

INVOLUNTARY ASSESSMENT AND STABILIZATION

The purpose of this process is to stabilize a substance abuser's condition and to assess the need for further treatment. It is **NOT** to be used for long-term treatment.

WHO MAY PETITION THE COURT

Person requiring assessment is an ADULT:

1. Spouse or Legal Guardian, or
2. Any relative, or
3. Private Practitioner, or
4. Director of a licensed service provider or the Director's designee, or
5. An adult who has direct personal knowledge of the person's substance abuse impairment.

Person requiring assessment is a MINOR:

1. Parent, legal guardian or legal custodian, or
2. Licensed service provider.

REQUIREMENTS FOR FILING

The Petition must state facts to support the need for involuntary assessment and stabilization, including:

1. The reason for the Petitioner's belief that the Respondent is substance abuse impaired;
2. The reason for the Petitioner's belief that because of such impairment the Respondent has lost the power of self-control with respect to substance abuse;

AND

3. a. The reason the Petitioner believes that the Respondent has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted:

OR

- b. The reason the Petitioner believes that the Respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse that the Respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care. If the Respondent has refused to submit to an assessment, such refusal must be alleged in the petition.

FEES

There is no filing fee for a Petition for Assessment and Stabilization. However, if the person requiring assessment is transported by an ambulance service, the Petitioner and/or the Respondent (Patient) may receive a bill from the ambulance service. The Petitioner and/or Respondent (Patient) will be responsible for this cost if the Respondent's (or if filing on behalf of a minor, Petitioner's) health insurance does not cover this expense.

PROCEDURE

1. The clerk will assist the Petitioner in the preparation of the required pleadings. The Clerk cannot provide legal advice or instruct the Petitioner as to what should be included in the Petitioner's statement.
2. Once the required pleadings are complete, the Clerk will submit to the Judge for review.
3. If the Petition is granted, certified copies will be delivered to the Sheriff for service. The Sheriff will coordinate with the ambulance service.
4. The receiving facility may hold the person for up to **5** days. If long term treatment is required, the receiving facility may Petition for Involuntary Treatment or with the proper documentation the Petitioner may Petition the court for the same Involuntary Treatment.

I, the undersigned Petitioner, acknowledge that I have read and received a copy of the above.

Petitioner's Signature

Date

**IN THE CIRCUIT COURT, EIGHTEENTH JUDICIAL CIRCUIT,
BREVARD COUNTY, FLORIDA**

DIVISION: MENTAL HEALTH

Case Number: 05 - - MH - - XXMH-BC

IN RE:

CLOCK IN

MARCHMAN ACT - MEMORANDUM TO LAW ENFORCEMENT

MENTAL HEALTH NO.: _____

DOB: _____ AGE: _____ SS#: _____

PHONE NUMBER(S): _____

SECONDARY ADDRESS: _____

RACE: _____ SEX: Male Female

HEIGHT: _____ WEIGHT: _____ HAIR: _____ EYES: _____

COMPLEXION: _____

MARKS/FEATURES: _____

DRIVES? Yes No

MAKE OF AUTOMOBILE: _____

LICENSE NO.: _____

REMARKS: VIOLENT? Yes No

ANY WEAPONS? Yes No

WHAT TYPE? _____

PETITIONER'S NAME: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NUMBER(S): _____

RELATIONSHIP TO PATIENT: _____

ALTERNATE MAILING ADDRESS: _____

Transport to one of the nearest facilities listed below:

Circles of Care, 400 E. Sheridan Rd., Melbourne, FL (321)722-5200 (Minors)

Circles of Care, 880 Airport Rd./Martin Luther King, Jr. Blvd., Melbourne FL (321)914-0644 (Adults)

IN THE CIRCUIT COURT OF THE _____ JUDICIAL CIRCUIT
IN AND FOR _____ COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____
RESPONDENT

Petition for Involuntary Substance Abuse Assessment and Stabilization

I, _____, being duly sworn, am filing this sworn statement requesting a court order
Print Name of Petitioner
for the involuntary assessment of _____ (hereinafter referred to as Person).
Print Name of Person

Is the Person eighteen (18) years of age or older? Yes No Age of Person (if known): _____

The petition and affidavit will be included in the Person's clinical record and may be viewed by the Person. I understand that by filling out this form, the Person may be taken by law enforcement to a hospital or licensed substance abuse facility for assessment and stabilization.

