At a _____ Part of the _____
Court of the State of New York, located at
_____
New York, on the _____ day of _____,
_____.

P R E S E N T :

Hon._____ , Judge/Justice

- x

In the Matter of the Application of _____
_____,

Petitioner,

ORDER TO SHOW CAUSE
PURSUANT TO MENTAL
HYGIENE LAW § 9.60

For an Order Authorizing Assisted Outpatient
Treatment

Index No.

- for -

_____, Respondent.

- x

Upon reading and filing the annexed petition of _____, dated

_____, and the affirmation of _____, M.D.,

dated _____, and upon all papers and proceedings had herein,

(And it appearing to the court that good cause exists to schedule a hearing in this matter

more than three days after the filing of this petition, as otherwise required by Mental Hygiene

Law §9.60(h), because _____

_____

_____,)

Let the respondent show cause before this Court at _____ _____on the _____ day of _____,_____ at _____ (a.m.)(p.m.), or as soon thereafter as counsel can be heard,

WHY an Order should not be made authorizing and requiring assisted outpatient treatment for the respondent in accordance with the written treatment plan that is submitted to the Court pursuant to Mental Hygiene Law §9.60(i);

SUFFICIENT CAUSE THEREFOR APPEARING, LET service of a copy of this Order to Show Cause, together with the papers upon which it was granted, be made on or before _____ _____ upon (1) the respondent, _____, by personal service; (2) the Mental Hygiene Legal Services, by overnight delivery service or, with its consent, by facsimile transmission; (3) _____, as the appropriate Program Coordinator appointed pursuant to Mental Hygiene Law §7.17(f), by overnight delivery service or, with his/her consent, by facsimile transmission; and (4) _____ _____, the nearest relative of the respondent known to petitioner, and any other person designated in writing by respondent pursuant to MHL § 9.29, by overnight delivery service, and (5) the Director or Community Services for the City/County of _____ _____appointed pursuant to Article 41 of the Mental Hygiene Law, by overnight delivery service or, with his/her consent, by facsimile transmission, and be deemed good and sufficient service.

_____
Judge/Justice

OMH-10/99
(For use by a Petitioner that is neither a Hospital nor a Director of Community Services)

_____ Court of the State of New York
County of _____
- x

In the Matter of the Application of _____
_____,

Petitioner,

PETITION PURSUANT TO MENTAL HYGIENE LAW § 9.60

For an Order Authorizing Assisted Outpatient Treatment

- for -

Index No.

_____, Respondent

- x

Petitioner _____, respectfully alleges that:

1. Petitioner is (check applicable box):

[ ] a. A person 18 years of age or older with whom the respondent resides;
[ ] b. The parent, spouse, sibling 18 years of age or older, or child 18 years of age or older of the respondent (specify relationship to petitioner) _____ _____;
[ ] c. The director of any public or charitable organization, agency or home providing mental health services to the subject of the petition in whose institution the respondent resides (specify nature of petitioner's business/organization) _____ _____ ;
[ ] d. A qualified psychiatrist who is either supervising the treatment of or treating the respondent;
[ ] e. A (parole officer)(probation officer) (strike inapplicable phrase) assigned to supervise the respondent.

2. Petitioner makes this application to the Court for an assisted outpatient treatment order for the respondent pursuant to Mental Hygiene Law §9.60.

3. Upon information and belief, respondent is present in _____ County, having a current residence of _____.

4. The respondent (has) (has not) provided information as to his/her nearest relative. If respondent has provided this information, set forth that relative's name, address, and relationship to the respondent: _____

_____.

5. The respondent (has) (has not) designated in writing other persons pursuant to MHL §9.29. If respondent has so designated other persons, set forth the names and addresses:

_____

_____

6. Upon information and belief, respondent suffers from _____

_____, a mental illness as defined in MHL §1.03(20).

7. Attached hereto is the affirmation of _____, M.D., a physician who recently conducted, or attempted to conduct, a psychiatric examination of respondent. Upon information and belief, the statements made in that affirmation are true, and such statements are incorporated herein by reference. This petition is being submitted within ten (10) days of the examination described in the affirmation.

