Name (and if appropriate, Attorney No.)	<u>—</u>
Address	
City, State, Zip Code	
Telephone No.	
E-Mail Address Self-Represented Petitioner Attorney for Petitioner	
IN THE FAMILY COURT	FOF THE THIRD CIRCUIT
STATE (OF HAWAI'I
IN THE MATTER OF Respondent.) FC-M No
Birthdate: [] Male [] Female [] Other) Includes Medication(s);) and NOTICE OF HEARING
[]a Minor.))

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, Hawai'i Revised Statutes ("HRS").

Respondent's [] legal parent(s) [] guardian(s) is/are: Name(s):	2.	The Respondent's name and date of birth is as follows:
Respondent's [] legal parent(s) [] guardian(s) is/are: Name(s):		(Respondent's Name) (Date of Birth)
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 liten [] parent(s) [] grandparent(s) [] spouse [] sibling(s) [] adult child(ren) [] reciprocal beneficiary [] leservice 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 spouse or reciprocal beneficiary, legal parents, adult children, and legal guardia 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:	[]3.	The Respondent is a minor and the name, address, and telephone number of the
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 liten [] 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 spouse or reciprocal beneficiary, legal parents, adult children, and legal guardia 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:		
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Address:	6.	Name(s):
Telephone Numbers		
I DIDDITUTIO INCITIDATO.		Telephone Numbers:

a.	I believe the Respondent continues to be mentally ill or suffering from substance
	abuse because of the following facts:
	; <u>and</u>
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:
		5
	-	
		; <u>and</u>
d.	Consider	ing less intrusive alternatives, assisted community treatment is essential
	to prevei	nt the danger posed by Respondent, is medically appropriate, and is in
	Respond	lent'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
				prior to the filing of this Petition.
	[] [b.	The Respondent refused to submit to a psychiatric examination.
9.	Tł	ne T	rea	Itment Plan is being filed with this Petition as Exhibit B as required by
	Н	RS :	§33	4-126(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: . Hawaiʻi
	DATED: , Hawaiʻi, (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 at (808) 961-7629, FAX (808) 961-7577 or send an e-mail to adarequest@courts.hawaii.gov. The ADA Coordinator will try to provide, but cannot guarantee, the requested auxiliary aid, service, or accommodation.

IN THE FAMILY COURT OF THE THIRD CIRCUIT

STATE OF HAWAI'I

IN THE MATTER OF) FC-M No
) EXHIBIT A: Certificate for Assisted) Community Treatment)
Respondent. Birthdate: [] Male [] Female [] Other [] a Minor.))))))))))
CERTIFICATE FOR ASSISTE The undersigned [] psychiatrist cer	IBIT A: ED COMMUNITY TREATMENT Tifies that he/she is a duly licensed physician in
registered nurse ("APRN") with prescriptive a in an APRN psychiatric specialization certif	the United States [] an advance practice uthority and an accredited national certification fies that he/she is duly licensed in an APRN e 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	, which is within
(Birthdate) (Age) (Sex) twenty (20) days prior to the filing of the	(Date of Examination) nis Petition.

[] suffering from substance abuse as manifested by (include examples): 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 deternat would predictably result in Respondent becoming imminently dangero himself/herself or others, and Respondent's current mental status or the nate Respondent's disorder limits or negates the person's ability to make an inflecision to voluntarily seek or comply with recommended treatment based up collowing:	; <u>and</u>
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 deter hat would predictably result in Respondent becoming imminently dangero simself/herself or others, and Respondent's current mental status or the nat Respondent's disorder limits or negates the person's ability to make an inflecision to voluntarily seek or comply with recommended treatment based up	; <u>and</u>
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	formed

mai Re	espondent has
[]a.	Mental illness that has caused him/her to refuse needed and appropriate mental health services in the community based upon the following:
	; <u>or</u>
[]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:
	; <u>and</u>
That aft	ter considering less intrusive alternatives, assisted community treatment is all to prevent the danger posed by Respondent, is medically appropriate, and

6.					sons for this belief, including the reports of others
	ar r			ne following attach	
	L] a. 1 ພ		arge summary by r	
	l r] b.			esignated mental health program.
	L] c.			Police Officer for Emergency Examination and
	L] d.	MH-4	`	mination/Hospitalization: Certificate of Physician/ Admission/Transportation to a Psychiatric Facility)
	[] e.	MH-5	(Application for \	/oluntary Admission)
	[] f.	MH-6	an accredited	Physician/Psychologist/APRN with prescriptive national certification in an APRN psychiatric Involuntary Hospitalization)
	[] g.	Finding	gs and Order of In	voluntary Hospitalization dated:
	[] h.	Other	(specify):	
	Lo	ortify	ındar na	anolty of norium, the	at the allogations made beroin to be true and correct
to the	e be	est of r	-		at the allegations made herein to be true and correct ation except s stated to be based upon information
ana				Ц	lowoifi
	Di	ated:		, п (City)	awaiʻi, (Date)
				· •	,
					Signature of Certifying Licensed []Psychiatrist
					[] APRN with Prescriptive Authority and an
					accredited national certification in an APRN
					psychiatric specialization
				Print Name:	
			Е	Business Address:	
			Tele	phone Numbers:	Business:
					Home:
					Der Cale Dil Cale

IN THE FAMILY COURT OF THE THIRD CIRCUIT

STATE OF HAWAI'I

IN THE MATTER OF) FC-M No
)
) EXHIBIT B: Treatment Plan for Assisted
) Community Treatment
) [] Includes Medication
)
	Respondent.)
Birthdate:)
[]Male []Female []Other)
)
[]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 (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 at (808) 961-7629, FAX (808) 961-7577 or send an e-mail to adarequest@courts.hawaii.gov. The ADA Coordinator will try to provide, but cannot guarantee, the requested auxiliary aid, service, or accommodation.

IN THE FAMILY COURT OF THE THIRD CIRCUIT

STATE OF HAWAI'I

IN THE MATTER OF) FC-M No	
)	NOTICE OF HEARING	
)		
Respondent.		
Birthdate:) []Male []Female []Other)		
[]a Minor.		
NOTICE OF	F 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):	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:	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 _____ at ____ before the presiding hearing on Judge of the Family Court at [] Hale Kauliike, 777 Kilauea Avenue, Hilo, Hawai'i; [] South Kohala, 67-5187 Kamamalu Street, Kamuela, Hawai'i; [] Keahuolu Courthouse, 74-5451 Kamakaeha Avenue, Kailua-Kona, Hawai'i 96740 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: 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.

CLERK OF THE ABOVE-ENTITLED COURT

I 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 at (808) 961-7629, FAX (808) 961-7577 or send an e-mail to adarequest@courts.hawaii.gov. The ADA Coordinator will try to provide, but cannot guarantee, the requested auxiliary aid, service, or accommodation.

DATED: ____, Hawaiʻi, ______ .