IN THE CIRCUIT COURT OF _______________ COUNTY, WEST VIRGINIA

For Clerk's Use Only

IN RE: INVOLUNTARY HOSPITALIZATION OF ________________________________, RESPONDENT

DATE: ________________________________ CASE NUMBER __________ - MH - __________

If this application is GRANTED, distribute copies of the application and Form 903CC ORDER to: Applicant, Respondent, Respondent's Attorney, Prosecuting Attorney and the Regional Mental Health Center.

APPLICATION FOR INVOLUNTARY CUSTODY FOR MENTAL HEALTH EXAMINATION

[*West Virginia Code*: § 27-5-2]

DO NOT USE THIS FORM IF THE PERSON TO BE EXAMINED IS INCARCERATED IN A JAIL, PRISON, OR OTHER CORRECTIONAL FACILITY

[USE FORM 901C]

INSTRUCTIONS TO APPLICANT:

A. READ THOROUGHLY the IMPORTANT INFORMATION TO APPLICANTS attached.

B All information must be printed or typed and be clearly readable.

C. All information requested must be provided, if known. If unknown, you must state it is unknown.

D. Any petition and application which does not provide the necessary information, or is unreadable, may be rejected or denied. Read and answer all questions carefully.

E. In this document, the **RESPONDENT** is the person whose examination is requested.

1. FULL NAME OF PERSON TO BE EXAMINED (***RESPONDENT***): ________________________________

   Identification Information of Respondent:: AGE ________;WEIGHT __________; HAIR COLOR ____________; HAIR LENGTH __________

   SEX ________; HEIGHT __________; EYE COLOR ____________; RACE __________

2. RESPONDENT'S LAST KNOWN ADDRESS: ________________________________

   ____

   RESPONDENT'S TELEPHONE NUMBER: (   ) ____________________

3. WHERE IS RESPONDENT NOW ? PROVIDE ADDRESS: ________________________________

   ____

   PROVIDE DIRECTIONS IF KNOWN: ________________________________

   ____

4. THE RESPONDENT IS:

   A. A RESIDENT OF ____________________ COUNTY ?

   B. CURRENTLY RESENT IN ____________________ COUNTY?

5. APPLICANT'S [*your*] FULL NAME : ______________________________

6. APPLICANT'S [*your*] MAILING ADDRESS: ______________________________

____

APPLICANT'S TELEPHONE NUMBER: WORK: (   ) ______________ HOME: (   ) ______________

PLEASE PROVIDE A WAY TO CONTACT YOU PENDING THIS APPLICATION PROCESS (example: cell phone, pager number). **THE COURT MUST BE ABLE TO REACH YOU AND NOTIFY YOU OF THE TIME AND PLACE OF ANY HEARING. YOUR FAILURE TO APPEAR AT THE HEARING MAY RESULT IN THE APPLICATION BEING DISMISSED AND THE RESPONDENT BEING RELEASED.** If you do not want the Respondent to have this information, you may supply the information separately to the Court.

PHONE, CELL, PAGER OR OTHER PHONE NUMBER TO REACH APPLICANT: ______________________________

7. WHAT IS YOUR RELATIONSHIP TO THE RESPONDENT? ______________________________

8. DO YOU BELIEVE THE RESPONDENT IS:

A. ADDICTED TO DRUGS, ALCOHOL AND/OR OTHER SUBSTANCES? ________YES ________NO

B. MENTALLY ILL ? ________YES ________NO

9. HOW LONG HAS THE RESPONDENT SHOWN SUCH BEHAVIOR ? ______________________________

10. IN YOUR OWN WORDS, PROVIDE ANY INFORMATION WHICH SUPPORTS YOUR BELIEF THAT THE RESPONDENT IS ADDICTED AND/OR MENTALLY ILL:

____

____

____

____

____

____

(Attach additional pages if necessary)

11. DO YOU BELIEVE THE RESPONDENT, ***BECAUSE OF MENTAL ILLNESS OR ADDICTION,*** IS LIKELY TO CAUSE SERIOUS HARM TO :

A. HIM/HER SELF ? ________YES ________NO

B. OTHER PEOPLE ? ________YES ________NO

12. LIST ANY AND ALL RECENT ACTS WHICH SUPPORT YOUR BELIEF THAT THE RESPONDENT IS LIKELY TO CAUSE SERIOUS HARM TO HIM/HER SELF AND/OR OTHERS. **INCLUDE APPROXIMATE DATE(S) WHEN EACH ACT OCCURRED:**

____

____

____

____

____

(Attach additional pages if necessary)

A. IS RESPONDENT A SUICIDE RISK? _______ YES _______ NO _______ UNKNOWN

IF YES, EXPLAIN: ____

____

B. IS RESPONDENT VIOLENT? _______ YES _______ NO _______ UNKNOWN

IF YES, EXPLAIN: ____

____

C. IS RESPONDENT IN POSSESSION OF WEAPONS? _______ YES _______ NO _______ UNKNOWN

IF YES, IDENTIFY WEAPON(S) AND EXPLAIN: ____

____

13. LIST THE NAMES AND ADDRESSES OF OTHER PERSONS WHO HAVE SEEN THE BEHAVIOR OR CONDITION OF THE RESPONDENT: ____

____

____

IF YOU WANT THESE PEOPLE TO APPEAR AT HEARING ON THIS APPLICATION, **YOU** MUST CONTACT THEM DIRECTLY.

