

# Jackson County Probate Court

312 S. Jackson St.  
Jackson, MI 49201  
Phone: 517-788-4290  
Fax: 517-788-4291

## Instructions for Mental Health Pick-up Order

The Court has the authority to order that a person be picked up by a peace officer and transported to a Prescreening unit or hospital for evaluation under certain circumstances. To qualify, the law requires that the individual has mental illness, and:

- As a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself, herself, or another individual, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation; or,
- The individual is unable to attend to those of his or her basic physical needs such as food, clothing, or shelter that must be attended to in order for the individual to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs; or,
- The individual's judgment is so impaired by that mental illness, and whose lack of understanding of the need for treatment has caused him or her to demonstrate an unwillingness to voluntarily participate in or adhere to treatment that is necessary, on the basis of competent clinical opinion, to prevent a relapse or harmful deterioration of his or her condition, and presents a substantial risk of significant physical or mental harm to the individual or others.

It is important while filling out these forms to be as detailed as possible.

### Forms

Below, you will find specific instructions for each form contained in the packet. There are additional instructions on the forms. Please read them carefully. Failure to follow them exactly may result in denial of your request.

1. Petition for Mental Health Treatment (PCM 201): Complete the entire form. Be as thorough as possible.

You must check one of the boxes under number 3.

- If you check box a, number 4 must contain specific examples of the individual engaging in assaultive behavior.
- If you check box b, number 4 must contain specific examples of how the individual is not currently attending to food, clothing, or shelter as a result of mental illness.
- If you check box c, you must have an opinion from a doctor that the individual requires mental health treatment. That doctor must be identified on the form. Number 4 also must contain specific examples of the individual demonstrating an unwillingness to treat voluntarily as well as examples of how the individual is currently a substantial risk of significant physical or mental harm to the individual or others.

**(If any additional sheets are used under no. 4, lined paper will not be accepted.)**

You must complete number 5 if the individual has a living spouse or guardian. You may include anyone else you believe should receive notice of the proceeding. Please include complete addresses (including city, state, and zip codes).

You must complete number 8 if you are seeking a Pick-up Order.

2. Protected Personal Identifying Information (MC 97): There are four places on the petition blocked off with instructions to put the required information on a different form. Please follow these instructions while completing this form.
3. Order for Examination/Transport (PCM 209a): This form is completed by the Court.
4. Jackson County Petition Review: After the petition has been completed, you will need to take it to the LifeWays Access Center at 1200 North West Avenue to have it reviewed. They will complete this form. After that, you will bring all four documents to the Court and file them.

#### Fees

- There is no filing fee.

\*\*\*\*\*Filings must comply with MCR 1.1109(D)(1)\*\*\*\*\*

<b>STATE OF MICHIGAN</b> <b>PROBATE COURT</b> <b>JACKSON COUNTY</b>	<b>PETITION FOR MENTAL</b> <b>HEALTH TREATMENT</b> <input type="checkbox"/> <b>AMENDED</b>	<b>CASE NO. and JUDGE</b>
---	--	---------------------------

**Court address** 312 S. JACKSON STREET JACKSON, MI 49201 **Court telephone no.** 517 788-4290

In the matter of \_\_\_\_\_ Put last 4 digits of SSN in  
XXX-XX- Ref. No. row 2 on MC 97.  
 First, middle, and last name Last four digits of SSN

Court ORI	Date of birth <small>Put DOB in Ref. No. row 1 on MC 97</small>	Driver's license no. <small>Put DLN I Rev. No. row 3 on MC 97</small>	Place of birth	Race	Sex
-----------	--	--	----------------	------	-----

1. I, \_\_\_\_\_, an adult \_\_\_\_\_ petition because  
 Name (type or print) specify whether a relative, neighbor, peace officer, etc.  
 I believe the individual named above needs treatment.

2. The individual was born \_\_\_\_\_, has a permanent residence in \_\_\_\_\_  
Put DOB in Ref. No. row 1 on MC 97.  
 Date \_\_\_\_\_  
 County at \_\_\_\_\_  
 Street address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
 and can presently be found at \_\_\_\_\_  
 Facility name or other address \_\_\_\_\_

This petition is for a person who was found not guilty by reason of insanity in this county (NGRI).

