Baker Act	Marchman Act
Release from Voluntary Status: 394.4625(2), FS and 65E-5.270, FAC ▪ Notice of right to request release given at time of admission ▪ Request for discharge -- notice within 12 hours to physician or psychologist & release within 24 hours (3 working days from State Treatment Facility) ▪ Refusal or revocation of consent to treatment – discharge within 24 hours ▪ Petition for involuntary placement filed with the circuit court within 2 court working days after request for discharge or refusal of treatment is made	

Involuntary Examination/ Admission Criteria

Baker Act (394.463(1),FS)

The Baker Act provides for an involuntary examination that may be initiated by two non-court procedures or one court procedure. The following criteria is the same regardless of which of the three methods of initiation is used:

1. Reason to believe person has a mental illness and because of mental illness, person has refused or is unable to determine if examination is necessary, and either:
2. Without care or treatment, is likely to suffer from neglect or refuse to care for self, and such neglect or refusal poses a real and present threat of substantial harm to one's well-being and it is not apparent that such harm may be avoided through the help of willing family members, friends, or the provision of other services; or
3. There is substantial likelihood that without treatment person will cause in the near future serious bodily harm to self or others, as evidenced by recent behavior.

Must meet all criteria

Initiation of Involuntary Examination: Upon determination that person ***appears to meet*** criteria for involuntary examination, the exam may be initiated by any one of the following three means:

- Court Order - the circuit court ***may*** enter an ex parte order; or
- A law enforcement officer ***shall*** take into custody a person who appears to meet the criteria describing ***circumstances***; or
- A mental health professional ***may*** execute a certificate stating that s/he has examined the person within the preceding 48 hours and found the person met the criteria and stating his/her ***observations*** upon which that conclusion is based.

More detail on each of the above methods of initiation is found below.

Marchman Act (397.675, FS)

The Marchman Act provides three distinct non-court procedures (protective custody, emergency admission, alternative assessment and stabilization of minors) and one court procedure (involuntary assessment and stabilization) for conducting assessments, which may include detoxification, stabilization, and short-term treatment. The criteria is:

There is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

1. Has lost the power of self-control with respect to substance use; and either

2a. Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or

2b. Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services.

Eligibility for initiation of involuntary admission proceedings under the Marchman Act is different depending on the age of the individual and the circumstances:

- The court may order an involuntary assessment / stabilization,
- A law enforcement officer can initiate Protective Custody,
- A parent/guardian can initiate assessment of a minor to a JARF, or
- a variety of individuals can initiate an Emergency Admission if a physician's certificate has been obtained.

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Baker Act	Marchman Act
Procedure for Involuntary Examination/Assessments	
Assessment & Examination Options	
The Baker Act provides that involuntary examinations be conducted only at designated hospital and non-hospital receiving facilities, as well as at hospitals that have provided examination and treatment of emergency medical conditions.	The Marchman Act provides several placement options for assessing persons (e.g., hospitals, addictions receiving facilities, detoxification facilities, less restrictive environments, jail).
Reporting Requirements	
394.459(9), 394.463(2)b, and 400.102(1)(c), FS The Baker Act requires that the ex parte order, law enforcement officer's report, or executed certificate be forwarded to the Agency for Healthcare Administration (AHCA) on the next working day following admission of a person to a receiving facility. Any receiving facility accepting person for involuntary examination must send to BA Reporting Center cover sheet (#3118) and copy of completed initiation form: ▪ Ex Parte Petition/Order ▪ Report of Law Enforcement Officer ▪ Certificate of a Professional All court orders for Involuntary Placement must also be sent to the BA Reporting Center within 1 day: ▪ Involuntary Inpatient Placement Order ▪ Involuntary Outpatient Placement Order Receiving facilities must report to AHCA, by certified mail within one working day, facilities licensed under chapter 400 / 429, FS that do not fully comply with Baker Act provisions governing: ▪ Voluntary admission ▪ Involuntary examination ▪ Transportation	The Marchman Act does not require contact with AHCA regarding involuntary admissions.

