Name (and if appropriate, Attorney No.)

Address

City, State, Zip Code

Telephone No.

E-Mail Address

[ ] Self-Represented Petitioner
[ ] Attorney for Petitioner

IN THE FAMILY COURT OF THE FIRST CIRCUIT

STATE OF HAWAIʻI

IN THE MATTER OF Respondent. Birthdate: _____ [ ] Male [ ] Female [ ] Other [ ] a Minor. _____	CASE NO.: _____ PETITION FOR ASSISTED COMMUNITY TREATMENT [ ] EXHIBIT A: Certificate for Assisted Community Treatment [ ] EXHIBIT B: Treatment Plan ☐ Includes Medication(s);

PETITION FOR ASSISTED COMMUNITY TREATMENT

TO THE JUDGE OF THE ABOVE-ENTITLED COURT:

Pursuant to Hawaiʻi Revised Statutes ("HRS") section § 334-123(a), the undersigned Petitioner does hereby solemnly declare, under penalty of perjury, that it is Petitioner's good faith belief that the statements made herein are true and correct:

1. That this Honorable Court has jurisdiction over this matter pursuant to the provisions in HRS Chapter 334, Part VIII.

CLEAR FORM

2. The Respondent's name and date of birth is as follows:

_____
(Respondent's Name) (Date of Birth)

3. a. The Respondent is [ ] a minor [ ] an adult.

b. The Respondent [ ] does not have a guardian.

[ ] has a guardian/guardians and the name(s), address, telephone number and e-mail address of the guardian(s) are as follows:

Name(s): _____

Address: _____

City, State, Zip Code: _____

Telephone number: _____

E-Mail Address: _____

4. The Respondent is present in this circuit at the following address:

_____

_____

5. The Petitioner(s) is/are interested party/parties as defined by HRS § 334-122 and is/are Respondent's [ ] parent(s) [ ] grandparent(s) [ ] spouse
[ ] reciprocal beneficiary [ ] adult child(ren) [ ] sibling(s)
[ ] service provider [ ] outreach worker [ ] mental health professional
[ ] case manager [ ] _____

6. The following is the name, address, and telephone number of at least one of the persons in the order of priority: the Respondent's spouse or reciprocal beneficiary, legal parents, adult children, and legal guardian if one has been appointed. If the Respondent has no living spouse or reciprocal beneficiary, legal parent, adult children, or legal guardian, or none can be found, the name, address, and telephone number of at least one of the Respondent's closest adult relatives, if any can be found shall be provided below:

Name:_____

Relationship to Respondent: _____

Address: _____

Telephone Numbers:_____

7. Based on the professional opinion of a licensed psychiatrist or advanced practice registered nurse (APRN) with prescriptive authority and an accredited national certification in an APRN psychiatric specialization, the Respondent meets each of the four (4) criteria for assisted community treatment set forth in HRS §334-121, as follows:

   a. I believe the Respondent is mentally ill or suffering from substance abuse because of the following facts:

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____; **and**

   b. I believe the Respondent is unlikely to live safely in the community without available supervision, is now in need of treatment in order to prevent relapse or deterioration that would predictably result in the Respondent becoming imminently dangerous to himself/herself or others, and the Respondent's current mental status or the nature of his/her disorder limits or negates the Respondent's ability to make an informed decision to voluntarily seek or with recommended treatment because of the following facts:

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____; **and**

c. I believe that Respondent has a

[ ] (1) Mental illness that has caused him/her to refuse needed and appropriate mental health services in the community; **or**

[ ] (2) History of not adhering to treatment for mental illness or substance abuse that resulted in the Respondent becoming dangerous to himself/herself or others and that now would predictably result in the person becoming imminently dangerous to self or others

because of the following facts:

_____

_____

_____

_____

_____

_____

_____

_____

_____; **and**

d. Considering less intrusive alternatives, assisted community treatment is essential to prevent the danger posed by Respondent, is medically appropriate, and is in Respondent's medical interests because of the following facts:

_____

_____

_____

_____

_____

_____

_____

_____

_____

8. The Certificate for Assisted Community Treatment (MH10), attached as **Exhibit A**, was completed by _____, a licensed [ ] psychiatrist

[ ] advanced practice registered nurse (APRN) with prescriptive authority and an accredited national certification in an APRN psychiatric specialization, and is based on his/her examination of Respondent on _____, which is within twenty (20) days prior to the filing of this Petition.

