Name (Attorney No.)

Address

City, State, Zip Code

Telephone No.

[ ] Petitioner Pro Se [ ] Attorney for Petitioner

IN THE FAMILY COURT OF THE SECOND CIRCUIT

STATE OF HAWAI'I

| | |
|---|---|
| In the Matter of<br><br>Respondent.<br><br>Birthdate: _____ [ ] Male [ ] Female<br><br>[ ] a Minor. | FC-M No. _____<br><br>PETITION FOR ASSISTED COMMUNITY TREATMENT ("ACT");<br>[ ] EXHIBIT A: Certificate for Assisted Community Treatment;<br>[ ] EXHIBIT B: Treatment Plan (Required);<br>[ ] Includes Medication(s);<br>and NOTICE OF HEARING |

PETITION FOR ASSISTED COMMUNITY TREATMENT

TO THE JUDGE OF THE ABOVE-ENTITLED COURT:

Pursuant to 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 Part VIII of Chapter 334, Hawai'i Revised Statutes (HRS).

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

| Name | Date of Birth |
|---|---|



**Americans with Disabilities Act Notice**

If you need an accommodation for a disability when participating in a court program, service, or activity, please contact the ADA Coordinator as soon as possible to allow the court time to provide an accommodation:

Call (808) 244-2855 FAX (808) 244-2932 OR Send an e-mail to: adarequest@courts.hawaii.gov. The court will try to provide, but cannot guarantee, your requested auxiliary aid, service or accommodation.

[ ] 3. The Respondent is a minor and the name, address, and telephone number of the Respondent's [ ] legal parent(s) [ ] guardian(s) is/are:

Name(s): _____

Address: _____

_____

Telephone Number(s): _____

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

_____

_____

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

6. The following is the name, address, and telephone number of at least one of the following persons in the following 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 if 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 section (§) 334-121, as amended, as follows:

(1) I believe the Respondent is mentally ill or suffering from substance abuse because of the following facts:

_____

_____

_____

_____

_____

_____

_____; **and**

(2) 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 comply with recommended treatment because of the following facts:

_____

_____

_____

_____

_____

_____

_____; **and**

(3) I believe that Respondent has a

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

[ ] b. 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**

(4) 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 (MH 10), attached as **Exhibit A**, was completed by _____, a licensed [ ] psychiatrist [ ] advanced practice registered nurse 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 [ ] advance practice registered nurse 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, may designate a publicly employed psychiatrist or an advanced practice registered nurse 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;

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: _____

IN THE FAMILY COURT OF THE SECOND CIRCUIT

STATE OF HAWAI‘I

| | |
|---|---|
| In the Matter of<br><br><br>Respondent.<br><br>Birthdate: _____ [ ] Male [ ] Female<br><br>[ ] a Minor. | ) FC-M No. _____<br>)<br>) EXHIBIT A: Certificate for Assisted<br>) Community Treatment<br>) |

EXHIBIT A:
CERTIFICATE FOR ASSISTED COMMUNITY TREATMENT

The undersigned [ ] psychiatrist certifies that he/she is a duly licensed physician in the State of Hawai‘i or is a medical officer of the United States [ ] an advanced practice registered nurse with prescriptive authority and an accredited national certification in an APRN psychiatric specialization certifies that he/she is duly licensed in the State of Hawai‘i; and

1. That he/she has examined:

_____
Name of Subject of the Petition/Respondent

_____
Address

_____
City, State, Zip Code

_____ on _____, which is within twenty (20)
Birthdate Age Sex Date of Examination

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

[ ] 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/Advanced Practice Registered Nurse 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
[ ] Advance Practice Registered Nurse 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 SECOND CIRCUIT

STATE OF HAWAI

| | |
|---|---|
| In the Matter of<br><br><br><br>Respondent.<br><br>Birthdate: _____ [ ] Male [ ] Female<br><br>[ ] a Minor. | FC-M No. _____<br><br>EXHIBIT B: Treatment Plan |

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 with prescriptive authority and an accredited national certification in an APRN psychiatric specialization may be designated as the treating psychiatrist or advanced practice registered nurse with prescriptive authority and an accredited national certification in an APRN psychiatric specialization, provided he/she agrees to the designation. HRS sec. 334-127(c).

IN THE FAMILY COURT OF THE SECOND CIRCUIT

STATE OF HAWAI

| | | |
|---|---|---|
| In the Matter of | ) | FC-M No. _____ |
| | ) | |
| | ) | NOTICE OF HEARING |
| | ) | |
| | ) | |
| Respondent. | ) | |
| | ) | |
| Birthdate: _____ [ ] Male [ ] Female | ) | |
| | ) | |
| [ ] a Minor. | ) | |
| _____ | ) | |

NOTICE OF HEARING

STATE OF HAWAI'I

TO:

Office of the Public Defender
ATTN: Assisted Community Treatment Division
81 North Market Street
Wailuku, HI 96793

Name and Address of Respondent's Attorney:

_____

_____

_____

_____

Name and Address of Respondent:

_____

_____

_____

Name and Address of Legal Parent(s):

_____

_____

_____

Name and Address of Spouse/Reciprocal Beneficiary:

_____

_____

_____

Name and Address of Adult Child:

_____

_____

_____

Name and Address of Adult Child:

_____

_____

_____

Name and Address of Adult Child:

_____

_____

_____

Name and Address of Adult Child:

_____

_____

_____

Name and Address of Adult Child:

Name and Address of Legal Guardian:

Name and Address of Administrator and Designated Mental Health Program:

Name and Address of Treating Psychiatrist:

Name and Address of Treating Advanced Practice Registered Nurse with Prescriptive Authority and APRN Psychiatric Specialization and Designated Mental Health Program:

Name and Address of Other(s):

Name and Address of Other(s):

Name and Address of Other(s):

Name and Address of Other(s):

Name and Address of Other(s):

Name and Address of Other(s):

Name and Address of Other(s):

Name and Address of Other(s):

**YOU ARE HEREBY NOTIFIED** that a *Petition for Assisted Community Treatment*, a copy of which is attached, has been filed in this court, alleging that the above-named Respondent should obtain assisted community treatment under Part VIII of Chapter 334, Hawai'i Revised Statutes.

**YOU ARE HEREBY FURTHER NOTIFIED** that the above-entitled matter is set for hearing on _____ at _____ before the presiding Judge of the Family Court at the Hoapili Hale Courthouse, 2145 Main Street, Third Floor, Wailuku, Hawai'i.

The purpose of the hearing is to determine whether the Respondent should be ordered to obtain assisted community treatment. If the Court finds that the Respondent is mentally ill or suffering from substance abuse beyond a reasonable doubt, and that all of the other criteria in paragraph number 7 of the Petition have been met by clear and convincing evidence, the Court shall order the Respondent to obtain assisted community treatment for a period of not more than one (1) year. The Court may make other orders as provided by law.

**NOTICE IS HEREBY GIVEN OF THE FOLLOWING:**

1. The Respondent is entitled to the assistance of an attorney. Notice shall be given to the Office of the Public Defender or the Respondent may contact his/her own attorney. HRS §334-125(b)(4).
2. This Notice of Hearing shall **not** be personally delivered between 10:00 p.m. and 6:00 a.m. on premises not open to the public, unless authorized in writing on the Notice of Hearing by a Judge of this Court that personal delivery is permitted during those hours.

DATED: Kapolei, Hawai'i, _____.

_____
CLERK OF THE ABOVE-ENTITLED COURT