

COURT CODE: \_\_\_\_\_  
Guardian's Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
This is a new address:  yes /  no  
Phone: \_\_\_\_\_  
 home /  cell /  work  
Email: \_\_\_\_\_  
Self-Represented

**DISTRICT COURT**  
\_\_\_\_\_ **COUNTY, NEVADA**

In the Matter of the Guardianship of the:

- Person  
 Person and Estate

of:

CASE NO.: \_\_\_\_\_

DEPT: \_\_\_\_\_

\_\_\_\_\_  
(name of adult who has a guardian)  
A Protected Person.

**REPORT OF THE GUARDIAN OF THE ADULT PERSON**

\_\_\_\_\_ through \_\_\_\_\_  
**BEGINNING DATE** **ENDING DATE**  
*If this is your first report, this is the date you were appointed the guardian.* *The date you sign this form.*  
*If this is a later report, this is the ending date of your last report.*

I, (guardian's name) \_\_\_\_\_, am the Guardian of the above-named Protected Person. My annual report is as follows:

**General Information**

1. The protected person's birthdate is (date of birth) \_\_\_\_\_, and he / she is currently (age) \_\_\_\_\_ years old.
2. How often have you visited the protected person in the last year? \_\_\_\_\_

3. Guardian's Residency: ( *check one*)

- One or both guardians are Nevada residents.
- Neither guardian is a Nevada resident. ( *check one*)
  - A registered agent is on file with the Nevada Secretary of State.
  - No resident agent is on file with the Nevada Secretary of State.

4. Guardianship Alternatives: ( *check one*)

- 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*)

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5. Do you believe the protected person still needs a guardian? ( *check one*)  Yes  No  
(*Explain why or why not*)

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6. The protected person's current address and phone number is:

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Name of Facility (if applicable)

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Address

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City, State, Zip Code

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Telephone number

7. The address listed above 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 individuals living in this home (*names of people living there*): \_\_\_\_\_  
\_\_\_\_\_

Living in someone else's private home, apartment, or condominium. He/she lives with (*names*): \_\_\_\_\_  
\_\_\_\_\_

An assisted living facility / supported adult residence / supported living arrangement.

A skilled nursing home.

A licensed group home.

A medical facility, hospital, or psychiatric facility.

A secured perimeter facility.

Other (explain): \_\_\_\_\_.

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

8. Do you believe the protected person is happy with the living arrangement? ( check one)  Yes  No

(*Explain why or why not*) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Appropriateness of Living Arrangement & Residential Supports.

( 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*)

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### Physical and Mental Health

10. 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
- Prescription Drug Coverage (*name of policy*): \_\_\_\_\_
- Private Health Insurance (*name of policy*): \_\_\_\_\_
- Other (*explain*): \_\_\_\_\_

11. The protected person's physical health is: ( *check one*)

- Good
- Fair
- Poor

Describe the protected person's overall physical health and physical limitations:

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12. The protected person's mental health is: ( *check one*)

- Good
- Fair
- Poor

Describe the protected person's overall mental health:

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13. Medical Services. The protected person receives the following services:

( *check all that apply*)

- Regular dental visits (*complete table below*)

Dentist	Frequency	Last Appt.	Next Appt. Due

- Regular doctor visits (*complete table below*)

Physician	Reason	Frequency	Last Appt.	Next Appt. Due

***\*File any medical records showing any significant health problems with a Confidential Medical / Educational Information Sheet.***

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

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- Full-time nursing care
- Hospice care

14. 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

15. List all prescription medication in the table below.

Medication	Diagnosis/Reason	Physician	Last Reviewed by Doctor/Psychiatrist

16. 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.

17. 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)*:

18. Abuse / Neglect. Has the protected person been abused or neglected in the last year?

No

Yes

Describe the abuse / neglect and any steps taken to address the abuse / neglect:

What agencies were notified of the abuse / neglect?

Law Enforcement  Elder Protective Services  Ombudsman  None

What was the outcome of the investigation?

**Education**

19. ( *check one*)

- The protected person is not enrolled in school.
- The protected person is enrolled in school. The protected person attends (*name of school*) \_\_\_\_\_.

**\*File any report cards with a Confidential Medical/Informational Sheet.**

20. The protected person had the following accomplishments and/or problems in school last year: (*Describe or write "N/A"*)

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**Activities & Recreation**

21. The protected person's recreation and social condition is: ( *check one*)

- Good
- Fair
- Poor

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

Personal Community Activities (*i.e. church, library, etc.*): \_\_\_\_\_

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Group outings. (*Describe*) \_\_\_\_\_

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Family gatherings. (*Describe*) \_\_\_\_\_

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Senior community center events. (*Describe*) \_\_\_\_\_

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Work and/or training program. (*Describe*) \_\_\_\_\_

\_\_\_\_\_

Events at assisted living facility or nursing home. (*Describe*) \_\_\_\_\_

\_\_\_\_\_

None. (*Describe why the protected person is not participating in any activities*)

\_\_\_\_\_

### **Financial Information**

23. ( *check one*)

The protected person's estate is less than \$10,000.

The protected person's estate is more than \$10,000. The finances are managed by  
(*name of person handling the estate*) \_\_\_\_\_.

*\*An annual accounting must be filed detailing the estate assets, income, and expenses.*

### **Protected Person's Wishes**

24. 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*)

\_\_\_\_\_

\_\_\_\_\_

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*)

\_\_\_\_\_

\_\_\_\_\_

25. 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*)

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**Miscellaneous**

26. I believe the protected person has the following unmet needs (*describe*)

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27. I would like the court to know the following: (*briefly state anything else that you would like the court to know, or write "N/A"*) \_\_\_\_\_

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

DATED (*month*) \_\_\_\_\_ (*day*) \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
SIGNATURE OF GUARDIAN(S)