

Superior Court of Washington, County of _____

In re Detention of:

Respondent _____ DOB _____

By: _____

Petitioner _____

Case No. _____

Petition for Initial Detention
(Emergency)

Adult:

- ☐ Mental Disorder (PIDEAM)
- ☐ Substance Use Disorder (PIDEAS)
- ☐ Co-occurring Disorders (PIDEAC)

Adolescent:

- ☐ Mental Disorder (PIDEM)
- ☐ Substance Use Disorder (PIDEMS)
- ☐ Co-occurring Disorders (PIDEMC)

Clerk's Action Required

I am a designated crisis responder (DCR) from ☐ (insert name of county) _____ County or ☐ Health Care Authority in consultation with (insert name of tribe) _____.

Respondent was brought to my attention under the following circumstances:

Based upon my personal observation and/or information obtained from reliable people and/or investigation, and/or following an interview with the respondent, **the facts that led me to conclude that the respondent suffers from a behavioral health disorder are as follows:**

Facts that led me to conclude that the respondent presents an imminent likelihood of serious harm and/or is in imminent danger because they are gravely disabled are as follows:

No less restrictive alternative than detention, including voluntary hospitalization or detoxification services, is clinically appropriate, necessary, and in the best interest of the respondent or others because:

The respondent was advised that behavioral health treatment was appropriate. **Respondent has failed to accept appropriate treatment voluntarily as evidenced by:**

Respondent is currently being held in emergency custody at *(insert facility's name and address):*

_____.

Therefore, the petitioner requests that the court order the respondent to an evaluation and treatment period not to extend beyond 120 hours.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signed at _____
City State

Date: _____

Time: _____ AM/PM

Sign here

Print Name

Superior Court of Washington, County of _____

In re Detention of:

Case No. _____

NOTICE OF RIGHTS

Respondent _____ DOB _____

By: _____

Petitioner _____

You are hereby given notice that you have the following rights:

1. To communicate with an attorney immediately, the right to have an attorney represent you before and at any court hearing, to have such attorney appointed if you cannot afford one, and the right to know the name and address of said attorney. You are entitled to contact an attorney of your choosing, or in place thereof (*insert name, address, phone number of public defender*)

_____ will be appointed to represent you.
2. To remain silent as any statement you make may be used against you.
3. To present evidence and to cross-examine witnesses who may testify about you at any probable cause hearing.
4. To a judicial hearing in a court of law within the next 120 hours (excluding Saturday, Sunday, and legal holidays) to determine whether there is probable cause to commit you for further mental health treatment for up to 14 days of inpatient, or 90 days of outpatient treatment, for the reason that you are a person whose mental disorder presents a likelihood of serious harm to yourself or others or that you are gravely disabled.
5. To apply for voluntary admission for treatment of a behavioral health disorder.
6. Within 24 hours of admission or acceptance at the facility, not counting time periods prior to medical clearance, you will be examined and evaluated by a physician and a mental health professional (or substance use disorder professional if detained for substance use disorder evaluation and treatment) and shall receive such treatment and care as your condition requires for the period that you are detained.

7. To have the court appoint a reasonably available independent professional person to examine you and testify at the hearing, at public expense, if you are unable to pay.
8. To refuse psychiatric medication, including antipsychotic medications, beginning 24 hours prior to the probable cause hearing. (This does not apply to minors detained per Ch. 71.34 RCW.)
9. To view and copy all petitions and reports in the court file.

Served on:

Respondent/Respondent's Attorney

Print Name

Dated: _____, 20____.

Reviewed and/or read by:

Legal Guardian or Conservator

Print Name

Dated: _____, 20____.

Served by:

Designated Crisis Responder

Print Name

Dated: _____, 20____.

Superior Court of Washington, County of _____

In re Detention of:

Case No. _____

Respondent _____ DOB _____

By:

Petitioner _____

PROOF OF SERVICE

I declare that I am 18 years of age or older. During the timing of this petition being sought and filed I was and am now a designated crisis responder duly designated by the ☐ County (*insert name of the county*) _____ or ☐ Health Care Authority in consultation with (*insert name of tribe*) _____.

On _____, 20____, at (*time*) _____ at (*location*) _____ in (*insert name of county*) _____ County, Washington, I personally served the respondent with the: *Petition for Initial Detention (Emergency)* and *Notice of Rights*. Copies of the documents were also ☐ served ☐ mailed to the Guardian/Conservator (*if applicable*).

☐ Copies were also served on the Department of Corrections because the respondent is either currently confined to a state correctional facility OR they are subject to the supervision of the Department of Corrections in the community.

☐ Copies were also served on the (*name of tribe and Indian health care provider*) _____, together with any orders issued by the court, upon the person and the person's guardian because I know or have reason to know that the respondent is an American Indian or Alaska Native who receives medical or behavioral health services from a tribe within this state.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signed at _____
City State

Date: _____

Sign here

Print Name

*This form is optional

Superior Court of Washington, County of _____

In re Detention of:

Case No. _____

Respondent	DOB
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DECLARATION OF WITNESS

By:

Petitioner

I declare the following, and I am willing to testify to these facts in any subsequent judicial proceedings: _____

(Add additional pages, if necessary)

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signed at _____ Date: _____
City State

Sign here

Print Name

DEMOGRAPHIC INFORMATION (*Optional*)

Respondent _____ Date _____

1. Address _____ Phone _____

2. Date of Birth _____

3. ☐ S ☐ M ☐ D ☐ W ☐ SEP/Spouse's name _____

4. Employment _____

5. Ethnicity: _____ 6. Primary Language: _____

7. Tribal Affiliation: ☐ Yes ☐ No

If "Yes", then is the respondent served by an Indian healthcare provider? ☐ Yes ☐ No

Tribe/Indian healthcare provider contact:

Agency: _____

Contact Person: _____

Phone: _____

Tribal Notification: ☐ Yes ☐ No

8. ☐ Nearest relatives/significant others ☐ Legal guardian/conservator

Relationship	Name	Address	Phone
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9. Alcohol/Drug History/Treatment _____

10. Witness: Available for hearing: ☐ Yes ☐ No

a. _____	H:
Relationship	W:
Name	Phone

b. _____	H:
Relationship	W:
Name	Phone

11. Mental Health Provider information: ☐ Registered ☐ Terminated ☐ No Record or Unknown ☐ Enrolled: Provider/PCP: _____

12. Other agencies involved with Respondent:

Agency	Contact Person	Phone
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13. BH-ASO of Residence: _____ /DCR: _____

Completed by: _____
Petitioner Print Name