·
Phone Number:	····		
Mothers Maiden Name:			•
Age: Date of Birth:	Birth Place:		_ Ethnic Origin:
Social Security Number:VA#:	:	 Branch:	· · · · · · · · · · · · · · · · · · ·
Marital Status:			
U.S. Citizen:	(Note if not U.S. citizen, att		

Does Proposed Ward live alone? (If proposed ward does not reside alone, names / relationships of other residents)
Location of Proposed Ward (hospital, Nursing Facility, Family Residence, etc.):
Date admitted to current facility:
Any previous placements:
Is there a discharge plan? If so, please describe:
Anticipated discharge date:
3. Legal / Assistance
Does any person, Institute, etc. have legal guardianship, Power of Attorney, custody, or control of Proposed Ward? If so, who?
Other agencies / Social Workers, etc. involved in case, including contact information:
Has a will been prepared: (If so attach a copy) Location:
Does Proposed Ward have attorney: If so, who and contact information?
4. Medical Information
List all Medical / Dental providers with contact information:
Current diagnoses:

diagnosis):	cluding contact information, (also	
5.	. Relatives / Significant Others	
Spousal Information		
•		
Name of Spouse:	Maiden Nam	e:
Address:	State:	7:
City:	State:	_ zīb:
Phone Numbers:		
SS #:	Place of Birth: U.S. Citizen:	
Date of Birth:	Place of Birth:	Victoria
Date of Marriage:	U.S. Cinzen:	veteran:
Source of income:	Amount.	
If Deceased, Date of Death: _	Place of Death:	
	Phone Number	
Income Source	5. Income / Insurance / Assets Amount Received	
	6. Income / Insurance / Assets Amount Received	
Income Source	5. Income / Insurance / Assets Amount Received	
Income Source	5. Income / Insurance / Assets Amount Received \$ \$	
Income Source	5. Income / Insurance / Assets Amount Received \$	
Income Source SSI SSA	5. Income / Insurance / Assets Amount Received \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	
Income Source SSI SSA VA PENSION	i. Income / Insurance / Assets Amount Received \$	
Income Source SSI SSA VA PENSION Insurance, including Medicaid	5. Income / Insurance / Assets Amount Received \$	or Date Applied
Income Source SSI SSA VA PENSION Insurance, including Medicaid	5. Income / Insurance / Assets Amount Received \$	
Income Source SSI SSA VA PENSION Insurance, including Medicaid Type Name of Comp	5. Income / Insurance / Assets Amount Received \$	or Date Applied
Income Source SSI SSA VA PENSION Insurance, including Medicaid Type Name of Comp	Amount Received \$	or Date Applied
Income Source SSI SSA VA PENSION Insurance, including Medicaid Type Name of Comp	Amount Received \$	or Date Applied
Income Source SSI SSA VA PENSION Insurance, including Medicaid Type Name of Comp	Amount Received \$	or Date Applied
Income Source SSI SSA VA PENSION Insurance, including Medicaid Type Name of Comp	Amount Received \$	or Date Applied

Assets (Property, Vein	cles, Recreational Vehicles, Stocks, Bonds, etc. :	•
<u> </u>		
	7. Criminal / Law Enforcement	
Criminal History:		
low Enforcement Invo	lvement, describe:	
Law Emorecinent inve	Tvoment, deserted.	
	8. Miscellaneous / Comments	

Attach all available copies of documentation required above, as well as photo identification, and proof of citizenship or nationality, i.e. Birth Certificate or U.S. Passport.

All referrals must include a copy of psychological assessment conducted by either a private individuals who is medically qualified or otherwise licensed to complete such assessment or by the State of Nevada from a professional qualified to complete such assessments. See Churchill County Procedure for referral request for further information.

Patient Name:	
---------------	--

PSYCHOLOGICAL & CLINICAL EVALUATION

1.	I. PHYSICAL AND MENTAL CONDITIONS			
A	Mental (DSM) Diagnoses			
	Overall Mental Health:			
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?			
C.	Reversible Causes. Have temporary or reversible causes of mental impairment been evaluated and treated? Yes No Uncertain			
D.	List all Medications.			
	Does mental impairment improve or is mental impairment controllable with medication? ☐ Yes ☐ No ☐ Uncertain			
F.	Physical Diagnoses:			
	Overall Physical Health:			
2.	COGNITIVE FUNCTIONING			
1.	Motor Activity and Skills (active, agitated, slowed; gross and fine motor skills) Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not eval.			
2.	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 eval.			
3.	Short term/recent memory and Learning (ability to encode, store, and retrieve information) Level of impairment: None Mild Moderate Severe Not eval.			
4.	Long term memory (remember information from the past) Level of impairment: None Mild Moderate Severe Not eval.			
5.	Understanding ("receptive language"; comprehend written, spoken, or visual information) Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not eval.			
6.	Communication ("expressive language"; express self in words, writing, signs; indicate choices) Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not eval.			
C A I	RE Law Program 1			

