

<p align="center">STATE OF MICHIGAN PROBATE COURT COUNTY CIRCUIT COURT - FAMILY DIVISION</p>	<p align="center">ORDER FOR REPORT ON ALTERNATIVE TREATMENT AND REPORT</p>	<p>FILE NO.</p>
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In the matter of _____, an alleged mentally ill person

ORDER

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

The report shall be made to the court by _____, the date of a hearing on
Date

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: _____

(PLEASE SEE OTHER SIDE)

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. The individual has been hospitalized involuntarily two or more times within the two-year period immediately preceding the filing of the petition and has rejected aftercare programs and treatment.

5. I recommend release.

hospitalization

6. I recommend a course of treatment of hospitalization for _____ days, followed by an alternative program
 an alternative program

as follows: _____

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

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

9. 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.

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

11. 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.

CMH emergency care funds.

Other assistance: _____

None. Reason: _____

Date

Signature