Superior Court of Washington, County of _____
华盛顿州 县高等法院

In re Detention of: ***拘留相关信息：*** _____ Respondent DOB *被申请人 出生日期* By: *发件人：* _____ Petitioner *呈请人*	**Case No. _____** ***案件编号*** **Petition for Initial Detention (Non-Emergency) – Adult** ***初次拘留申请书（非紧急情况）– 成人*** **[ ] Mental Disorder (PIDNEAM)** ***精神障碍(PIDNEAM)*** **[ ] Substance Use Disorder (PIDNEAS)** ***物质使用障碍 (PIDNEAS)*** **[ ] Co-occurring Disorders (PIDNEAC)** ***伴随性障碍 (PIDNEAC)*** **Clerk's Action Required** ***书记员需要采取的行动***

I am a designated crisis responder (DCR) from [ ] County (*insert name of county*) _____ or [ ] Health Care Authority in consultation with (*insert name of tribe*) _____.
本人系[-]县（插入县名） 或[-]卫生保健管理局的指定危机应对人员(DCR)，与（插入部落名）协商后提交

Respondent was brought to my attention under the following circumstances:
以下情况促使我关注被申请人：

_____

_____

_____

_____

_____

_____

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:**
*基于本人观察和/或从可靠人士处获取的信息和/或调查结果，和/或与被申请人面谈后，**我得出被申请人患有行为健康障碍的事实依据如下：***

Facts that led me to conclude that the respondent presents a likelihood of serious harm and/or is gravely disabled are as follows:
促使我得出被申请人存在造成严重伤害的可能性和/或属于重度残障这一结论的事实如下：

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:
除拘留外，不存在限制程度更低的替代措施（包括自愿住院或戒毒服务）在临床上是适当且必要的，且符合被申请人或他人的最佳利益，理由如下：

The respondent was advised that behavioral health treatment was appropriate. **Respondent has failed to accept appropriate evaluation and treatment voluntarily as evidenced by:**
*已告知被申请人接受行为健康治疗是适当的。**被申请人未能自愿接受适当的评估和治疗，证据如下：***

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.
因此，申请人请求法院命令被申请人在送达命令后 24 小时内按指令接受评估和治疗，且该期限不得超过 120 小时。

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.
本人特此声明，以上陈述属实且正确。若有不实之词，愿依照华盛顿州法律而接受伪证罪处罚。

Signed at _____ Date: _____
签署地点 *日期：*

City *State*
城市 *州*

Time: _____ AM/PM
时间： *上午/下午*

_____ _____
Sign here *Print name*
在此处签名 *请工整填写姓名*

Superior Court of Washington, County of _____
华盛顿州 县高等法院

In re Detention of: *拘留相关信息：* _____ Respondent *被申请人* DOB *出生日期* By: *发件人：* _____ Petitioner *呈请人*	**Case No. _____** *案件编号* **NOTICE OF RIGHTS** ***权利通知书***

You are hereby given notice that you have the following rights:
特此通知您享有以下权利：

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*)

   _____
   有权立即联系律师，并有权在任何法院听证会前及听证期间由律师代理，若无力支付律师费，您有权申请指定律师，并有权知晓该律师的姓名和地址。您有权自行选择联系律师，若无法自行选择，将为您指定一名律师（插入公设辩护人的姓名、地址和电话号码）

   _____ will be appointed to represent you.
   作为代理人。

2. To remain silent as any statement you make may be used against you.
   保持沉默的权利，因为您所作的任何陈述可能被用作对您不利的证据。

3. To present evidence and to cross-examine witnesses who may testify about you at any probable cause hearing.
   提交证据的权利，以及在任何合理理由听证会上对可能就您作证的证人进行盘问的权利。

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.
   在未来 120 个小时内（不含周六、周日和法定节假日）向法院申请司法听证会的权利，以裁定是否存在合理理由将您强制收治，接受最长 14 天的住院治疗或 90 天的门诊治疗（若您的精神障碍存在对自身或他人造成严重伤害的可能性，或您属于重度残障）。