Pa	atient Name:
7.	Arithmetic (understand basic quantities; make simple calculations) Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not eval.
	Verbal Reasoning (compare two choices and to reason logically about outcomes) Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not eval.
9.	Executive Functioning (plan for the future, demonstrate judgment, inhibit inappropriate responses) Level of impairment: None Mild Moderate Severe Not eval.
3.	EMOTIONAL AND PSYCHIATRIC FUNCTIONING
1.	Disorganized Thinking (rambling thoughts, nonsensical, incoherent thinking) Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not eval. ☐ No impairment or mild impairment when on regular/daily psychotropic medications.
2.	Hallucinations (seeing, hearing, smelling things that are not there) or Delusions (extreme
su	spiciousness; believing things that are not true against reason or evidence) Level of impairment: None Mild Moderate Severe Not eval. No impairment or mild impairment when on regular/daily psychotropic medications.
3.	Anxiety (uncontrollable worry, fear, thoughts, or behaviors) Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not eval. ☐ No impairment or mild impairment when on regular/daily psychotropic medications.
4.	Mania (very high mood, disinhibition, sleeplessness, high energy) Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not eval. ☐ No impairment or mild impairment when on regular/daily psychotropic medications.
	Depressed Mood (sad or irritable mood) Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not eval. ☐ No impairment or mild impairment when on regular/daily psychotropic medications.
6.	Insight (ability to acknowledge illness and accept help) or Noncompliance (refuses to accept help) Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not eval. ☐ No impairment or mild impairment when on regular/daily psychotropic medications.
7.	 Impulsivity (acting without considering the consequences of behavior) Level of impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Not eval. ☐ No impairment or mild impairment when on regular/daily psychotropic medications.
4.	RISK OF HARM AND LEVEL OF SUPERVISION NEEDED
A.	How severe is risk of harm to self or others: Mild Moderate Severe No risk when on regular/daily psychotropic medications.
В.	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.	EVE	RYD	AY FU	NCTIONING
1. Independent	2. Needs Support	3. Needs Assistance	4. Total Care	and related activities
				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
5.	<u>CAP</u>	ACI	TY AND	ATTENDANCE AT HEARINGS
	testa	menta	ary or lega	Does patient have the capacity necessary to understand and execute al documents? (ie. will or trust)
В.	Votin forms	g. Do and	oes patier to vote?	nt have the capacity necessary to understand and complete voter registration Yes No Uncertain
c.	Drivi	ng. Is	s patient c	apable of driving? Yes No Uncertain
D.				ring regarding guardianship.
	Contri] Pat bute	tient woul to the pro	d not comprehend the reason for attendance at the hearing and could not ceedings.
] Atte	endance a	at a hearing would be detrimental to patient's mental and/or physical health.

Patient Name:

Pa	tient Name:			
E.	Appointment of attorney. Was patient was informed of the patient's right to an attorney in the guardianship proceedings?			
	Patient has requested appointment of an attorney.			
	Patient would not comprehend the need for attorney representation.			
	Discussing need for attorney representation with patient would be detrimental to patient's mental health.			
	Response of patient:			
F.	Guardianship.			
	Patient is capable of living independently and does not require a guardian.			
	Patient is capable of living independently but requires oversight to take psychotropic medications and/or financial oversight (limited guardianship or case manager).			
	Patient is capable of living independently or in a minimal supervision facility and requires a guardian to <u>assist</u> in medical and financial decisions (limited guardianship).			
	☐ 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.			
DAT	ΓΕD this day of, 200			
	(signature of doctor, psychologist or psychiatrist)			
	(printed name of doctor, psychologist or psychiatrist)			
DAT	ED this day of, 200			
	(signature of case manager or social worker)			
	(printed name of case manager or social worker)			

Procedure for referral requesting a quardianship for Churchill County.

Any individual who is stated to be in need of a guardianship who maybe referred to Churchill County Social Services must have a psychological assessment before the referral is received completed by either by a private individual who is medically qualified or otherwise licensed to complete such an assessment or by the State of Nevada Department of Human and Social Services by a person medically qualified or licensed to complete such an assessment.

All referrals for a county guardianship must be made through the Churchill County Social Services Department. All referrals must be accompanied by as much information as possible in the following areas with as much documentation as possible:

- 1) medical condition of the individual
- 2) doctor of the individual including the doctors name, address and phone number
- 3) date last seen by a doctor
- 4) names and account numbers for all financial institutions
- 5) name, address and phone number of all relatives
- 6) local address and length of time where the individual has been living and
- 7) if the individual is receiving social security, veterans compensation or pension or any other income the individual has and where it is received from.
- 8) Any documentation or statement to support reason for referral

The final decision to accept an individual for a guardianship will be made solely by the Churchill County Public Guardian after consultation with the Director of the Churchill County Social Services.