8. The respondent meets the following criteria set forth in Mental Hygiene Law §9.60(c):

i. The respondent is 18 years of age or older;

ii. The respondent is suffering from a mental illness;

iii. The respondent is unlikely to survive safely in the community without supervision, based on a clinical determination;

iv. The respondent has a history of lack of compliance with treatment for mental illness that (check applicable paragraph(s)):

[ ] (a) at least twice within the last 36 months has been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any period during which respondent was hospitalized or incarcerated immediately preceding the filing of this petition; or

[ ] (b) has resulted in one or more acts of serious violent behavior toward self or others, or threats of, or attempts at, serious physical harm to self or others within the last 48 months, not including any period in which respondent was hospitalized or incarcerated immediately preceding the filing of this petition;

v. The respondent is, as a result of his/her mental illness, unlikely to participate voluntarily in the treatment recommended in the proposed treatment plan that is submitted to the Court;

vi. In view of the respondent's treatment history and current behavior, he/she is in need of assisted outpatient treatment in order to prevent a relapse or deterioration of his/her present mental status which would be likely to result in serious harm to the respondent or others as defined in section 9.01 of the Mental Hygiene Law; and

vii. The respondent will likely benefit from assisted outpatient treatment.

9. The basis for the allegation that the petitioner meets the criteria set forth in section 9.60(c) of the Mental Hygiene Law is (check applicable paragraph(s)):

[ ] the statements made in the attached physician's affirmation, which, upon information and belief, are true and are incorporated herein by reference

[ ] the following facts and circumstances (State basis for conclusion) _____

_____

_____

_____

_____

_____

10. The relief requested herein is in the respondent's best interests, has been narrowly tailored to give substantive effect to his/her liberty interests, and is the least restrictive alternative form of treatment appropriate for the respondent.

11. It is requested that an order be issued requiring assisted outpatient treatment, as set forth in the proposed treatment plan that is submitted to the Court pursuant to MHL § 9.60(i), for a period of (Insert time period of up to one year) _____.

12. The treatment recommended herein has been developed while taking into account any directions that may have been included in a health care proxy, as defined in Article 29-C of the Public Health Law, which has been executed by the respondent.

13. I (have)(have not) been appointed by the Director of Community Services to prepare the written treatment plan for submission to the court pursuant to section 9.60(i)(1) of the Mental Hygiene Law. If such an appointment has been made, the treatment recommended herein is also set forth in the attached treatment plan.

14. No previous application for this relief requested has been made to this or any other Court except (Insert details of any previous applications) _____

_____.

WHEREFORE, it is respectfully requested that the Court order assisted outpatient

treatment for respondent pursuant to the proposed treatment plan that is submitted to the Court.

Date: _____

Respectfully submitted,

_____

Attorney for Petitioner
P.O. Address:

Tel. No.

VERIFICATION

STATE OF NEW YORK)
) ss.:
COUNTY OF)

_____, being duly sworn, deposes and says that (s)he is the petitioner in this proceeding; (s)he has read the foregoing petition and the same is true to the knowledge of the deponent except as to matters therein stated to be alleged on information and belief, and as to those matters (s)he believes it to be true.

_____

Sworn to before me this _____
day of _____ , _____

_____
Notary Public

OMH-10/99

_____ Court of the State of New York
County of _____
- x

In the Matter of the Application of _____
_____,

Petitioner,

For an Order Authorizing Assisted Outpatient Treatment

- for -

_____, Respondent.

PHYSICIAN'S AFFIRMATION FOLLOWING EXAMINATION OF RESPONDENT

Index No.

