Approved, SCAO

PCS CODE: PFH/PAS
TCS CODE: IPFH/PFH/PAS

STATE OF MICHIGAN PROBATE COURT COUNTY OF	PETITION FOR MENTAL HEALTH TREATMENT	FILE NO.

In the matter of _____ XXX-XX-_____
First, middle, and last name — Last four digits of SSN

Court ORI	Date of Birth	Place of Birth	Race	Sex

1. I, _____ (Name (type or print)), an adult _____ (specify whether a relative, neighbor, peace officer, etc.) petition because I believe the individual named above needs treatment.

2. The individual was born _____ (Date), has a permanent residence in _____

   County at _____ (Street address, City, State, ZIP)

   and can presently be found at _____ (Facility name or other address).

   ☐ This petition is for a person who was found not guilty by reason of insanity in this county.

3. I believe the individual has mental illness and

   ☐ a. as a result of that mental illness, the individual can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or others, and has engaged in an act or acts or made significant threats that are substantially supportive of this expectation.

   ☐ b. as a result of that mental illness, the individual is unable to attend to those basic physical needs that must be attended to in order to avoid serious harm in the near future, and has demonstrated that inability by failing to attend to those basic physical needs.

   ☐ c. the individual's judgment is so impaired by that mental illness that s/he is unable to understand his/her need for treatment, and whose impaired judgment, on the basis of competent clinical opinion, presents a substantial risk of significant physical or mental harm to the individual or presents a substantial risk of physical harm to others in the near future.

   ☐ d. the individual's understanding of the need for treatment is impaired to the point that s/he is unlikely to voluntarily participate in or to adhere to treatment that has been determined necessary to prevent a relapse or harmful deterioration of his/her condition. The individual's noncompliance with treatment has been a factor in the individual's

   ☐ i. placement in ☐ a psychiatric hospital ☐ jail ☐ prison at least two times within the last 48 months.
   (Specify the name[s] and location[s] of the hospital, jail, or prison and the date[s] of hospitalization or incarceration.)

   _____

   _____

   AND/OR

   ☐ ii. committing one or more acts, attempts, or threats of serious violent behavior within the last 48 months.
   (Specify the acts, attempts, or threats of serious violent behavior.)

   _____

   _____

(SEE SECOND PAGE)

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

MCL 330.1100a(29), MCL 330.1401, MCL 330.1423, MCL 330.1427, MCL 330.1434, MCL 330.1438, MCL 330.2050, MCR 5.125(C)(18)

4. The conclusions stated above are based on

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

_____

_____

b. the following conduct and statements that others have seen or heard and have told me about:

_____

_____

by: _____
Witness name Complete address Telephone no.

5. The persons interested in these proceedings are:

NAME	RELATIONSHIP	ADDRESS	TELEPHONE
	Spouse		
	Guardian*		

*(Specify the county where the guardianship was established and the case number.) _____

6. The individual ☐ is ☐ is not a veteran.

☐ 7. Attached is a ☐ clinical certificate by a physician or licensed psychologist taken within the last 72 hours.
☐ clinical certificate by a psychiatrist taken within the last 72 hours.
☐ petition/affidavit for examination (form PCM 209a) because an examination could not be secured.

8. I request the court to determine the individual to be a person requiring treatment and

☐ a. (Check if item 3a, 3b, or 3c is checked.) order appropriate mental health treatment.
☐ b. (Check if item 3d is checked.) order that the individual participate in assisted outpatient treatment without hospitalization.

☐ 9. I request the individual be hospitalized pending a hearing.

I declare under the penalties of perjury that this petition/application has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

_____ _____
Signature of attorney Date

_____ _____
Name (type or print) Bar no. Signature of petitioner

_____ _____
Address Address

_____ _____
City, state, zip Telephone no. City, state, zip

_____ _____
Home telephone no. Work telephone no.

FOR HOSPITAL USE ONLY

This petition for mental health treatment was received by the hospital on _____ at _____ .
Date Time

_____
Signature of hospital representative