Exhibit Cover Page

EXHIBIT NUMBER A

EXHIBIT A: PHYSICIAN'S CERTIFICATE WITH NEEDS ASSESSMENT

(*Please answer **all** questions*)

I, _____, am qualified to complete this form because:
Physician's Full Name (*please print legibly*)

(☒ *check one*)

- ☐ I am a physician licensed to practice in the State of Nevada.
- ☐ I am a physician employed by the Department of Veterans Affairs.
- ☐ I am employed by the following Nevada governmental agency that conducts investigations* (*agency name*): _____.
- ☐ I am a person who is otherwise qualified to execute this certificate (subject to the court's determination).* My qualifications are as follows:

  _____

  _____

SECTION 1: Examination Information, Diagnosis and Condition

I last examined _____, an adult, on _____,
Patient's Full Name ("Patient") Date of Exam

at _____.
Name of Facility or Address of Office or Residence

I have been the Patient's physician since _____; Patient (☒ *check one*) ☐ is / ☐ is not under my continuing care/treatment.
Date of First Encounter

A. Prior to the examination, I informed the Patient that my communications with him or her **would not be privileged**: ..... (☒ *check one*) ☐ Unable to Comprehend ☐ Yes ☐ No

B. In addition to examining the Patient, I reviewed the following documents: _____

   _____

   _____

C. I (☒ *check one*) ☐ AM / ☐ AM NOT aware of the existence of a healthcare directive, living will, power of attorney, guardian nomination, or other similar document executed by the Patient.

   If you ARE aware of such a document, provide additional information *(location of document, identity of designated agent, etc.)*: _____

   _____

   _____

D. Was the Patient given or diagnosed using any generally accepted cognitive assessment exam or tool, including but not limited to Folstein's mini-mental status exam? If YES, please attach a copy. ..... ☐ Yes ☐ No

* 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.

E. The Patient's **physical diagnosis** (DSM or ICD Diagnoses) and condition is: _____

_____

_____

_____

Prognosis is: _____

Severity/Degree is: (☒ *check one*) ☐ Mild ☐ Moderate ☐ Severe

F. The Patient's **mental diagnosis** (DSM or ICD Diagnoses) and condition is: _____

_____

_____

_____

Prognosis is: _____

Severity/Degree is: (☒ *check one*) ☐ Mild ☐ Moderate ☐ Severe

G. Which 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.
- ☐ None of the above.

H. Is the Patient facing an immediate need for medical attention? ..... ☐ Yes ☐ No
If YES, is the Patient unable to respond to the need for medical attention? ..... ☐ Yes ☐ No
If YES, explain the immediate attention needed and why the Patient is unable to respond:

_____

_____

I. Is the Patient facing a substantial and immediate risk of physical harm? ..... ☐ Yes ☐ No
If YES, is the Patient unable to respond to that risk of physical harm? ..... ☐ Yes ☐ No
If YES, explain the immediate risk and why the Patient is unable to respond:

_____

_____

J. Is the Patient facing a substantial and immediate risk of financial loss? ..... ☐ Yes ☐ No
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? ..... ☐ Yes ☐ No
Does the Patient present a danger to others? ..... ☐ Yes ☐ No
If YES, explain:

_____

_____

L. Has the Patient been subjected to abuse, neglect, or exploitation? ..... ☐ Yes ☐ No
If YES, explain:

_____

_____

M. Is the Patient capable of living independently? (☒ *check one*)
☐ 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 (☒ *check all that apply, if applicable*):

- ☐ 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.

SECTION 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? ..... ☐ Yes ☐ No
If YES, why?

_____

_____

B. Would attending the hearing for appointment of a guardian be detrimental to the Patient's physical health? ..... ☐ Yes ☐ No
If YES, why?

_____

_____

C. Is the patient able to appear at a court hearing? ..... ☐ Yes ☐ No
If NO, why not?

_____

_____

D. Would the patient comprehend the reason for a hearing? ..... ☐ Yes ☐ No

E. Would the patient contribute to a hearing? ..... ☐ Yes ☐ No

SECTION 3: Limitations, Abilities, and Needs

A. The Patient's level of needed supervision is as follows:

☐ Locked Facility
☐ 24-hour supervision
☐ Independent living with some supervision
☐ No supervision
☐ No supervision when taking medication

B. My opinion as to the Patient's everyday functions is as follows:

CARE OF SELF (Activities of Daily Living (ADLs) and related activities)	Independent	Needs Support	Needs Substantial Assistance	Needs Total Care	Unknown
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					
FINANCIAL					
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					
Identify financial exploitation, coercion, undue influence					
Protect self from financial exploitation, coercion, undue influence					
Give gifts and donations					

	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 ☐ Uncertain

C. Would the Patient present a risk or threat to self or others if Patient were to own or purchase a firearm? ..... ☐ Yes ☐ No ☐ Uncertain

D. Does the Patient have the capacity necessary to understand and complete voter registration forms and vote? ..... ☐ Yes ☐ No ☐ Uncertain

SECTION 5: Remarks and Recommendations

A. If you have any remarks concerning other sections, or if you believe the court should be aware of other concerns about the Patient which are not included above, please explain:

_____

_____

B. If you have any recommendations for needed treatment or services which are not included above, please explain:

_____

_____

(This certificate must be signed by the physician, agency employee, or other person identified at the top of page 1 of the certificate.)

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

Date: _____ Signature: _____

Print Name: _____

Address: _____

_____

Telephone: _____

The following psychologist, nurse, nurse practitioner, physicians' assistant, social worker, case manager, or other assisted in completion of this form *(print all names below, if applicable)*:

_____

_____

_____