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 guardian's incapacitation, this completed form to the Nevada child welfare agency responsible for the child's guardianship subsidy payment.*

Once completed send form to:
Clark County Department of Family Services: dfsguardianships@clarkcountynv.gov
Washoe County Human Services Agency: 775-785-8600
Division of Child and Family Services: Contact local Office

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:	DOB:
Child's Legal Name:	DOB:
Child's Legal Name:	DOB:
Child's Legal Name:	DOB:
Former Relative Guardian's Name:	
Guardian's Incapacitation or Death Date:	
Reason for Guardian's Incapacitation:	

_____ _____
Successor Guardian Date

_____ _____
Successor Guardian Date