
Name of Petitioner(s)

Mailing Address

City, State, Zip Code

Telephone Number

- Petitioner(s) Pro Se
- Attorney for Petitioner(s)

IN THE FAMILY COURT OF THE SECOND CIRCUIT
STATE OF HAWAI'I

In the Matter of _____) FC-M No. _____
)
)
) PETITION FOR ADDITIONAL
) PERIOD OF ASSISTED COMMUNITY
) TREATMENT
 _____,)
 Respondent) EXHIBIT A: Certificate for Assisted
) Community Treatment
 Birthdate: _____ Male Female) EXHIBIT B: Treatment Plan for
) Assisted Community Treatment
 a Minor.) Includes Medication
 _____) and NOTICE OF HEARING

PETITION FOR ADDITIONAL PERIOD OF ASSISTED COMMUNITY TREATMENT

TO THE JUDGE OF THE ABOVE-ENTITLED COURT:

The undersigned Petitioner does hereby solemnly declare, under penalty of perjury, that it is the 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 is as follows:

<u>Name</u>	<u>Date of Birth</u>
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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 above-named 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

- spouse reciprocal beneficiary legal parent(s)
- adult child(ren) legal guardian(s) closest adult relative
- siblings grandparent(s) service provider
- outreach worker case manager mental health provider
- _____

6. HRS § 334-123(c) requires the name, address, and telephone number of at least one of the following persons in the following order of priority: spouse or reciprocal beneficiary, legal parent(s), adult children, and legal guardian, if one has been appointed.

a. The following is the contact information for Respondent's

- spouse reciprocal beneficiary
- legal parents adult child(ren) legal guardian(s)

Name(s): _____

Address: _____

City, State, Zip Code: _____

Telephone Number(s): _____

7. The Respondent continues to meet each of the criteria for assisted community treatment set forth in HRS sec. 334-121(1)-(4), as amended, as follows:

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

_____; **and**

- (2) I believe the Respondent continues to be 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 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 his/her 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 Respondent becoming dangerous to him/her self or others and that now would predictably result in the person becoming imminently dangerous to himself/herself or others because of the following facts:

_____; **and**

- (4) Considering less intrusive alternative, assisted community treatment is

essential to prevent the danger posed by Respondent, is medically appropriate, and is in Respondent’s medical interest because of the following facts:

8. a. The Certificate for Assisted Community Treatment (MH 10) is attached to this Petition as **Exhibit A**. It was completed by _____, a licensed psychiatrist advanced practice registered nurse (APRN) with prescriptive authority and accredited national certification in an APRN psychiatric specialization who examined the Respondent on:

_____, which is twenty (20) calendar days prior to the
Date of Examination
filing of this Petition.

- b. The Respondent refused to submit to a psychiatric examination.

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). [HRS sec. 334-126\(h\)](#).

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, will 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 the treating psychiatrist or advanced practice registered nurse with prescriptive authority and an accredited national certification in an APRN psychiatric specialization, 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 for Additional Period of Assisted Community Treatment be heard prior to the intended date of Respondent's discharge from assisted community treatment;
2. That, at the hearing, the Court make findings and order that the previously ordered assisted community treatment shall continue for not more than one year after the date of the hearing on this Petition pursuant to HRS § 334-133(b);
3. That the Court order such other and further relief as it may deem just and proper.

] Petitioner further requests further the following relief:

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

] Petitioner, Pro Se] Attorney for Petitioner

IN THE FAMILY COURT OF THE SECOND CIRCUIT
STATE OF HAWAI'I

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

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 HRS§ 334-121(1)

[] 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 [HRS §334-121\(3\)](#)

- 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'I

In the Matter of)	FC-M No. _____
)	
)	EXHIBIT B: Treatment Plan for
)	Assisted Community Treatment
_____ ,)	<input type="checkbox"/> Includes Medication
Respondent)	
)	
Birthdate: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female)	
)	
<input type="checkbox"/> a Minor.)	
_____)	

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 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):

YOU ARE HEREBY NOTIFIED that a *Petition for Additional Period of Assisted Community Treatment*, a copy of which is attached, has been filed in this court, alleging that the above-named Respondent should continue the 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 _____m. 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 court-ordered assisted community treatment for Respondent should be continued for a period of not more than one (1) year. 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 this 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: Wailukui, Hawai'i, _____.

CLERK OF THE ABOVE-ENTITLED COURT

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.