Baker Act	Marchman Act
MH/SA Professional Initiation (394.463(2)(a)3, FS and 65E-5.280(3), FAC) The Baker Act permits a physician, clinical psychologist, psychiatric nurse, clinical social worker, mental health counselor, or marriage and family therapist to execute a certificate if a person has been examined within the preceding 48 hours. The Florida Attorney General issued an opinion in 2008 that a Physician Assistant was also eligible to initiate and involuntary examination, but didn't authorize the PA to perform any other activities permitted for a physician. The authorized professional must cite his/her own observations on which his/her conclusion is based on a Certificate of a MH Professional (3052b) form and can't rely only upon the observations or input of others. The individual must be transported to the nearest receiving facility unless the County Commission and DCF have approved a Transportation Exception Plan (can transfer later if appropriate).	**Emergency Admissions (397.679, FS)** An application for emergency admission may be initiated: For a <u>minor</u> by the parent, guardian or legal custodian or for <u>adults</u> by: ▪ Certifying physician ▪ Spouse or guardian ▪ Any relative ▪ Any other responsible adult who has personal knowledge of the person's substance abuse impairment. An application for Emergency Admission must be accompanied by a Physician's Certificate. The Physician's Certificate must include: ▪ Name of client ▪ Relationship between client and physician ▪ Relationship between physician and provider ▪ Statement that exam & assessment occurred within 5 days of application date, and ▪ Factual allegations about the need for emergency admission: ▪ Reasons for physician's belief the person meets each criteria for involuntary admission ▪ Recommend the least restrictive type of service ▪ Be signed by the physician ▪ State if transport assistance is required and specify the type needed. ▪ Accompany the person and be in chart with signed copy of application. A person meeting involuntary admission criteria may be admitted for emergency assessment and stabilization upon receipt of a completed application with an attached completed physician's certificate to: ▪ A hospital, or ▪ A licensed detox, or ▪ An ARF, or ▪ A less intensive component of a licensed service provider for assessment only
	Release from Emergency Admission: Within 72 hours after emergency residential admission, client must be assessed by attending doctor to determine need for further services (5 days in OP). Based on assessment, a qualified professional* must: ▪ Release the client / refer ▪ Retain the client voluntarily ▪ Retain the client and file a petition for involuntary assessment or treatment (authorizes retention pending court order).

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Baker Act	Marchman Act
Law Enforcement 384.463(2)(a)2, FS and 65E-5.280(2), FAC ▪ Law enforcement officer is defined to mean a law enforcement officer as defined in s. 943.10, FS. The Florida Attorney General has issued several opinions excluding various federal law enforcement agencies from this definition because they are not certified by the State of Florida. ▪ A Law Enforcement Officer is required to describe the circumstances under which he/she has taken the individual into custody under the involuntary examination provisions of the Baker Act. The officer is not required to personally observe the behavior leading to the Baker Act, as is a Mental Health Profession who initiates the examination. ▪ The mandatory Report of Law Enforcement Officer -- Form (3052a) – must be completed by the officer and accompany the individual to a receiving facility or hospital. ▪ Transportation by the law enforcement officer must be to the nearest receiving facility unless the individual has an emergency medical condition. He/she can be transferred later by the facility if appropriate	**Protective Custody (397.677, FS)** A law enforcement officer means a law enforcement officer as defined in 943.10(1), FS Law enforcement may implement for adults or minors when involuntary admission criteria appears to be met who is in a public place or is brought to attention of LEO. A person may ***consent*** to LEO assistance to: ▪ home, or ▪ hospital, or ▪ licensed detox center, or ▪ addictions receiving facility, whichever the LEO determines is most appropriate. Law enforcement officer may take person (after considering wishes of person) ***without consent*** to: ▪ Hospital, or Detox, or ARF, or ▪ An ***adult*** may be taken to jail. Not an arrest and no record made. Jail must notify nearest appropriate licensed provider within 8 hours and shall arrange transport to provider with an available bed. The person must be assessed by jail's attending physician without unnecessary delay but within 72-hours
	Release from Protective Custody must be by a qualified professional* when: ▪ Client no longer meets the involuntary admission criteria, or ▪ The 72-hour period has elapsed; or ▪ Client has consented to remain voluntarily, or ▪ Petition for involuntary assessment or treatment has been initiated. Timely filing of petition authorizes retention of client pending further order of the court.
No corresponding provision in the Baker Act	**Alternative Assessment for Minors** Admission to a Juvenile Addiction Receiving Facility (JARF) for a minor meeting involuntary criteria upon application from: ▪ Parent, ▪ Guardian, or Legal custodian Application must establish need for immediate admission and contain specific information, including reasons why applicant believes criteria is met. ▪ Assessment by qualified professional within 72 hours to determine need for further services. ▪ Physician can extend to total of 5 days if further services are needed. ▪ Minor must be timely released or referred for further voluntary or involuntary treatment, whichever is most appropriate to minor's needs.