5. To apply for voluntary admission for treatment of a behavioral health disorder.
   申请自愿入院接受行为健康障碍治疗的权利。

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.
入院或入住机构后 24 小时内（不包括获得医疗许可前的时间段），您将接受一名医师及一名精神健康专业人员的检查和评估（若因物质使用障碍评估和治疗被拘留，则由物质使用障碍专业人员进行评估和治疗），并应在拘留期间接受您的病情要求的治疗和护理。

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.
若您无力支付费用，有权要求法院指定一名可合理联系到的独立专业人员为您检查并在听证会上作证，相关费用由公众承担。

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.)
自合理理由听证会前 24 小时起，您有权拒绝服用精神类处方药物（包括抗精神病药物）。（根据 RCW 第 71.34 章被拘留的未成年人不适用本条款。）

9. To view and copy all petitions and reports in the court file.
查阅和复印法庭档案中的所有申请书和报告的权利。

Served on:
送达对象：

Respondent *被申请人*	Print Name *请工整填写姓名*

Dated: _____, 20___.
日期：　　，20

Reviewed and/or read by:
审阅和/或阅读人：

Legal Guardian or Conservator *法定监护人或保护人*	Print Name *请工整填写姓名*

Dated: _____, 20___.
日期：　　，20

Served by:
送达人：

Designated Crisis Responder *指定危机应对人员*	Print Name *请工整填写姓名*

Dated: _____, 20___.
日期：　　，20

Superior Court of Washington, County of _____
华盛顿州 县高等法院

In re Detention of: ***拘留相关信息：*** _____ Respondent DOB *被申请人* *出生日期* By: *发件人：* _____ Petitioner *呈请人*	**Case No. _____** ***案件编号*** **ORDER FOR INITIAL DETENTION & PROOF OF SERVICE** ***初次拘留令及送达证明***

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:
[-]县（插入县名） *或[-]卫生保健管理局与（插入部落名）协商后* *，已提交一份初次拘留申请书（非紧急情况）。法院认定，因被申请人患有行为健康障碍，其存在造成严重伤害的可能性或属于重度残障，且被申请人已拒绝或未能自愿接受适当的评估和治疗。现命令、裁定并宣告如下：*

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).

被申请人须在本命令送达后24小时内亲自前往（插入机构名称）
。若被申请人目前由任何惩教机构或监狱羁押：上述惩教机构或监狱须在本命令送达后24小时内将被申请人移送至上述机构。若被申请人未按命令到庭，（插入县或部落名称）

[-]县[-]部落的DCR可依据RCW第71.05章，将被申请人拘留并移送至评估与治疗机构、安全戒断管理与稳定机构或经批准的物质使用障碍治疗计划，接受最长120小时的评估和治疗（若被申请人已被惩教机构或监狱羁押，本条款不适用）。

DATED: _____, 20___.
日期：，20

JUDGE/COURT COMMISSIONER
法官/助理法官

----------PROOF OF SERVICE----------
----------*送达证明*----------

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*).

本人声明已年满 18 周岁。在申请及提交本申请书期间，本人曾为且目前仍为[-]县（插入县名）或[-]卫生保健管理局正式指定的指定危机应对人员，与（插入部落名）协商后提交 。于（日期）， 20 ，（时间） ，在华盛顿州（插入县名）县（地点），本人亲自向被申请人送达以下文件：初次拘留申请书（非紧急情况）；出庭令；以及权利通知书。文件副本亦已[-]送达[-]邮寄至监护人/保护人（如有）。

[ ] 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*).

副本同时送达至（插入姓名） ，即被申请人羁押的惩教机构或监狱工作人员（如有）。

[ ] 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.