3. I believe the individual has mental illness and
- a. as a result of that mental illness, the individual can be reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or others, and has engaged in an act or acts or made significant threats that are substantially supportive of this expectation.
  - b. as a result of that mental illness, the individual is unable to attend to those basic physical needs that must be attended to in order to avoid serious harm in the near future, and has demonstrated that inability by failing to attend to those basic physical needs.
  - c. the individual's judgment is so impaired by that mental illness, and whose lack of understanding of the need for treatment has caused him or her to demonstrate an unwillingness to voluntarily participate in or adhere to treatment that is necessary, on the basis of competent clinical opinion, to prevent a relapse or harmful deterioration of his or her condition, and presents a substantial risk of significant physical or mental harm to the individual or others.

4. The conclusions stated above are based on
- a. my personal observation of the person doing the following acts and saying the following things: (if necessary, include additional sheets.)
  - b. the following conduct and statements that others have seen or heard and have told me about: (if necessary, include additional sheets.)

by: \_\_\_\_\_  
 Witness name Complete address Telephone no.

5. The persons interested in these proceedings are

NAME	RELATIONSHIP	ADDRESS	TELEPHONE
	Spouse		
	Guardian*		

\*(Specify the county where the guardianship was established and the case number.) \_\_\_\_\_

6. The individual  is  is not a veteran.

7. Attached is a  clinical certificate by a physician or licensed psychologist taken within the last 72 hours.  
 clinical certificate by a psychiatrist taken within the last 72 hours.  
 no clinical certificate is attached because only assisted outpatient treatment is requested.

8. (For hospitalization and combined treatment only.) An examination could not be secured because \_\_\_\_\_

I request:

- a. the individual be examined at \_\_\_\_\_,  
the preadmission screening unit or hospital designated by the community mental health services program.  
 b. a peace officer take the individual into protective custody. After the individual is taken into protective custody, a  
peace officer or security transport official shall transport the individual to \_\_\_\_\_

9. I request the court to determine the individual to be a person requiring treatment and to order:

- a. hospitalization only.  
 b. a combination of hospitalization and assisted outpatient treatment.  
 c. assisted outpatient treatment without hospitalization.

10. I request the individual be hospitalized pending a hearing.

I declare under the penalties of perjury that this petition has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

\_\_\_\_\_  
Signature of attorney

\_\_\_\_\_  
Name (type or print) Bar no.

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, state, zip Telephone no.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of petitioner

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, state, zip

\_\_\_\_\_  
Home telephone no. Work telephone no.

<p>FOR HOSPITAL USE ONLY</p>	<p>This petition for mental health treatment was received by the hospital on _____ at _____  Date Time</p> <p>_____ Signature of hospital representative</p>
--------------------------------------	--

<b>STATE OF MICHIGAN PROBATE COURT COUNTY</b>	<b>ORDER FOR EXAMINATION/TRANSPORT</b>	<b>CASE NO. and JUDGE</b>
---	--	---------------------------

Court address \_\_\_\_\_ Court telephone no. \_\_\_\_\_

In the matter of \_\_\_\_\_ DOB: \_\_\_\_\_  
First, middle, and last name

1. Date of hearing: \_\_\_\_\_ Judge: \_\_\_\_\_

**THE COURT FINDS:**

2. A petition alleging the individual is a person requiring treatment and requesting hospitalization or a combined treatment order has been filed with the court, and
- a. one clinical certificate accompanies the petition. The individual must be examined by a psychiatrist.
  - b. no clinical certificate accompanies the petition. A reasonable effort was made to secure an examination. The individual must be examined by a psychiatrist and either a physician or a licensed psychologist.
3. The court has received information that a petition for assisted outpatient treatment has been filed, the petitioner has made reasonable efforts to secure an examination, and the individual will not make himself/herself available for evaluation.
4. The individual requires immediate assessment because the individual presents a substantial risk of significant physical or mental harm to himself/herself in the near future or presents a substantial risk of significant physical harm to others in the near future.
5. There does not appear to be probable cause to order the individual be taken into protective custody and transported to the designated prescreening unit or hospital.

**IT IS ORDERED:**

6. The individual be examined by a  psychiatrist  psychiatrist and a physician or licensed psychologist  
 at \_\_\_\_\_  
Prescreening unit or hospital

Upon completion of the examination(s), the executed clinical certificate(s) shall be filed with the court or a report that a clinical certificate is not warranted shall be made to the court.

