

\_\_\_\_\_  
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 THIRD CIRCUIT

STATE OF HAWAI'I

IN THE MATTER OF

) FC-M No. \_\_\_\_\_

)

) PETITION FOR ADDITIONAL PERIOD OF  
) ASSISTED COMMUNITY TREATMENT

)  EXHIBIT A: Certificate for Assisted  
) Community Treatment

Respondent.

)  EXHIBIT B: Treatment Plan

Birthdate: \_\_\_\_\_

)  Includes Medication(s);

Male  Female  Other

) 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").

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 Petitioner(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: \_\_\_\_\_



- 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:

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\_\_\_\_\_ ; **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:

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\_\_\_\_\_ ; **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.

Date of Examination

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 at (808) 961-7629, FAX (808) 961-7577 or send an e-mail to [adarequest@courts.hawaii.gov](mailto: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.

)

)

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 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 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) (Date of Examination)

twenty (20) days prior to the filing of this Petition.





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:

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[ ] 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:

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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**;



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](mailto: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.

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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):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_

Name and Address of Adult Child:

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Name and Address of Adult Child:

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Name and Address of Adult Child:

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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):

\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_

Relationship to Respondent: \_\_\_\_\_

Relationship to Respondent: \_\_\_\_\_

Name and Address of Other(s):

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Name and Address of Other(s):

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\_\_\_\_\_  
\_\_\_\_\_

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 hearing on \_\_\_\_\_ at \_\_\_\_\_ before the presiding 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:**

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: \_\_\_\_\_, Hawai'i, \_\_\_\_\_ .

\_\_\_\_\_  
CLERK OF THE ABOVE-ENTITLED COURT



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