Exhibit Cover Page

EXHIBIT NUMBER A

EXHIBIT A: PHYSICIAN'S CERTIFICATE WITH NEEDS ASSESSMENT

(Please answer <u>all</u> questions)

I, _			m qualified to complete this form because:
	check		
(123		im a physician licensed to practice in the Stat	e of Nevada.
		am a physician employed by the Department	
		am employed by the following Nevada gover	
	inv	vestigations* (agency name):	·
		m a person who is otherwise qualified to exe	
	det	termination).* My qualifications are as follo	ws:
CT.	CTION	N.1. Examination Information Diagnosis	and Candition
<u>SE</u>	CHO	N 1: Examination Information, Diagnosis	and Condition
I la	ıst exan	mined	, an adult, on
		ninedPatient's Full Name ("Patient")	
at _		Name of Facility or Address of Office or Residence	I have been the Patient's physician
sino	ce	; Patient (\boxtimes check one) \square i	s / \square is not under my continuing care/treatment.
	would	to the examination, I informed the Patient the d not be privileged: (\overline{\times} check one) \overline{\times} dition to examining the Patient, I reviewed the	☐ Unable to Comprehend ☐ Yes ☐ No
C.	•	check one) □ AM / □ AM NOT aware of the power of attorney, guardian nomination, or ont.	
		a ARE aware of such a document, provide addry of designated agent, etc.):	
D.	or too	the Patient given or diagnosed using any general, including but not limited to Folstein's min a copy.	i-mental status exam? If YES, please

^{*} Before the court can appoint a guardian, a licensed physician must complete an assessment of the Patient's needs that identifies limitations of capacity and how such limitations affect the Patient's ability to maintain safety and basic needs.

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110	gnosis is:
Sev	verity/Degree is: (⊠ check one) □ Mild □ Moderate □ Severe
The	e Patient's mental diagnosis (DSM or ICD Diagnoses) and condition is:
Pro	gnosis is:
Sev	verity/Degree is: (\boxtimes check one) \square Mild \square Moderate \square Severe
	ich of the following descriptions apply to the patient's degree of cognitive impairment check all that apply)? ☐ The patient has a ☐ sufficient loss or ☐ total loss of executive function resulting in a barrier to meaningful understanding or rational response. ☐ The Patient is able to make independently some but not all of the decisions necessary for his or her own care and management of property. ☐ The patient is unable to execute on desires, preferences, or stated goals, preventing the ability to pursue the patient's own best interest. ☐ The patient is unable to receive or evaluate information. ☐ The patient is unable to make or communicate decisions to such an extent that the patient lacks the ability to meet essential requirements for physical health, safety, or self-care without proper assistance.
If Y	□ None of the above. The Patient facing an immediate need for medical attention?□ Yes □ No YES, is the Patient unable to respond to the need for medical attention?□ Yes □ No YES, explain the immediate attention needed and why the Patient is unable to respond:

J.	Is the Patient facing a substantial and immediate risk of financial loss?□ Yes If YES, is the Patient unable to respond to that risk of financial loss?□ Yes □ No If YES, explain the immediate risk and why the Patient is unable to respond:
K.	Does the Patient present a danger to himself/herself?
L.	Has the Patient been subjected to abuse, neglect, or exploitation? □ Yes □ No If YES, explain:
M.	Is the Patient capable of living independently? (⊠ <i>check one</i>) ☐ Yes, without assistance ☐ Yes, with assistance ☐ No If WITH ASSISTANCE, describe the assistance needed; if NO, explain why not:
N.	Attached to this certificate is (⊠ <i>check all that apply, if applicable</i>): □ A copy of my report of the above exam which includes my findings, opinion, and diagnosis regarding the Patient and his/her mental condition and/or capacity. □ A copy of the Patient's chart notes which support and/or detail my findings, opinion, and diagnosis regarding the Patient and his/her mental condition and/or capacity. □ A letter, signed by me, detailing my findings, opinion, and diagnosis regarding the Patient and his/her mental condition and/or capacity.
<u>SE</u>	CTION 2: Ability to Appear at Hearing
A.	Would the Patient's attendance at a hearing for appointment of a guardian be detrimental to the Patient's mental health?
В.	Would attending the hearing for appointment of a guardian be detrimental to the Patient's physical health?

C. Is the patient able to appear at a court hearing? If NO, why not?		1	□ Yes	s 🗆	No
D. Would the patient comprehend the reason for a hearing?	•••••	I	□ Yes	· 🗆	No
E. Would the patient contribute to a hearing?			□ Ye	s \square	No
SECTION 3: Limitations, Abilities, and Needs					
A. The Patient's level of needed supervision is as follows: □ Locked □ 24-hour □ Indepensupervis □ No supervis □ No supermedicat B. My opinion as to the Patient's everyday functions is as follows:	super dent l sion ervisio ervisio	vision iving on	with		
2. The opinion as to the Fatient's everyday functions is as follows.	•				
	Independent	Needs Support	Needs Substantial Assistance	Needs Total Care	Unknown
CARE OF SELF (Activities of Daily Living (ADLs) and related					
activities) Bathe and shower					
Personal hygiene and grooming (e.g., brushing teeth, hair)					
Dress self					
Toilet hygiene (getting to toilet, cleaning self, getting back up)					
Functional mobility (e.g., walking, transferring to/from bed or chair)					
Feed self and eat for adequate nutrition					
Identify physical abuse or neglect and protect self from harm					
ETRIA NICHA I					
FINANCIAL Manage denotit withdraw dispose of and invest manay and assets	1	-			
Manage, deposit, withdraw, dispose of, and invest money and assets	+	-			
Protect, and spend small amounts of cash Employ persons to advise or assist him/her	1				
Identify financial exploitation, coercion, undue influence	+	-			
Protect self from financial exploitation, coercion, undue influence	+				
Give gifts and donations	†				

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	Independent	Needs Support	Needs Substantial Assistance	Needs Total Care	Unknown
MEDICAL					
Give/withhold medical consent to medical, dental, psychological					
Admit self to health facility					
Make or change an advance directive or healthcare power of attorney					
Manage medications					
Contact help if ill or in medical emergency					
HOME AND COMMUNITY LIFE					
Choose/establish residence					
Maintain reasonably safe and clean shelter					
Drive or use public transportation					
Prepare food/meals, cleanup					
Shop for groceries and necessities					
Use telephone or other forms of communication					
Make and communicate choices about roommates					
Avoid environmental dangers such as stove, poisons					
Maintain and pay household bills, utilities, mortgage/rent, taxes					
 SECTION 4: Civil and Legal A. In my opinion, the Patient lacks the capacity necessary to (⋈ check all that apply): □ Enter into a contract, financial commitment, or lease arrangement □ Make or modify a will or power of attorney □ Participate in mediation 					
B. Is the Patient capable of driving?	Yes [□No	□ t	Incer	tain
C. Would the Patient present a risk or threat to self or others if Patien a firearm?					
D. Does the Patient have the capacity necessary to understand and co forms and vote?				stratio Uncer	

SECTION 5: Remarks and Recommendations

	_	A. If you have any rema aware of other concer	
d treatment or se	endations for need	3. If you have any recorabove, please explain	
		This certificate must be signe the certificate.) declare under penalty	e cert decla
		s true and correct.	
	C	Date:	ate: _
	Address: _		
	Telephone: _		
		The following psycholog manager, or other assiste	
_			
	- Completion of the		