Name (and if appropriate, Attorney No.)

Address

City, State, Zip Code

Telephone No.

E-Mail Address

[ ] Self-Represented Petitioner
[ ] Attorney for Petitioner

IN THE FAMILY COURT OF THE FIRST CIRCUIT

STATE OF HAWAIʻI

IN THE MATTER OF Respondent. Birthdate: _____ [ ] Male [ ] Female [ ] Other [ ] a Minor.	FC-M No. _____ PETITION FOR ADDITIONAL PERIOD OF ASSISTED COMMUNITY TREATMENT [ ] EXHIBIT A: Certificate for Assisted Community Treatment [ ] EXHIBIT B: Treatment Plan ☐ Includes Medication(s); 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 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, Hawaiʻi Revised Statutes ("HRS").

CLEAR FORM

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

_____
(Respondent's Name) (Date of Birth)

[ ]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: _____

City, State, Zip Code: _____

Telephone number(s): _____

E-Mail Address:_____

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

_____

_____

5. The Petitioners(s) is/are interested party/parties as defined by HRS § 334-122 and is/are Respondent's [ ] guardian(s) [ ] attorney [ ] guardian ad litem
[ ] parent(s) [ ] grandparent(s) [ ] spouse
[ ] sibling(s) [ ] adult child(ren) [ ] reciprocal beneficiary
[ ] service provider [ ] case manager [ ] outreach worker
[ ] 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: 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 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(s):_____

Relationship to Respondent:_____

Address: _____

Telephone Numbers: _____

7. The Respondent continues to meet each of the criteria for assisted community treatment set forth in HRS §334-121(1)-(4).

   a. I believe the Respondent continues to be mentally ill or suffering from substance abuse because of the following facts:

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____; **and**

   b. 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 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 with recommended treatment because of the following facts:

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____; **and**

c. I believe that Respondent has a

[ ] (1) mental illness that has caused him/her to refuse needed and appropriate mental health services in the community; **or**

[ ] (2) 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**

d. 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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____; **and**

8. [ ] a. The Certificate for Assisted Community Treatment (MH10),attached to this Petition as **Exhibit A,** 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
Date of Examination
prior to the 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).

10. [ ] a. The following treating [ ] psychiatrist [ ] advanced practice registered nurse (APRN) 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 public employed psychiatrist or an advance 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 advance 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 the following relief:

_____

_____

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

_____

Signature of [ ] Self-Represented Petitioner
[ ] Attorney for Petitioner

If you need an accommodation for a disability when participating in a court program, service, or activity, please contact the ADA Coordinator as far in advance as possible to allow time to provide an accommodation: Call the ADA Coordinator of the First Circuit Family Court Office at 954-8200, fax 954-8308, or send an e-mail to adarequest@courts.hawaii.gov. The ADA Coordinator will work to provide, but cannot guarantee your requested auxiliary aid, service, or accommodation.

Please call the Family Court Service Center at 954-8290 if you have any questions about forms or procedures.

IN THE FAMILY COURT OF THE FIRST CIRCUIT

STATE OF HAWAIʻI

IN THE MATTER OF Respondent. Birthdate: _____ [ ] Male [ ] Female [ ] Other [ ] a Minor. _____	FC-M No. _____ EXHIBIT A: Certificate for Assisted Community Treatment

EXHIBIT A:
CERTIFICATE FOR ASSISTED COMMUNITY TREATMENT

The undersigned [ ] psychiatrist certifies that he/she is a duly licensed physician in the State of Hawaiʻi or is a medical officer of the United States [ ] an advance practice registered nurse ("APRN") with prescriptive authority and an accredited national certification in an APRN psychiatric specialization certifies that he/she is duly licensed in an APRN psychiatric specialization, certifies that he/she is duly licensed in the State of Hawaiʻi; and

1. That he/she has examined:

_____
Name of Subject of the Petition/Respondent

_____
Address

_____
City, State, Zip Code

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

[ ] 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/APRN with prescriptive 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 s stated to be based upon information and belief.

Dated: _____. Hawai‘i. _____.
(City) (Date)

_____
Signature of Certifying Licensed [ ]Psychiatrist
[ ] APRN 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 FIRST CIRCUIT

STATE OF HAWAI'I

IN THE MATTER OF Respondent. Birthdate: _____ [ ] Male [ ] Female [ ] Other [ ] a Minor. _____	FC-M No. _____ EXHIBIT B: Treatment Plan for Assisted Community Treatment [☐] Includes Medication

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 (APRN) with prescriptive authority and an accredited national certification in an APRN prescriptive authority and an accredited national certification in an APRN psychiatric specialization, provided he/she agrees to the designation. HRS § 334-127(c).*

If you need an accommodation for a disability when participating in a court program, service, or activity, please contact the ADA Coordinator as far in advance as possible to allow time to provide an accommodation: Call the ADA Coordinator of the First Circuit Family Court Office at 954-8200, fax 954-8308, or send an e-mail to adarequest@courts.hawaii.gov. The ADA Coordinator will work to provide, but cannot guarantee your requested auxiliary aid, service, or accommodation.

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IN THE FAMILY COURT OF THE FIRST CIRCUIT

STATE OF HAWAI‘I

IN THE MATTER OF Respondent. Birthdate: _____ [ ] Male [ ] Female [ ] Other [ ] a Minor. _____	FC-M No. _____ NOTICE OF HEARING

NOTICE OF HEARING

TO THE JUDGE OF THE ABOVE-ENTITLED COURT:

STATE OF HAWAI‘I

TO:

Name and Address of Guardian Ad Litem:

_____
_____
_____
_____

Name and Address of Respondent’s Attorney:

_____
_____
_____
_____

Name and Address of Respondent:

_____
_____
_____
_____

Name and Address of Petitioner/Petitioner’s Attorney:

_____
_____
_____
_____

Name and Address of Respondent’s Spouse/Reciprocal Beneficiary:

_____
_____
_____

Name and Address of Legal Parent(s):

_____
_____
_____

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 Respondent's Closest Adult Relative:

Name and Address of Administrator and Designated Mental Health Program:

Name and Address of Treating Psychiatrist:

Name and Address of APRN and Designated Mental Health Program:

Name and Address of Other(s):

Relationship to Respondent: _____

Name and Address of Other(s):

Relationship to Respondent: _____

Name and Address of Other(s):

Relationship to Respondent: _____

Name and Address of Other(s):

Relationship to Respondent: _____

YOU ARE HEARBY 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 _____ before the presiding Judge of the Family Court at the Ronald T.Y. Moon Kapolei Courthouse, 4675 Kapolei Parkway, Kapolei, 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 continue with the 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. 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.

[ ] 2. _____

_____

_____

_____

DATED: Kapolei, Hawai'i, _____.

_____

CLERK OF THE ABOVE-ENTITLED COURT

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