STATE OF MICHIGAN PROBATE COURT COUNTY OF	ORDER AND REPORT ON ALTERNATIVE MENTAL HEALTH TREATMENT	FILE NO.

In the matter of _____
First, middle, and last name

ORDER

IT IS ORDERED that _____ shall prepare a report assessing the current
Name (type or print)

availability and appropriateness of alternatives to hospitalization for the individual named above including alternatives available following an initial period of court-ordered hospitalization.

The report shall be made to the court before the hearing on _____ for
Date and time of hearing

_____ .
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: _____

   _____

   _____

(SEE SECOND PAGE)

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. I recommend release.

☐ 5. I recommend a course of treatment of ☐ hospitalization ☐ hospitalization for _____ days, followed by assisted outpatient treatment as follows:

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

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

8. I recommend the following agency or independent mental health professional to supervise the outpatient treatment:

_____
Name Complete address

The agency or professional ☐ has ☐ has not indicated capability and willingness to supervise the recommended program.

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

☐ 10. 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.
      ☐ MDHHS/CMH emergency care funds.
      ☐ Other assistance: _____
      ☐ None. Reason: _____

_____ _____
Date Signature