**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**
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| 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 [ ]  NoIndividual’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)***
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| 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:**
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| Hospital Staff Signature: **Date:**Print Name: |