*Nevada Kinship Guardianship Assistance Program*

**Successor Guardian Notification Form**

*To initiate the change in guardianship and continue to receive a subsidy payment for the child, the* ***Successor Guardian*** *must provide within 10 business days from the date of the relative guardian’s incapacitation, this completed form to the Nevada child welfare agency responsible for the child’s guardianship subsidy payment.*

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| --- | --- | --- | --- |
| Successor Guardian Name: | | | |
| Co-Successor Guardian Name: | | | |
| Physical Address: | | | |
| City: | | State: | Zip Code: |
| Mailing Address: | | | |
| City: | | State: | Zip Code: |
| Home Phone: | Cell Phone: | | Work Phone: |

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Legal Name: | Age: | | DOB: |
| Child’s Legal Name: | Age: | | DOB: |
| Child’s Legal Name: | Age: | | DOB: |
| Child’s Legal Name: | Age: | | DOB: |
| Former Relative Guardian’s Name: | | | |
| Relative Guardian’s Incapacitation Date: | | | |
| Reason for Relative Guardian’s Incapacitation: | | | |
|  | | |  | | |
| Successor Guardian | | | Date | | |
| Successor Guardian | | | Date | | |