

STATE OF MICHIGAN PROBATE COURT COUNTY OF	PETITION FOR MENTAL HEALTH TREATMENT	FILE NO. <div style="border: 2px solid blue; padding: 5px; display: inline-block; background-color: #0056b3; color: white; text-align: center; width: 60px; height: 30px;">DRAFT</div>
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In the matter of _____ **XXX-XX-**
Last four digits of SSN

Court ORI	Date of Birth	Place of Birth	Race	Sex
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1. I, _____, an adult _____ petition because
Name (type or print) specify whether a relative, neighbor, peace officer, etc.
I believe the individual named above needs treatment.

2. The individual was born _____, has a permanent residence in _____
Date
County at _____
Street address City State ZIP
and can presently be found at _____
Address or name of facility

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 harm to the individual or 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 or 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 on a separate sheet.)
- 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 on a separate sheet.)

(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

4. The conclusions stated above are based on

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

[Redacted]

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

[Redacted]

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 order:

Should parenthetical be before checkbox?

- 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. _____

Remove

FOR
HOSPITAL
USE ONLY

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

Signature of hospital representative _____