COURT CODE: _____
Your Name: _____
Address: _____
City, State, Zip: _____
Telephone: _____
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Self-Represented

DISTRICT COURT
_____ COUNTY, NEVADA

In the Matter of the Guardianship of the: ☐ Person ☐ Estate ☐ Person and Estate of: _____ (*name of adult who has a guardian*) A Protected Person.	CASE NO.: _____ DEPT: _____

INITIAL PLAN OF CARE FOR THE PROTECTED ADULT PERSON

The guardians have determined that the following plan of care is the appropriate level of care for the protected person and that this plan of care serves the protected person's best interests.

A. Living Arrangements

1. **Address.** The protected person's current address and phone number is:

_____
Name of Facility (if applicable)

_____
Address

_____
City, State, Zip Code

_____
Telephone number

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2. **Residency.** He / she has been at the above address since (*date*) _____.

3. **Current Placement**. The address listed in item #1 is best described as: (☒ *check one*)
   - ☐ Living independently in his/her private home, apartment, or condominium.
   - ☐ Living in his/her private home, apartment, or condominium with another person or persons. List the names of all other individuals living in the home (*names/relationship to adult*): _____
     _____.
   - ☐ Living in someone else's private home, apartment, or condominium with a relative or friend. He/she lives with (*names/relationship to adult*):
     _____
     _____.
   - ☐ Assisted living facility/supported adult residence/supported living arrangement.
   - ☐ A skilled nursing home.
   - ☐ A licensed group home.
   - ☐ A medical facility/hospital/psychiatric facility: (*name*) _____.
   - ☐ A secured facility.
   - ☐ Other (*explain*): _____.

     Is the facility locked? (☒ ***check one***) ☐ Yes or ☐ No

4. **Protected Person's Wishes**. (☒ *check one*)
   - ☐ The protected person wants to stay at the current placement.
   - ☐ The protected person does not want to stay at the current placement. He/she would prefer (*describe where the protected person wants to live and why*):
     _____
     _____

5. **Private Residence**. The protected person: (☒ *check one*)
   - ☐ Is able to live in a private residence with assistance. The protected person requires the following level of in-home assistance (*describe*):
     _____
     _____

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☐ Is not able to live in any private residence because (*describe*):

_____

_____

6. **Future Placement**. (☒ *check all that apply*)

☐ The current placement is appropriate as is.

☐ The current placement is appropriate with additional services (*list the additional services needed*) _____.

☐ Once the current medical situation is stable, the protected person will return to his/her previous residence. This is expected to happen on (*estimated date of return*): _____ and he/she will return to live at (*address*) _____.

☐ A higher level of care is needed. The protected person should be placed at: (☒ *check all that apply*)

☐ An assisted living facility.

☐ A skilled nursing home.

☐ A licensed group home.

☐ A medical facility, hospital, or psychiatric facility.

☐ A secured perimeter facility.

☐ Other (explain): _____.

The above option would be a more appropriate placement because (*explain*)

_____

_____

B. Physical and Mental Condition

7. **Insurance.** The protected person has the following insurance coverage for medical / dental / mental health services: (☒ *check all that apply*)

☐ Medicare

☐ Medicare Part B

☐ Medicaid

☐ VA Health Benefits

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☐ Prescription Drug Coverage (*name of policy*): _____

☐ Private Health Insurance (*name of policy*): _____

☐ Other (*explain*): _____

8. **Physical Health.** The protected person's physical health is: (☒ *check one*)

   ☐ Good

   ☐ Fair

   ☐ Poor

   Describe the overall physical health and physical limitations:

   _____

   _____

   _____

9. **Medical Services.** The protected person receives the following services:

   (☒ *check all that apply*)

   ☐ Regular doctor visits (*complete table below*)

Physician	Reason	Frequency	Last Appt.	Next Appt. Due

   ☐ Regular dental visits (*complete table below*)

Dentist	Frequency	Last Appt.	Next Appt. Due

   ☐ Home health care every (*how often, i.e. "daily" "weekly" "monthly"*)