- x

STATE OF NEW YORK)
) ss.:
COUNTY OF)

_____, M.D., affirms the following to be true under penalty of perjury:

1. I am a physician licensed to practice medicine by the State of New York and I am practicing (Insert specialties and nature of practice) _____ at (Indicate service provider affiliation, if any, and location of practice) _____ _____. I make this affirmation in support of the petition by _____ _____ for an order authorizing assisted outpatient treatment for the respondent in accordance with §9.60 of the Mental Hygiene Law and the attached treatment plan.

2. I performed a psychiatric evaluation of _____ , the respondent, on (Date must be no more than 10 days before date of Affirmation) _____, _____ , and have had occasion to observe him/her.

3. Currently, the respondent is (State whether the respondent is receiving inpatient or outpatient services and location where services are delivered) _____ _____.

4. The respondent is at least 18 years of age. His/her diagnosis is_____ _____, a mental illness as defined in section 1.03(20) of the Mental Hygiene Law that is described in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

5. Based upon my clinical observations, the respondent is unlikely to survive safely in the community without supervision because: (Insert basis for conclusion)

_____

_____

_____ .

6. (Complete applicable paragraph(s))

(a). As indicated below, the respondent has a history of lack of compliance with treatment that has necessitated hospitalization, or receipt of services in a forensic or mental health unit of a correctional facility or a local correctional facility, at least twice within the last 36 months, not including any period in which the respondent was hospitalized or incarcerated immediately preceding the filing of this petition: (Insert facts showing two hospitalizations or instances of service in a correctional setting) _____

_____

_____

_____ .

(b). As indicated below, the respondent has a history of lack of compliance with treatment that has resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others, within the last 48 months, not including any period in which the respondent was hospitalized or incarcerated immediately preceding the filing of this petition: (State factual basis for conclusion)

_____

_____

_____ .

7. Because of the respondent's mental illness and past failure to comply with treatment, it is my opinion that (s)he is unlikely to participate voluntarily in the treatment recommended for him/her.

8. In view of the respondent's treatment history and current behavior, (s)he is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in serious harm to the respondent or others. (State clinical basis for conclusion)

_____

_____

_____

_____.

9. After consultation with the respondent and (If applicable, insert name of any significant individual designated by the respondent, such as a relative, close friend, or health care agent)_____

_____ , I recommend the following outpatient treatment for the respondent

(List the services recommended for respondent):

_____

_____

_____

_____ .

10. The recommended treatment has been narrowly tailored taking into consideration all relevant information available for the respondent. I do not believe the respondent can be safely maintained under any less restrictive provision of services.

11. It is my opinion that the respondent will likely benefit from assisted outpatient treatment and that the recommended treatment is in the respondent's best interests. The recommended treatment may enhance the respondent's ability to remain out of an inpatient setting. In my opinion, without care and treatment on an outpatient basis, the respondent will deteriorate and once again require inpatient psychiatric hospitalization.

12. The recommended treatment includes care coordination in the form of (State form of coordination, e.g. Assertive Community Treatment team, intensive case management, or supportive case management)

_____ .

13. It is requested that an order be issued requiring assisted outpatient treatment, as set forth in the proposed treatment plan that is submitted to the Court pursuant to MHL § 9.60(i), for a period of (Insert time period of up to one year) _____ .

14. I (have)(have not) been appointed by the Director of Community Services to prepare the written treatment plan for submission to the court pursuant to section 9.60(i)(1) of the Mental Hygiene Law. If such an appointment has been made, the treatment recommended herein is also set forth in the attached treatment plan.

15. I am willing and able to testify at the hearing in this matter.

16. To my knowledge, no previous application for the relief requested has been made before this or any other Court, except: (Insert details of any previous applications)

_____.

WHEREFORE, your affirmant respectfully requests that the Court issue an order requiring assisted outpatient treatment for the respondent pursuant to the proposed treatment plan that is submitted to the Court.