Baker Act	Marchman Act
Circuit Court Order 394.463(2)(a)1, FS and 65E-5.280(1), FAC ▪ Ex Parte means one-sided communication with the court and is generally used in emergency situations. The judge doesn't hear testimony about the circumstances of the petition, but only considers the information on the petition. ▪ The Baker Act requires that an Ex Parte order be based on sworn testimony. This can be as few as one petitioner or as many as needed to inform the circuit court judge that the criteria for involuntary examination appears to be met. ▪ Recommended petition form (#3002) may be used by the courts. ▪ The petition must be filed with Clerk of the Court (Probate) and no fee can be charged ▪ The Ex Parte Order is valid for seven days unless the court has specified a longer or shorter time limit for execution of order ▪ Law enforcement can execute the Ex Parte Order any hour of the day, on any day of the week and is authorized to use whatever reasonable force is needed to enter the premises to take the person into custody. ▪ Transportation must be to the nearest receiving facility (unless a transportation exception plan has been approved by the Board of County Commissioners and the DCF Secretary) the facility will transfer the individual later to a different facility if appropriate.	**Ex parte Order (397. 681, FS)** The Marchman Act permits entering an ex parte order based solely on the contents of a petition for involuntary assessment and stabilization. **Petitions (397.6811, FS)** ▪ Petitions filed with Clerk of Court in county where person is located. ▪ Circuit court has jurisdiction ▪ Chief judge may appoint general or special master. ▪ Person has right to counsel at every stage of a petition for involuntary assessment or treatment. ▪ Court will appoint counsel if requested or if needed and person cannot afford to pay. ▪ Un-represented minor must have court-appointed guardian ad litem to act on the minor's behalf. **Adult:** Petition may be filed by: ▪ Spouse, ▪ Guardian, ▪ Any relative, ▪ Private practitioner, ▪ Any three adults having personal knowledge of person's condition, or ▪ Service provider director/designee. **Minor:** Petition may be filed by: ▪ Parent ▪ Legal guardian ▪ Legal custodian, or ▪ Licensed service provider. Providers may initiate petitions for involuntary assessment and stabilization, or involuntary treatment when that provider has direct knowledge of the respondent's substance abuse impairment or when an extension of the involuntary admission period is needed.
	Petition for Assessment & Stabilization (397.6814, FS) must contain: ▪ Name of applicants and respondent ▪ Relationship between them ▪ Name of attorney, if known ▪ Ability to afford an attorney ▪ Facts to support the need for involuntary admission, including why petitioner believes person meets each criteria for involuntary intervention.

Baker Act	Marchman Act
	Role of the Court: ■ Clerk must determine whether person is represented by an attorney, and if not, whether an attorney should be appointed. ■ Based on a hearing or solely on petition and without an attorney, enter an ex parte order authorizing assessment & stabilization. ■ If hearing is scheduled, a summons issued to respondent and hearing scheduled within 10 days
	Court Determination (397.6818, FS) ■ Court shall hear all relevant testimony at hearing. ■ Respondent must be present unless injurious and a guardian advocate is appointed. ■ Right to examination by court-appointed qualified professional. ■ Determination by court whether a reasonable basis to believe person meets involuntary admission criteria. ■ Court may either enter an order authorizing assessment & stabilization or dismiss petition. ■ Court may initiate Baker Act if condition is due to mental illness other than or in addition to substance abuse ■ Respondent or court may choose provider ■ Order must include findings as to availability & appropriateness of least restrictive alternatives & need for attorney to represent respondent. ■ If court determines that person meets criteria, he/she may be admitted: ■ Up to 5 days to hospital, detox or ARF for assessment & stabilization, or ■ Less restrictive licensed setting for assessment only
	Provider Response for Court Ordered Evaluation (397.6819, FS) ■ Licensed provider may admit person for assessment without unnecessary delay, for a period of up to 5 days. ■ Assessment must be conducted by a "qualified professional". ■ Assessment must be reviewed by a physician prior to end of assessment period. ■ Provider may request court to extend time for assessment & stabilization for 7 more days, if timely filed within the 5-day assessment period. Based upon involuntary assessment (397.822, FS), person may be: ■ Released ■ Remain voluntarily ■ Retained if a petition for involuntary treatment has been initiated. Timely petition authorizes retention of client pending further order of the court.