因本人知晓或有合理理由相信被申请人为从本州内部落接受医疗或行为健康服务的美洲印第安人或阿拉斯加原住民，副本及法院签发的任何命令亦一并送达至（部落名称及印第安医疗保健服务提供者名称） 及其本人和监护人。

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

本人特此声明，以上陈述属实且正确。若有不实之词，愿依照华盛顿州法律而接受伪证罪处罚。

Signed at _____ Date:_____
签署地点 *日期：*
City *State*
城市 *州*

_____ _____
Sign here *Print name*
在此处签名 *请工整填写姓名*

***This form is optional**
****本表格为可选***

Superior Court of Washington, County of _____
华盛顿州 县高等法院

In re Detention of: ***拘留相关信息：*** _____ Respondent DOB *被申请人* *出生日期* By: *发件人：* _____ Petitioner *呈请人*	**Case No. _____** ***案件编号*** **DECLARATION OF WITNESS** ***证人声明***

I declare the following, and I am willing to testify to these facts in any subsequent judicial proceedings: _____
本人声明如下，并愿在后续任何司法程序中就以下事实作证：

(*Add additional pages, if necessary*)
（如有需要，可另加附页）

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.
本人特此声明，以上陈述属实且正确。若有不实之词，愿依照华盛顿州法律而接受伪证罪处罚。

Signed at _____ Date: _____
签署地点 *日期：*

City *State*
城市 *州*

_____ _____
Sign here *Print name*
在此处签名 *请工整填写姓名*

DEMOGRAPHIC INFORMATION (*Optional*)
人口统计信息（可选）

Respondent _____ Date _____
被申请人 *日期*

1. Address _____ Phone _____
   地址 *电话*
2. Date of Birth _____
   出生日期
3. [ ] S [ ] M [ ] D [ ] W [ ] SEP/Spouse's name _____
   S [-] M [-] D [-] W [-] SEP/配偶姓名
4. Employment _____
   就业情况
5. Ethnicity: _____ 6. Primary Language: _____
   民族： *主要语言：*
7. Tribal Affiliation: [ ] Yes [ ] No
   部落归属：[-]是 [-]否

   If "Yes", then is the respondent served by an Indian healthcare provider? [ ] Yes [ ] No
   如果回答"是"，被申请人是否由印第安医疗保健服务提供者提供服务？[-]是 [-]否

   Tribe/Indian healthcare provider contact:
   部落/印第安医疗保健服务提供者联系方式：

   Agency: _____
   机构：

   Contact Person: _____
   联系人：

   Phone: _____
   电话：

   Tribal Notification: [ ] Yes [ ] No
   部落通知情况：[-]是 [-]否

8. [ ] Nearest Relatives/Significant Others [ ] Legal guardian/conservator
最近的亲属/重要他人[-]法定监护人/保护人

Relationship *关系*	Name *姓名*	Address *地址*	Phone *电话*

9. Alcohol/Drug History/Treatment _____
酒精/药物史/治疗

10. Witness: Available for hearing: [ ] Yes [ ] No
证人：可参加听证会：[-]是 [-]否

a. _____ H: *H：* W: *W：*

Relationship *关系*	Name *姓名*	Phone *电话*

b. _____ HH: *HH：* W: *W：*

Relationship *关系*	Name *姓名*	Phone *电话*

11. Mental Health Provider information: [ ] Registered [ ] Terminated [ ] No Record or Unknown [ ] Enrolled: Provider/PCP: _____
心理健康服务提供者信息：[-] 已注册[-] 已终止[-] 无记录或未知 [-] 已登记：提供者/PCP：

12. Other agencies involved with Respondent:
与被申请人相关的其他机构：

Agency *机构*	Contact Person *联系人*	Phone *电话*

13. BH-ASO of Residence: _____ /DCR: _____
居住地的 BH-ASO： */DCR：*

Completed by: _____ / _____
填表人：
Petitioner / Print Name
申请人 *请工整填写姓名*