**NOTE: SUBMIT THIS FORM TO THE HCS HOSPITAL CASE MANAGER WHEN REQUESTING DSHS TO FIND A CPG OR PETITION GUARDIANSHIP/CONSERVATORSHIP**

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| 1. **GENERAL INFORMATION COMPLETED BY HOSPITAL STAFF** | |
| 1.1 | Hospital Name: |
| Address: |
| Contact name: |
| Telephone number: E-mail Address: |
| 1.2 | DSHS/HCS Hospital Case Manager assigned to client/Respondent:  Name: Region: |
| Address: |
| Telephone number: |
| 1.3 | Respondent Name: |
| Age / Date of birth: Social Security Number: |
| Address: |
| Mailing address, if different: |
| Telephone number: Preferred Region to Discharge: |
| 1.14 | Does the respondent have a current payee?  Yes  No  Individual’s name: Relationship: |
| Name of corporation: Contact person: |
| Address: |
| Mailing address, if different: |
| Telephone number: |
| 1.15 | Confirm if client meets the following criteria:  Lack of decision-making capacity is related to a primary diagnosis of a neuro-cognitive condition:  Yes  No If yes, include diagnosis |
| Client has been assessed and are eligible for HCS Services:  Yes  No |
| Medicaid Financial Application has been submitted:  Yes  No |
| No professional or lay guardian/conservator is available:  Yes  No |
| List names of Certified Professional Guardianship (CPP) Agencies your hospital has contacted: |
| 1. **FOR COMPLETION BY DSHS REPRESENTATIVE (*Region CPG CM complete Qn1)*** | |
| 2.1 | **Date Hospital Request Received:** |
| **Request Approved or Declined:  Yes  No** |
| **Date Request was submitted to CPG/OPG:** |
| **Date CPG was assigned:** |
| **Individual’s name:       Name of Agency:** |
| **Address:** |
| **Mailing Address, if different:** |
| **Telephone number:** |
| 1. **SUBMITTED BY:** | |
| Hospital Staff Signature: **Date:**  Print Name: | |