

STATE OF MICHIGAN  
PROBATE COURT  
COUNTY OF

NOTIFICATION OF NONCOMPLIANCE  
 REQUEST FOR MODIFIED ORDER

FILE NO.



In the matter of \_\_\_\_\_

Should SSN or DOB be added to help police agencies verify they have the correct individual in protective custody?

XXX-XX-XXXX  
SSN

1. I, \_\_\_\_\_, make this notification as the  
Name (type or print)

- agency.
- mental health professional who is supervising the individual's alternative/assisted outpatient treatment program.
- individual.

2. The individual who is the subject of this notification was ordered to undergo a program of alternative/assisted outpatient treatment or combined hospitalization and alternative/assisted outpatient treatment.

- a. The alternative treatment has not been or will not be sufficient to prevent the individual from inflicting harm or injuries to self or others.
- b. The individual is not complying with the order for alternative/assisted outpatient treatment or combined hospitalization and alternative/assisted outpatient treatment.
- c. I believe that my alternative treatment program is not appropriate.

3. There remain \_\_\_\_\_ days of hospitalization under the last order. The individual needs immediate hospitalization.

4. This conclusion is based upon

- a. my personal observation of the individual doing the following acts and saying the following things:

\_\_\_\_\_  
\_\_\_\_\_

- b. conduct and statements seen or heard by others and related to me: State the conduct and statements and the name, address, and telephone number of each witness.

\_\_\_\_\_  
\_\_\_\_\_

5. A psychiatrist has ordered the individual to return to the hospital.

6. I request the court to modify its last order of  alternative treatment  assisted outpatient treatment  combined hospitalization and alternative/assisted outpatient treatment to direct the individual to:

- a. undergo another alternative/assisted outpatient treatment program.
- b. undergo hospitalization or combined hospitalization and alternative/assisted outpatient treatment, with hospitalization not to exceed \_\_\_\_\_ days.
- c. to be transported to the hospital by a peace officer if the individual refuses to comply with the psychiatrist's order to return to the hospital.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Business Address

\_\_\_\_\_  
Agency

\_\_\_\_\_  
City, state, zip Telephone no.

**USE NOTE:** If this form is being filed in the circuit court family division, please enter the court name and county in the upper left-hand corner of the form.

Do not write below this line - For court use only