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: _____ (*name of adult who has a guardian*) A Protected Person.	CASE NO.: _____ DEPT: _____

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. If this is a later report, this is the ending date of your last report.	*The date you sign this form.*

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? _____

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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. Less Restrictive Alternatives. Less restrictive alternatives are not being considered as an alternative to guardianship because (*Less restrictive alternatives may include, without limitation, a durable power of attorney for financial matters, a durable power of attorney for health care, and/or a supported decision-making agreement*): (☒ *check one*)
    - ☐ The protected person is incapacitated and unable to choose a less restrictive alternative.
    - ☐ Other (*explain*):

      _____

      _____

      _____

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

   _____

   _____

   _____

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

   _____
   Name of Facility (if applicable)

   _____
   Address

   _____
   City, State, Zip Code

   _____
   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 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*)

_____

_____

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:

_____

_____

_____

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

☐ Good

☐ Fair

☐ Poor

Describe the protected person's overall mental health:

_____

_____

_____

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"*)

_____

☐ 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"*)

_____

_____

_____

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.*)*:* _____

_____

_____

☐ Group outings. (*Describe*) _____

_____

_____

☐ Family gatherings. (*Describe*) _____

_____

_____

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

_____

_____

☐ 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*)

_____

_____

_____

Miscellaneous

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

_____

_____

_____

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"*) _____

_____

_____

_____

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

This document does not contain the personal information of any person as defined by NRS 603A.040.

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

_____

SIGNATURE OF GUARDIAN(S)