_____

Date:_____

OMH-10/99

At a _____ Part of the _____
Court of the State of New York, located at
_____ , New York
on the _____ day of _____ ,
_____ .

P R E S E N T:
HON. , Judge/Justice
----------X
In the Matter of the Application of _____
_____,

Petitioner,

FINAL ORDER
AND JUDGMENT
PURSUANT TO MENTAL
HYGIENE LAW § 9.60

For an Order Authorizing
Assisted Outpatient Treatment

Index No.

- for -

_____, Respondent.
----------X

Upon reading and filing the petition of _____, verified the _____ day of _____, _____ , and the affirmation of _____ _____, M.D., signed the _____ day of _____, _____, and this matter having come before the undersigned on the _____ day of _____, _____, and the respondent, having been represented by _____ , Esq. of _____, and a hearing having been held before the undersigned and testimony having been given therein by Dr. _____

(Add "and others" if more than one witness testified) _____

And the Court having found by clear and convincing evidence that:

(a) the respondent meets the criteria for assisted outpatient treatment as set forth in Mental Hygiene Law section 9.60 (c), and

(b) the assisted outpatient treatment set forth below is the least restrictive treatment that is appropriate and feasible;

NOW, on motion of _____, Esq.,

It is hereby ORDERED AND ADJUDGED:

1. That respondent shall receive and accept assisted outpatient treatment for a period of (Insert duration of up to one year) _____ from the date of this order consisting of the treatment recommended in the treatment plan attached hereto;

2. That the Director of Community Services for the City/County of _____ _____, which is the City/County where the petitioner is currently present, shall provide and/or arrange for all the categories of service to respondent that are recommended in the attached treatment plan for the duration of this order and judgment.

ENTER

_____

Judge/Justice

OMH-10/99

TREATMENT PLAN UNDER MENTAL HYGIENE LAW §9.60 [1]

Respondent's/Patient's name _____

Physician who developed treatment plan _____

Physician's employer _____

Physician's business address _____

Date of examination _____

COMPLETE PARTS A, B, C AND D.

A. In preparing a treatment plan, the respondent must be given an opportunity to actively participate in developing the plan. In addition, upon the request of the respondent, an individual significant to the respondent (e.g. a relative, close friend, or health care agent) may participate in developing the plan. List the name(s) of any individual(s) in addition to the respondent who participated in the development of this treatment plan, or indicate "none":

_____

B. Will medication be included as a category of service on this treatment plan? _____

If yes, the MEDICATION WORKSHEET must be completed and attached.

---

[1] Section 9.60(a)(1) of the Mental Hygiene Law mandates case management/care coordination for any person ordered by the court to receive assisted outpatient treatment, and authorizes the court to order the following categories of service as recommended by a physician:

- Medication
- Periodic blood tests or urinalysis to determine compliance with prescribed medications
- Individual or group therapy
- Day or partial day programming activities
- Educational and vocational training or activities
- Alcohol or substance abuse treatment and counseling, and periodic tests for the presence of alcohol or illegal drugs
- Supervision of living arrangements
- Any other services prescribed to treat the person's mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization.

C. Will alcohol or substance abuse counseling and treatment be included as a category of service? _____ If yes, the ALCOHOL/SUBSTANCE ABUSE WORKSHEET must be completed and attached. [Note: Blood tests or urinalysis for the presence of alcohol or illegal drugs shall be subject toreview after six months by this physician (or another physician designated by the Director), and such physician shall be authorized to terminate such blood tests or urinalysis without further action by the court.]

D. For all categories of service other than medication and alcohol or substance abuse counseling and treatment, list the category of service, a brief description of the service recommended, and the name, address, telephone number and contact person of the program providing the service. (The description of the services should be detailed, e.g. "day or partial day programming activities" should indicate particular services which will be provided, such as anger management, medication education group, group therapy, etc. Add additional sheets of paper if necessary.)

