Superior Court of Washington, County of _____

In re Detention of: _____ Respondent DOB By: _____ Petitioner	**Case No.** _____ **Petition for Initial Detention (Non-Emergency) – Adult** **[ ] Mental Disorder (PIDNEAM)** **[ ] Substance Use Disorder (PIDNEAS)** **[ ] Co-occurring Disorders (PIDNEAC)** **Clerk's Action Required**

I am a designated crisis responder (DCR) from [ ] County (*insert name of 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 a likelihood of serious harm and/or is 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 evaluation and treatment voluntarily as evidenced by:**

Therefore, the petitioner requests that the court order the respondent to appear for an evaluation and treatment period not to extend beyond 120 hours within 24 hours after service of the order.

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*

Time: _____ AM/PM

_____ _____
Sign here *Print name*

Superior Court of Washington, County of _____

In re Detention of:	**Case No.** _____
_____	
Respondent DOB	
By:	**NOTICE OF RIGHTS**
_____	
Petitioner	

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

1. To communicate with an attorney immediately and the right to have an attorney represent you before and at any court hearing and 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	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: _____ Respondent DOB By: _____ Petitioner	**Case No.** _____ **ORDER FOR INITIAL DETENTION & PROOF OF SERVICE**

A *Petition for Initial Detention (Non-emergency)* was filed by the [ ] County (*insert name of county*) _____ or [ ] Health Care Authority in consultation with (*insert name of tribe*) _____. The court finds that the respondent presents, as a result of a behavioral health disorder, a likelihood of serious harm, or is gravely disabled and that the person has refused or failed to accept appropriate evaluation and treatment voluntarily. Now IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

Respondent shall appear in person at (*insert name of facility*) _____ _____ no later than 24 hours from the service of this order. If the respondent is in the custody of any correctional facility or jail: said correctional facility or jail shall transport the respondent to the facility named above within 24 hours of service of this order. If the respondent fails to appear as ordered, the (*insert name of county or tribe*) _____ [ ] County [ ] Tribe DCR may cause the respondent to be taken into custody and delivered into the custody of an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program for up to 120 hours of evaluation and treatment pursuant to ch. 71.05 RCW (not applicable if the respondent is in a correctional facility or jail).

DATED: _____, 20___.

_____
JUDGE/COURT COMMISSIONER

----------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 county*) _____ or [ ] Health Care Authority in consultation with (*insert name of tribe*) _____.
On (*date*)_____, 20___, at (*time*) _____ at (*location*) _____ in *(insert name of county)* _____ County, Washington, I personally served the respondent with the: *Petition for Initial Detention (Non-emergency)*; *Order to Appear*; and *Notice of Rights*. Copies of the documents were also [ ] served [ ] mailed to the Guardian/Conservator (*if applicable*).

[ ] Copies were also served on (*insert name*) _____, a member of the staff of the correctional facility or jail in which the respondent is being held (*if applicable*).

[ ] 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 _____ Date:_____
City *State*

_____ _____
Sign here *Print name*

*This form is optional

Superior Court of Washington, County of _____

In re Detention of: _____ Respondent DOB By: _____ Petitioner	**Case No.** _____ **DECLARATION OF WITNESS**

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
9. Alcohol/Drug History/Treatment _____
10. Witness: Available for hearing: [ ] Yes [ ] No

    a. _____ H: W:

    Relationship Name Phone

    b. _____ H: W:

    Relationship 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
13. BH-ASO of Residence: _____ /DCR: _____

    Completed by: _____ / _____

    Petitioner / Print Name