14. IS THE RESPONDENT CURRENTLY HOSPITALIZED? _________ YES _________ NO

IF **YES**, STATE WHERE HOSPITALIZED AND EXPECTED LENGTH OF STAY IN HOSPITAL: ____

____

15. HAS THE RESPONDENT BEEN UNDER THE RECENT CARE OF A PHYSICIAN? ________YES ________NO

IF **YES**, STATE PHYSICIAN'S NAME, ADDRESS, AND PHONE NUMBER: ____

____

16. IS THE RESPONDENT IN NEED OF MEDICAL CARE FOR ANY PHYSICAL CONDITION OR DISEASE? _____ YES _____ NO

IF **YES**, DESCRIBE THE CONDITION/DISEASE: ____

____

17. IS THE RESPONDENT TAKING ANY MEDICATIONS? _________ YES _________ NO

IF **YES**, LIST THE MEDICATIONS AND DOSAGE: ____

____

18. WOULD ANY NEEDED MEDICAL CARE, TREATMENT, OR HOSPITALIZATION PREVENT OR PRECLUDE TRANSPORTATION BY AUTOMOBILE, EXAMINATION BY A MENTAL HEALTH PROFESSIONAL, OR COURT APPEARANCE:

A. IMMEDIATELY? _________YES _________NO

B. WITHIN THE NEXT 24 HOURS? _________YES _________NO

19. HAS THE RESPONDENT BEEN EXAMINED BY A PSYCHIATRIST OR PSYCHOLOGIST? __________YES __________NO

IF YES, STATE PSYCHIATRIST'S OR PSYCHOLOGIST'S NAME, ADDRESS, AND DATE OF LAST EXAMINATION:

____

____

20. HAS THE RESPONDENT EVER BEEN CONFINED IN A HOSPITAL FOR MENTAL ILLNESS OR ADDICTION?
_____ YES ______ NO

IF YES, STATE THE REASON FOR HOSPITALIZATION, THE FACILITY IN WHICH THE RESPONDENT WAS HOSPITALIZED, AND THE DATE (S) OF HOSPITALIZATION:

____

____

21. NOTICE INFORMATION - **YOU MUST COMPLETE THIS SECTION:**

A. Respondent's Spouse: ____________________ ____________________
Name *Address*

____________________ ____________________
City, State, Zip *Telephone*

B. Respondent's Parents/Guardians: ____________________ ____________________
Name(s) *Address*

____________________ ____________________
City, State, Zip *Telephone*

C. Respondent's Next-of-Kin: ____________________ ____________________
Name *Address*

____________________ ____________________
City, State, Zip *Telephone*

22. __________ *[Initial as true, or upon information and belief, believed to be true.]* **THIS APPLICATION IS INVOLUNTARY. THE NAMED RESPONDENT HAS BEEN OFFERED VOLUNTARY TREATMENT, BUT HAS EITHER REFUSED APPROPRIATE VOLUNTARY HOSPITALIZATION AND/OR TREATMENT, OR IS IN A MENTAL OR MEDICAL CONDITION PRECLUDING HIS OR HER ABILITY TO CONSENT TO VOLUNTARY HOSPITALIZATION AND TREATMENT.**

I, ____, the Applicant, do hereby certify that I truly
*[print **YOUR** name here]*
believe that the Respondent, ____ is
*[print **RESPONDENT'S** name here]*
[***check category(s)***] _____ addicted and/or _____ mentally ill and because of ***mental illness or addiction*** is likely to cause serious harm to him/her self and/or others if allowed to remain at liberty, and should, therefore, be taken into custody for examination and treatment. I therefore petition that the Respondent be brought before the Court in order that the Court may determine what further actions, if any, are warranted according to the provisions of the ***West Virginia Code***: § 27-5-2. I understand that **MALICIOUS MAKING OF AN APPLICATION** to any circuit court or mental hygiene commissioner for the purpose of having another person declared mentally ill or an inebriate **IS A CRIME** and can result in fine or imprisonment up to one year, or both as provided in W.Va. Code § 27-12-1.

I further certify, **UNDER PENALTIES OF FALSE SWEARING** as provided by law, that the information, statements and allegations contained in this Petition and Application are true and accurate to the best of my knowledge, information and belief and constitute the sole basis and reasons for the making of this application. I understand that if I knowingly provide ***FALSE*** information in the application, I could be subject to a criminal charge of false swearing.

[NOTE: APPLICATION MUST BE MADE UNDER OATH/NOTARIZED OR WILL BE DENIED.]

DATE: ____________________ ____

APPLICANT'S SIGNATURE

The foregoing Petition and Application was subscribed and sworn to or affirmed before the undersigned authority this _____ day of ____________________, 20 _____.

[*if notary - affix Notarial Seal*] ____

NOTARY PUBLIC/ CIRCUIT CLERK

My Commission Expires: ________________________________.