1. _____

_____

2. _____

_____

_____

3. _____

_____

4. _____

_____

5. _____

_____

_____ _____

Physician's Signature Date

MEDICATION WORKSHEET

Respondent's/Patient's name_____ Date of birth_____

Physician who developed treatment plan _____

Date of treatment plan_____

1. List the types or classes of medications recommended (e.g., antipsychotics, antidepressants, mood stabilizers, anxiolytics, antiparkinsonians) _____

_____

_____

2. List each medication recommended, the dosage, frequency, and route you anticipate prescribing, and whether self-administration or administration by authorized personnel is recommended for each medication. W henever possible, indicate contingencies/medication alternatives (e.g., if X medication is prescribed, but is determined to be ineffective after a specified trial period, Y medication will be initiated in its place).

(a) Medication: _____

Class: _____
Dosage Range/Frequency: _____
Route: _____
Administration: _____
Contingencies: _____

_____

_____

(b) Medication: _____

Class: _____
Dosage Range/Frequency: _____
Route: _____
Administration: _____
Contingencies: _____

_____

_____

(c) Medication: _____

Class: _____
Dosage Range/Frequency: _____
Route: _____
Administration: _____
Contingencies: _____

_____

_____

(d) Medication: _____

Class: _____
Dosage Range/Frequency: _____
Route: _____
Administration: _____
Contingencies: _____

_____

_____

(e) Medication: _____

Class: _____
Dosage Range/Frequency: _____
Route: _____
Administration: _____
Contingencies: _____

_____

_____

3. Briefly describe the beneficial and detrimental physical and mental effects of each medication.

_____

_____

_____

_____

4. Have the beneficial and detrimental physical and mental effects of each medication been discussed with the respondent/patient (and the respondent's relative, close friend, or health care agent, if applicable)? _____If not, please explain:_____

_____

_____

5. Will the medication(s) listed above be likely to provide maximum benefit to this respondent/patient? _____ If not, are there other medications which would likely provide maximum benefit to this respondent/patient? _____ If so, explain why they are not recommended here:

_____

_____

_____

_____

_____ _____

Physician's Signature Date

OMH-10/99

ALCOHOL/SUBSTANCE ABUSE WORKSHEET

Respondent's/Patient's name_____ Date of birth_____

Physician who developed treatment plan _____

Date of treatment plan _____

1. List the respondent's/patient's alcohol abuse and or substance abuse diagnosis(es): _____

_____

2. What treatments and/or counseling to address alcohol and/or substance abuse are recommended for this respondent/patient?

	TYPE OF SERVICE	FREQUENCY/DURATION	SERVICE PROVIDER
a)	_____	_____	_____
b)	_____	_____	_____
c)	_____	_____	_____
d)	_____	_____	_____
e)	_____	_____	_____

3. If alcohol testing (blood level and/or breathalyser) is recommended:

a) Does this respondent/patient have a history of alcohol abuse that is clinically related to his/her mental illness? _____ If yes, state facts which support this conclusion:

_____

_____

_____

_____

b) Is such testing necessary to prevent a relapse or deterioration that would be likely to result

in serious harm to self or others? _____ If yes, state facts which support this conclusion:

_____

_____

_____

_____

4. If testing for illegal substances (blood or urinalysis) is recommended:

a) Does this respondent/patient have a history of substance abuse that is clinically related to his/her mental illness? _____ If yes, state facts which support this conclusion:

_____

_____

_____

_____

b) Is such testing necessary to prevent a relapse or deterioration that would be likely to result in serious harm to self or others? _____ If yes, state facts which support this conclusion:

_____

_____

_____

_____

[Note: Blood tests or urinalysis for the presence of alcohol or illegal drugs shall be subject to review after six months by this physician (or another physician designated by the Director) and such physician shall be authorized to terminate such blood tests or urinalysis without further action by the court.]

_____ _____

Physician's Signature Date