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Baker Act	Marchman Act

Transportation Requirements for Involuntary Examination / Admission

Baker Act 394.462, FS and 65E-5.260, FAC

Law enforcement is mandated to provide the transportation of persons under involuntary status to the nearest receiving facility regardless of how the examination was initiated (court, law enforcement or MH professional), except transfers from a hospital that is governed by the federal EMTALA law.

The designated law enforcement agency may decline to transport the person to a receiving facility only if one of the following exceptions applies:

1. The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service or private transport company for transportation of persons to receiving facilities at the sole cost of the county; and the law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.
2. When a jurisdiction has entered into a contract with an emergency medical transport service or a private transport company for transportation of persons to receiving facilities, such service or company shall be given preference for transportation of persons from nursing homes, assisted living facilities, adult day care centers, or adult family-care homes, unless the behavior of the person being transported is such that transportation by a law enforcement officer is necessary.
3. When a law enforcement officer takes custody of a person pursuant to this part, the officer may request assistance from emergency medical personnel if such assistance is needed for the safety of the officer or the person in custody.
4. If the law enforcement officer believes that a person has an emergency medical condition as defined in s. 395.002, the person may be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility.
5. When a member of a mental health overlay program or a mobile crisis response service it may call on the law enforcement agency or other transportation arrangement best suited to the needs of the patient.
6. When a Transportation Exception Plan has been approved by the Board of County Commissioners and the Secretary of DCF.

Criminal Charges:

When any law enforcement officer has custody of a person based on either noncriminal or minor criminal behavior that meets the statutory guidelines for involuntary examination, the law enforcement officer shall transport the person to the nearest receiving facility for examination.

Marchman Act

Transportation for ***Emergency Admission*** may be provided by:

- An applicant for a person's emergency admission, or
- Spouse or guardian, or
- Law enforcement officer, or
- Health officer

The Court may order law enforcement to transport a person to nearest appropriate licensed service provider for a ***court-ordered assessment and stabilization.***

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Baker Act	Marchman Act
Baker Act 394.462, FS and 65E-5.260, FAC When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person shall first be processed in the same manner as any other criminal suspect. The law enforcement agency shall thereafter immediately notify the nearest public receiving facility, which shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide mental health examination and treatment to the person where he or she is held. Each law enforcement agency shall develop a memorandum of understanding with each receiving facility within the law enforcement agency's jurisdiction which reflects a single set of protocols for the safe and secure transportation of the person and transfer of custody of the person. These protocols must also address crisis intervention measures. The nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination. Procedures, facilities, vehicles, and restraining devices used for criminals may not be used with persons who have a mental illness, except for protection of the person or others. (Right to Individual Dignity) Law enforcement has no responsibility to provide transportation of individuals on voluntary status or to "treatment" facilities. ***Paperwork Required:*** Form Initiating Involuntary Exam: ▪ BA 52a (Law Enforcement) or ▪ BA 52b (MH Professional) or ▪ Ex Parte Order (Circuit Judge), and ▪ BA 3100 (transportation form)	

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Baker Act	Marchman Act
Admission Notices	
Baker Act 394.4599, FS Voluntary Admission – No notice for adults except in emergencies Involuntary Admission -- Prompt notice (within 24 hours) of arrival by phone or in person to: ▪ Guardian/Guardian Advocate or Representative ▪ May waive notice of admission to designated representative only if person requests no notification. No other required notices to representatives may be waived. Case Manager must be notified (65E-5.130(1) and (2), FAC) ▪ Identity of case manager noted in chart ▪ Contact, with consent, of Case Management agency within 12 hours ▪ CM visit within 2 working days after notice to assist with discharge & aftercare planning ▪ If case manager out of district, telephone call may substitute Other required notices (394.4599, FS) require prompt delivery to: ▪ Individual ▪ Representative ▪ Guardian or Gardian Advocate ▪ Attorney Notice to individuals held in facilities must be provided: ▪ Orally and in writing ▪ Using language/terminology person can understand ▪ Using an interpreter if needed To others, notices provided by U.S. mail and by registered or certified mail, with receipts in chart or by hand delivery documented in chart.	**Marchman Act** Nearest relative of a minor must be notified by the law enforcement officer of protective custody, as must the nearest relative of an adult, unless the adult requests that there be no notification. Upon receipt of petition for a court-ordered assessment and stabilization and if a hearing is scheduled, a copy of petition & notice of hearing (394.6815, FS) must be provided to: ▪ Respondent, ▪ Attorney, ▪ Petitioner, ▪ Spouse or guardian, ▪ Parent of a minor, and ▪ Others as directed by the court