9. The Treatment Plan is being filed with this Petition as **Exhibit B** as required by HRS §334-126(h).

[ ] a. Treatment includes medication. The Treatment Plan describes the types or classes of medication for which court authorization is being sought and describes the beneficial and detrimental physical and mental effects of such medication(s).

10. [ ] a. The following treating [ ] psychiatrist [ ] APRN with prescriptive authority and accredited national certification in an APRN psychiatric specialization has agreed to be responsible for the management and supervision of Respondent's treatment:

Name: _____

Address: _____

_____

Telephone Numbers: _____

[ ] b. The following administrator of the mental health program named below designate a publicly employed psychiatrist or an APRN with prescriptive authority and an accredited national certification in an APRN psychiatric specialization, or a private psychiatrist who agrees to being designated as being responsible for the management and supervision of Respondent's treatment:

Administrator's Name: _____

Name of Mental Health Program: _____

_____

Address: _____

_____

Telephone Numbers: _____

WHEREFORE, Petitioner respectfully requests:

1. That this Petition be heard as soon as possible;

   [ ] a. That, as Respondent does not have a guardian, that Respondent be appointed a guardian ad litem prior to the hearing on this Petition.

2. [ ] a. That further evaluation is necessary before treatment;

   [ ] b. That, at the hearing, the Court make findings and order that the Respondent obtain community treatment as set forth in the *Treatment Plan*; and

3. That the Court order such other and further relief as it may deem just and proper.

[ ] Petitioner requests further relief as follows:

_____

_____

_____

_____

_____

I hereby solemnly and sincerely declare, under penalty of perjury, that the statements made herein are true and correct to the best of my belief, information, and knowledge.

DATED: _____, Hawai‘i, _____.
(City) (Date)

_____
Signature of [ ] Petitioner
[ ] Petitioner’s Attorney

Print Name: _____

If you need an accommodation for a disability when participating in a court program, service, or activity, please contact the ADA Coordinator as far in advance as possible to allow time to provide an accommodation: Call the ADA Coordinator of the First Circuit Family Court Office at (808)954-8200, fax (808)954-8308, or send an e-mail to adarequest@courts.hawaii.gov. The ADA Coordinator will work to provide, but cannot guarantee your requested auxiliary aid, service, or accommodation.

*Please call the Family Court Service Center at **(808)954-8290** if you have any questions about forms or procedures.*

IN THE FAMILY COURT OF THE FIRST CIRCUIT

STATE OF HAWAIʻI

IN THE MATTER OF Respondent. Birthdate: _____ [ ] Male [ ] Female [ ] Other [ ] a Minor. _____	CASE NO.: _____ EXHIBIT A: Certificate for Assisted Community Treatment

EXHIBIT A:
CERTIFICATE FOR ASSISTED COMMUNITY TREATMENT

The undersigned [ ] psychiatrist certifies that he/she is a duly licensed physician in the State of Hawaiʻi or is a medical officer of the United States [ ] an advance practice registered nurse ("APRN") with prescriptive authority and an accredited national certification in an APRN psychiatric specialization certifies that he/she is duly licensed in an APRN psychiatric specialization, certifies that he/she is duly licensed in the State of Hawaiʻi; and

1. That he/she has examined:

_____
Name of Subject of the Petition/Respondent

_____
Address

_____
City, State, Zip Code

_____ _____, which is within
(Birthdate) (Age) (Sex) (Date of Examination)

twenty (20) days prior to the filing of this Petition.

