PCS Code: PFH/PAS/APM
TCS Code: IPFH/PFH/PAS/APM

STATE OF MICHIGAN PROBATE COURT COUNTY	PETITION FOR MENTAL HEALTH TREATMENT ☐ AMENDED	CASE NUMBER and JUDGE

Court address **Court telephone number**

In the matter of _____ **XXX-XX-** _____
First, middle, and last name — Last 4 digits of SSN (Put last 4 digits of SSN in Ref. No. row 2 on MC 97.)

Court ORI	Date of birth Put DOB in Ref. No. row 1 on MC 97	Driver's license no. Put DLN in Ref. No. row 3 on MC 97	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 Put DOB in Ref. No. row 1 on MC 97. (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 (NGRI).
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, and whose lack of understanding of the need for treatment has caused him or her to demonstrate an unwillingness to voluntarily participate in or adhere to treatment that is necessary, on the basis of competent clinical opinion, to prevent a relapse or harmful deterioration of his or her condition, and presents a substantial risk of significant physical or mental harm to the individual or others.
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.
☐ no clinical certificate is attached because only assisted outpatient treatment is requested.

☐ 8. (For hospitalization and combined treatment only.) An examination could not be secured because: _____

_____

I request:
☐ a. the individual be examined at _____ , the preadmission screening unit or hospital designated by the community mental health services program.
☐ b. a peace officer take the individual into protective custody. After the individual is taken into protective custody, a peace officer or security transport officer shall transport the individual to _____

_____ .

9. I request the court to determine the individual to be a person requiring treatment and to order:

☐ a. hospitalization only.
☐ b. a combination of hospitalization and assisted outpatient treatment.
☐ c. assisted outpatient treatment without hospitalization.

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

I declare under the penalties of perjury that this petition 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 _____ (Date) at _____ (Time)

_____
Signature of hospital representative