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Baker Act	Marchman Act
Examination or Assessment	
Baker Act (394.463(2)(f)and 65E-5.2801(1), FAC) The Baker Act provides that a person must be examined within 72 hours of admission by a physician or a clinical psychologist. The person may not be released by the receiving facility without the documented approval of a psychiatrist, a clinical psychologist, or if the receiving facility is a hospital, the release may also be approved by an emergency department physician. A "Baker Act" is not lifted, rescinded, overturned, reversed, or abrogated! Once an Involuntary Exam is initiated, the Initial Mandatory Involuntary Examination must be conducted without unnecessary delay by a physician or licensed clinical psychologist at a receiving facility or a hospital and documented in the clinical record. Minimum standards for Initial Mandatory Involuntary Examination as required in law and rule (394.463(2)(f), FS and65E-5.2801, FAC) must include: ▪ Thorough review of any observations of the person's recent behavior; ▪ Review "Transportation to Receiving Facility" form (#3100) and ▪ Review one of the following: ▪ "Ex Parte Order for Involuntary Examination" or ▪ "Report of Law Enforcement Officer Initiating involuntary Examination" or ▪ "Certificate of Professional Initiating Involuntary Examination" ▪ Conduct brief psychiatric history; and ▪ Conduct face-to-face examination in a timely manner to determine if person meets criteria for release. Within the 72 hour examination period: ▪ Person shall be released, unless charged with a crime. If so, returned to law enforcement, or ▪ Person, unless charged with a crime, shall be asked to give express and informed consent to voluntary placement, or ▪ Petition for involuntary placement filed with Clerk of Circuit Court.	**Marchman Act** Under protective custody and emergency admission, the assessment must be completed by a physician within 72 hours of admission. For alternative involuntary assessment of a minor, the assessment must be completed by a qualified professional within 72 hours of admission but the minor may be retained for an additional 2 days if further assessment is determined necessary by a physician. For involuntary assessment and stabilization, the assessment must be completed by a "qualified professional" within 5 days of the court's order with sign-off by a physician. If additional time is needed to complete an assessment the court, if requested by the service provider, may grant an extension not to exceed 7 days after the renewal order.

Baker Act	Marchman Act
Release or Discharge	
Baker Act 394.459(11), FS and 65E-5.1303, FAC Notification of right upon discharge to seek treatment from the professional or agency of person's choice Discharge planning, beginning at admission, must include: ▪ Transportation resources ▪ Access to stable living arrangements ▪ Assistance in securing need living arrangements or shelter for those at risk of readmission within 3 weeks due to homelessness and prior to discharge shall request a commitment from a shelter provider that assistance will be rendered ▪ Education and written information about the person's mental illness and medications ▪ Information about & referral to community resources, including peer support ▪ Referral to substance abuse treatment programs, trauma services, or other self-help programs ▪ Assistance in obtaining a timely aftercare appointment for needed services, including continuation of prescribed psychotropic medications within 7 days of discharge ▪ Access to psychotropic medications or prescriptions or a combination thereof provided until scheduled aftercare appointment or 21 calendar days	**Marchman Act (65E-30.004(22), FAC)** A minor may only be released to: ▪ Parent, legal guardian or legal custodian ▪ To DCF pursuant to s.39, FS ▪ To DJJ pursuant to s.984, FS Summaries required for all voluntary and involuntary departures from services. ▪ Transfer Summary: Completed immediately for clients transferring between components of same provider and within 5 calendar days when transferring to another provider. Entry must be made in record about circumstances of the transfer signed and dated by primary counselor. A Transfer Summary is defined to mean a written justification of the circumstances of the transfer of a client from one component to another or from one provider to another. ▪ Discharge Summary: A Discharge Summary is legally defined to mean a written narrative of the client's treatment record describing the client's accomplishments and problems during treatment, reasons for discharge, and recommendations for further services. A written discharge summary signed and dated by primary counselor must be completed for clients completing or leaving prior to completion including client's involvement in services, reason for discharge, and services needed following discharge, including aftercare.
Discharge from State Hospitals 65E-5.1305, FAC ▪ Completion of State Mental Health Facility Discharge form (CF-MH 7001) ▪ 7 days prior notice to community case management agency ▪ On day of discharge, physician or charge nurse immediately notifies aftercare provider using the Physician-to-Physician Transfer form (#7002)	

