

STATE OF MICHIGAN PROBATE COURT COUNTY OF	ORDER AND REPORT ON ALTERNATIVE MENTAL HEALTH TREATMENT	FILE NO.
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In the matter of _____
First, middle, and last name

ORDER

IT IS ORDERED that _____ shall prepare a report assessing the current
Name (type or print)
availability and appropriateness of alternatives to hospitalization for the individual named above including alternatives available following an initial period of court-ordered hospitalization.

The report shall be made to the court before the hearing on _____ for
Date and time of hearing

Petition for 60-day order, discharge, etc.

Date

Judge

Bar no.

REPORT ON EVALUATION OF HOSPITAL TREATMENT AND/OR ALTERNATIVE PROGRAMS

1. I, _____, as _____, report as follows.
Name Profession, organization, and position

2. I have reviewed, as to their availability in or near the individual's home community, treatment resources alternative to hospitalization and report as follows: (If practical, give name of agency, program, etc.)

a. Independent mental health professional: _____

b. Community mental health day treatment, aftercare service, work activity, or other program: _____

c. Substance abuse, rehabilitation service, or similar program of public or private agency: _____

d. Other: _____

(SEE SECOND PAGE)

Do not write below this line - For court use only

3. I have reviewed, as to their availability in or near the individual's home community, residential accommodations and report as follows: (If practical, give name of residence, location, etc.)

a. Independent: _____
Individual's own house, apartment, etc.

b. Residence of relative or friend: _____

c. Foster care home: _____

d. Nursing home: _____

e. Other: _____

4. I recommend release.

5. I recommend a course of treatment of _____ hospitalization _____ hospitalization for _____ days, followed by
alternative treatment assisted outpatient treatment as follows:

6. My recommendation is based upon the following described interviews, observations, and information:

7. I believe the hospital to which admission is proposed _____ can _____ cannot _____ provide its prescribed treatment program
appropriately and adequately because _____

8. I recommend the following agency or independent mental health professional to supervise the alternative treatment:

Name _____ Complete address _____

The agency or professional _____ has _____ has not _____ indicated capability and willingness to supervise the recommended program.

9. The individual currently has the following source(s) of funds to cover his or her care in the community:

10. The individual does not currently have sufficient sources of funds for community living.

a. Application for supplemental funds has been made. They should be available _____ .

b. Application for supplemental funds has not been made because _____ .

Application will be made on _____ and should be available about _____ .

c. Pending receipt of supplemental funds, the following funds will be available:

Direct relief.

DHHS/CMH emergency care funds.

Other assistance: _____

None. Reason: _____