I SWEAR that the answers to the following questions are given honestly, in good faith, and to the best of my knowledge.

1. a. Petitioner lives at (print full residence address): Phone (including area code): () - _____

Street Address City State Zip

b. The Person lives at, or may be found at:

Street Address City State Zip

Street Address City State Zip

2. I have the following relationship with the Person: _____

3. I am on good terms with the Person at the present time (check one box). Yes No If "no", please explain:

4. Check the box that applies:

a. I or a family member have have not previously made allegations to law enforcement involving this Person on _____ (date) such as domestic violence, trespassing, battery, child abuse or neglect, Baker Act, neighborhood disputes, etc. as described:

b. This Person has has not previously made allegations to law enforcement about me or my family on _____ (date) such as domestic violence, trespassing, battery, child abuse or neglect, Baker Act, neighborhood disputes, etc. as described:

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c. This Person has has not previously (or currently) been involved in criminal or delinquency charges.

5. Check the box that applies:

a. I or a family member am not now, and have not in the past, been involved in a court case with the Person.

b. I or a family member am now, or was, involved in a court case with the Person. This case is/was a:

_____ in _____
(Type of case) (When)

Explain:

6. I have known the Person for _____ (how long)

a. The Person has only recently displayed behavior related to substance abuse.

b. The Person has, over a period of time, had a substance abuse problem. Specify how long:

COMPLETE THE FOLLOWING ONLY IF THE SECTION APPLIES TO THIS CASE:

7. I believe that the Person is substance abuse impaired because:

8. I believe that because of such impairment, the Person has lost the power of self-control with respect to substance abuse for these reasons:

9. I believe the Person is in need of substance abuse services by reason of substance abuse impairment because:

10. Without care or treatment, he or she is likely to suffer from neglect or refuse to care for himself or herself because:

11. Other similar behavior I have personally seen as follows:

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CHECK AND/OR ANSWER APPLICABLE SECTIONS:

12. a. I have attempted to get the Person to seek assistance for a substance abuse problem(s) as follows:

b. I did not try to get the Person to agree to a voluntary assessment or treatment because:

c. The Person refused a voluntary assessment or treatment because:

13. The name of the Person's attorney is (if any):

Please provide the following identifying information about the person (if known) if it is determined necessary to take the PERSON into custody for examination:

County of Residence: _____ Date of Birth: _____ Age: _____

Race: _____ Sex: _____ SS#: _____

Attach a picture of the Person if possible. Picture attached: Yes No

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Does Person have access to any weapons: Yes No

If yes, please describe:

Is the Person violent now? Yes No

If yes, please describe:

Has the Person been violent in the recent past? Yes No

If yes, please describe:

Does the Person have any pending criminal charges against him/her? Yes No

If yes, please describe:

Does the Person have a legal guardian? Yes No

If yes, who? _____

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Is there a pending petition to determine the Person's capacity and to appoint a guardian? Yes No

If yes, provide the name, address and phone number of the current or proposed guardian:

Name: _____ Phone: () - _____

Address

City

State

Zip

Physician's Name: _____ Phone: () - _____

Provide name of medications, if known:

I understand that this sworn statement is given under oath and will be treated as though it was made before a judge in a court of law. I understand that any information in this sworn statement which is not to the best of my knowledge and not done in good faith may expose me to a penalty for perjury and other possible penalties under the statutes of the State of Florida. Under penalties of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

Signature of Petitioner: _____

Petitioner's signature can be verified by a Notary Public or by the Clerk of the Court

SWORN TO AND SUBSCRIBED before me this
_____ day of _____, 20____ by

_____ who is personally known to me or presented

_____ as identification.

Notary Public – State of Florida

My Commission expires: Date: _____

SWORN TO AND SUBSCRIBED before me this
_____ day of _____, 20____

Clerk of Circuit Court _____ County,
Florida.

By: _____
Deputy Clerk