- The individual shall be hospitalized. If the examinations and clinical certificates are not completed within 24 hours after hospitalization, the individual shall be released.
- A peace officer shall take the individual into protective custody. After the individual is taken into protective custody, a peace officer or security transport officer shall transport the individual to the designated prescreening unit or hospital. If the order is not executed by \_\_\_\_\_, the law enforcement agency must  
10 days from entry of order  
 report to the court the reason the order was not executed within the prescribed time period.

7. A peace officer shall take the individual into protective custody. After the individual is taken into protective custody, a peace officer or security transport officer shall transport the individual to the designated prescreening unit or hospital for assessment for assisted outpatient treatment. If the order is not executed by

\_\_\_\_\_, the law enforcement agency must report to the court the reason the order was not  
10 days from entry of order  
executed within the prescribed time period.

8. The request to take the individual into protective custody for transport is denied.

\_\_\_\_\_  
Judge signature and date

**REPORT OF NON-EXECUTION**

The Order for Examination/Transport issued on \_\_\_\_\_ has not been executed. The reason the order  
Date  
was not executed within 10 days after entry is: \_\_\_\_\_

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
Law enforcement agency

\_\_\_\_\_  
Telephone no.

**TO THE LAW ENFORCEMENT AGENCY:** Under MCL 330.1436(2), this report must be filed with the court that issued the Order for Examination/Transport if the order is not executed within 10 days after entry of the order.

STATE OF MICHIGAN JUDICIAL DISTRICT JUDICIAL CIRCUIT COUNTY PROBATE	PROTECTED PERSONAL IDENTIFYING INFORMATION	CASE NO. and JUDGE
--	---	--------------------

Court address

Court telephone no.

Plaintiff's/Petitioner's name	v	Defendant's/Respondent's name
In the matter of _____		

This form is nonpublic because it contains personal identifying information (PII) that is protected from public inspection under MCR 1.109(D)(9)(a). Use this form to provide PII only for a person who is a defendant, respondent, or decedent. If the person is a plaintiff, petitioner, or other individual, use form MC 97a.

**Instructions:**

- When PII (such as date of birth) must be filed with the court on a public document, DO NOT include it on that public document. Instead, you must provide it on this form.
- **Provide only** the protected PII required for your particular case. For example, if you are filing a public document that requires you to provide a date of birth to the court, complete only that field on this form.

Name of form/document that this MC 97 is being filed with: \_\_\_\_\_

Printed name of individual completing form and date \_\_\_\_\_

**Instructions:** Provide the name of the person that the PII applies to, followed by the specific PII that is required to be provided. For Other, specify the type of PII in addition to the PII itself. Use the below reference number (Ref. No.) in the public document in place of the protected PII. For example, insert "Ref. No. 1" in place of the DOB in the public document.

Ref. No.	Name (required)
1	Date of birth
2	National ID no. / Last 4 digits of SSN XXX-XX-_____
3	Driver's License / State-issued ID no.
4	Passport no.
5	Other

Ref. No.	<b>Instructions:</b> List the name of the financial institution and the account number. List the paragraph that references the account, if needed for clarity. Use reference number (Ref. No.) when necessary to refer to account in public documents.		
6	Financial institution	Account no.	Paragraph no.
7	Financial institution	Account no.	Paragraph no.
8	Financial institution	Account no.	Paragraph no.
9	Financial institution	Account no.	Paragraph no.



## Petition Review

Name of person being petitioned	
Name of petitioner	
Date of Petition	

Mental Health Professional Name:		
Clinical Review organization:		
Review findings:		Petition appears appropriate based on information provided by the petitioner to support need for treatment. LifeWays or the designee did not evaluate the person being petitioned.
		Petition <u>does not</u> appear to support a person in need of treatment. LifeWays or the designee did not evaluate the person being petitioned.
		Petition was unable to be reviewed by LifeWays staff, or designee.
Clinician Signature/Credentials:		Date:
Agency:		

This document should be paper clipped to the original petition document (no staples).

Compliant with **MCL330.1434 Petition; filing** Any individual 18 years of age or over may file with the court a petition that asserts that an individual is a person requiring treatment. The petition shall contain the facts that are the basis for the assertion. LifeWays, or its designee is reviewing the assertion of the petitioner.

LifeWays, or its designee have NOT conducted examination of the individual whom is being reported to need treatment.

LifeWays or its designee does NOT give legal advice. Please see a qualified attorney for legal advice.