2. That he/she has reason to believe that the above-named Respondent is

[ ] mentally ill; or

[ ] suffering from substance abuse

as manifested by (include examples): _____

_____

_____

_____

_____

_____

_____; **and**

3. That Respondent is unlikely to live safely in the community without available supervision, is now in need of treatment in order to prevent a relapse or deterioration that would predictably result in Respondent becoming imminently dangerous to himself/herself or others, and Respondent's current mental status or the nature of Respondent's disorder limits or negates the person's ability to make an informed decision to voluntarily seek or comply with recommended treatment based upon the following:

_____

_____

_____

_____

_____

_____; **and**

4. That Respondent has

[ ] a. Mental illness that has caused him/her to refuse needed and appropriate mental health services in the community based upon the following:

_____

_____

_____

_____

_____

_____

_____

_____; **or**

[ ] b. History of lack of adherence to treatment for mental illness or substance abuse that resulted in the person becoming dangerous to himself/herself or others and that now would predictably result in the person becoming imminently dangerous to himself/herself or others based upon the following:

_____

_____

_____

_____

_____

_____

_____; **and**

5. That after considering less intrusive alternatives, assisted community treatment is essential to prevent the danger posed by Respondent, is medically appropriate, and is in the Respondent's medical interests as indicated in the treatment plan dated _____, which is being filed with this Petition as **Exhibit B**;

6. Additional circumstances and reasons for this belief, including the reports of others are detailed in the following attachments:

[ ] a. Discharge summary by referring hospital.

[ ] b. Clinical reports by the designated mental health program.

[ ] c. MH-1 (Application by Police Officer for Emergency Examination and Treatment)

[ ] d. MH-4 (Emergency Examination/Hospitalization: Certificate of Physician/ Psychologist for Admission/Transportation to a Psychiatric Facility)

[ ] e. MH-5 (Application for Voluntary Admission)

[ ] f. MH-6 (Certificate of Physician/Psychologist/APRN with prescriptive authority and an accredited national certification in an APRN psychiatric specialization for Involuntary Hospitalization)

[ ] g. Findings and Order of Involuntary Hospitalization dated:_____

[ ] h. Other (specify): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify under penalty of perjury that the allegations made herein to be true and correct to the best of my knowledge and information except as stated to be based upon information and belief.

Dated: _____, Hawai‘i, _____.
(City) (Date)

_____
Signature of Certifying Licensed [ ] Psychiatrist
[ ] APRN with Prescriptive Authority and an accredited national certification in an APRN psychiatric specialization

Print Name: _____

Business Address: _____

_____

Telephone Numbers: Business: _____

Home: _____

IN THE FAMILY COURT OF THE FIRST CIRCUIT

STATE OF HAWAIʻI

IN THE MATTER OF Respondent. Birthdate: _____ [ ] Male [ ] Female [ ] Other [ ] a Minor. _____	CASE NO.: _____ EXHIBIT B: Treatment Plan (required) ☐ Includes Medication(s)

EXHIBIT B:
TREATMENT PLAN FOR ASSISTED COMMUNITY TREATMENT

(Attach Treatment Plan*)

**If treatment includes medication, describe the types or classes of medication for which court authorization is being sought and describe the beneficial and detrimental mental and physical effects of the recommended medication(s). The Treatment Plan must include the rationale for the recommended treatment, any non-mental health treatment, if appropriate, and identify the designated mental health program and treating psychiatrist responsible for the coordination of care. HRS §§ 334-126(h), 334-127(c). A private psychiatrist or advanced practice registered nurse (APRN) with prescriptive authority and an accredited national certification in an APRN prescriptive authority and an accredited national certification in an APRN psychiatric specialization, provided he/she agrees to the designation. HRS § 334-127(c).*

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