   _____

   ☐ Full-time nursing care

   ☐ Hospice care

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10. **Mental Health.** The protected person's mental health is: (☒ *check one*)

☐ Good

☐ Fair

☐ Poor

Describe the protected person's overall mental health:

_____

_____

_____

11. **Mental Health Services.** The protected person receives the following services: (☒ *check all that apply*)

☐ Behavioral health visits every (*complete table below*)

Specialist	Reason	Frequency	Last Appt.	Next Appt. Due

☐ Psychiatric appointments every (*complete table below)*

Psychiatrist	Frequency	Last Appt.	Next Appt. Due

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12. **Prescription Medication**: (*complete table below*)

Medication	Diagnosis/Reason	Physician	Last Reviewed by Doctor / Psychiatrist

13. **Medical / Mental Health Needs.** The protected person requires the following medical or mental health examinations to determine necessary and/or ongoing treatment needs (*describe any medical tests/appointments that are needed*):

_____

_____

C. Personal Care

14. **Care Needs.** The protected person's personal care needs are:

(☒ *check all that apply*)

☐ No assistance is needed in performing activities of daily living.

☐ Personal caregivers are needed. Caregivers are needed an average of (*number*) _____ hours per week. Caregivers provide assistance with the following activities of daily living (*explain what assistance is provided, such as housekeeping, bathing, meal preparation, etc.*) _____

_____

_____

☐ Assistance with medication is required.

☐ 24-hour assistance is needed.

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D. Protected Person's Wishes

15. **Written Care Plan**. Did the protected person ever sign a written care plan to indicate what kind of care he/she would like if he/she ever became incapacitated? (☒ *check one*)

☐ No, the protected person did not sign a written care plan.

☐ Yes, the protected person signed a written care plan that indicates his/her following wishes in the event of incapacity: (*explain what the person stated in their written plan for the following areas*)

Health:

_____

_____

_____

Daily Living Activities:

_____

_____

_____

Personal Care:

_____

_____

_____

Social/Recreational:

_____

_____

_____

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16. **Consultation With Protected Person**.: (☒ *check one*)

☐ I have talked with the protected person about how he/she would like to be cared for. The protected person's wishes are: (*explain*)

Health:

_____

_____

_____

Daily Living Activities:

_____

_____

_____

Personal Care:

_____

_____

_____

Social/Recreational:

_____

_____

_____

☐ I have not talked with the protected person about how he/she would like to be cared for because: (*explain why you have not asked the person about their wishes*)

_____

_____

_____

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17. **Honoring Wishes.** (☒ *check one*)

☐ To the extent possible, I am honoring the protected person's wishes.

☐ I have not been able to honor the protected person's wishes because: (*explain*)

_____

_____

_____

18. **Alternatives to Guardianship:**

☐ I have talked with the protected person about alternatives to guardianship and how he/she could access such supports that may replace guardianship in the future.

☐ I have not talked with the protected person about alternatives to guardianship and how he/she could access such supports because: (*explain why not*)

_____

_____

_____

Activities & Recreation

19. **Activities.** The protected person's recreation and social activities include: (☒ *check all that apply*)

☐ Personal Community Activities (*i.e. church, library, etc.*)

_____

_____

_____

☐ Group outings. (*describe*) _____

_____

_____

☐ Family gatherings. (*describe*) _____

_____

_____

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☐ Senior community center events. (*describe*) _____

_____

_____

☐ Work and/or training program. (*describe*) _____

_____

_____

☐ Events at assisted living facility or nursing home. (*describe*) _____

_____

_____

E. Other Information

20. The guardian(s) would like the court to know the following: (*explain anything else that the court should know about the protected person*)

_____

_____

_____

_____

_____

_____

I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.

DATED (*month*) _____ (*day*) _____, 20___.

_____ _____

(First Guardian's Signature) (Second Guardian's Signature)

_____ _____

(Printed Name) (Printed Name)

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