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Baker Act	Marchman Act
Notice of Release from Involuntary Examination / Involuntary Admission	
Baker Act Notice of release must be given to the individual's guardian, guardian advocate, attorney, designated representative, to any person who executed a certificate admitting the patient, and to any court which ordered the examination.	**Marchman Act** Notice of release must be given to the applicant in the case of emergency admission or an alternative assessment of a minor, or to the petitioner and the court in the case of involuntary assessment and that minor client can only be released to authorized individuals or agencies. A client involuntarily admitted may be released without further order of the court only by a qualified professional. (397.6758, FS)
Involuntary Placement / Involuntary Treatment — Procedure for Filing Petitions	
Baker Act (394.467, FS) Criteria: 394.467(1), FS and 65E-5.290, FAC Finding of the court by clear and convincing evidence that the individual: ▪ Has a mental illness and because of the mental illness: ▪ Has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or was unable to determine whether placement is necessary; and ▪ Is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for self, and such neglect or refusal poses a real and present threat of substantial harm to his or her well being; or ▪ There is substantial likelihood that in the near future s/he will inflict serious bodily harm on self or others, as evidenced by recent behavior causing, attempting, or threatening such harm; and ▪ All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate. All criteria must be met	**Marchman Act** Criteria: There is good faith reason to believe the person is substance abuse impaired and, because of such impairment: 1. Has lost the power of self-control with respect to substance use; and either 2a. Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or 2b. Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services. In addition to meeting the above criteria for involuntary admissions, a person for whom a petition for involuntary treatment is filed must have met additional conditions including: ▪ Having been placed under protective custody within the previous 10 days; ▪ Having been subject to an emergency admission within the previous 10 days, ▪ Having been assessed by a qualified professional within the previous 5 days; ▪ Having been subject to a court ordered involuntary assessment and stabilization within the previous 12 days ▪ Having been subject to alternative involuntary admission within the previous 12 days.

Baker Act	Marchman Act
Petition for Involuntary Placement	
The Baker Act permits the administrator of a receiving facility to recommend placement in a treatment facility and to file a petition with the court as long as the recommendation is supported by a psychiatrist and a second opinion by another psychiatrist or clinical psychologist, both of whom have personally examined the patient within the preceding 72 hours and the criteria for involuntary examination are met. (2nd opinion may be electronic, maintaining visual & audio communication). Case law requires factual substantiation of each criteria alleged in the petition for involuntary inpatient placement – not just opinions, conclusions, or hearsay ▪ Petition (#3032) completed and filed within 72 hours of person's arrival at facility or filed on next court working day if 72-hour period ended on weekend or legal holiday – no exception for weeknights ▪ No fee charged.	**Marchman Act (397.6951, FS)** The Marchman Act permits an adult's spouse or guardian, any relative, a service provider, or any three adults that have knowledge of the respondent and prior course of assessment or treatment to file a petition with the court. If the respondent is a minor, the petition may be filed by a parent, legal guardian, or service provider. The Marchman Act also requires that the respondent have been involved in at least one of the other involuntary admission procedures within specified time frames before a petition can be filed for involuntary treatment: Contents of Petition must include: ▪ Name of respondent ▪ Name of petitioner(s) ▪ Relationship between the respondent & petitioner ▪ Name of respondent's attorney ▪ Statement of petitioner's knowledge of respondent's ability to afford an attorney ▪ Findings & recommendations of the assessment performed by qualified professional ▪ Factual allegations presented by the petitioner establishing need for involuntary treatment, including: ▪ Reason for petitioner's belief that respondent is substance abuse impaired; and ▪ Reason for petitioner's belief that because of such impairment, respondent has lost power of self-control with respect to substance abuse; and either ▪ Reason petitioner believes the respondent has inflicted or is likely to inflict physical harm on self/others unless admitted; or ▪ Reason petitioner believes respondent's refusal to voluntarily receive care is based on judgment so impaired by reason of substance abuse to be incapable of appreciating need for care and making a rational decision
Duties of the Court	
Clerk of Court – provides required copies of the petition to individual, DCF, guardian, or representative, state attorney and public defender Written notice of filing of petition for involuntary placement must contain: (394.4599(2)(c), FS) ▪ Petition filed with the circuit court in county where person is hospitalized. ▪ Office of public defender appointed to represent person if not otherwise represented by counsel. ▪ Date, time, and place of hearing, and name of each examining expert and every other person expected to testify in support of continued detention. ▪ Person entitled to independent expert examination and, if person cannot afford examination, court will provide for one; and ▪ Notice that person, guardian, representative or administrator may apply for change of venue for convenience of parties or witnesses or because of person's condition.	**Marchman Act (397.6955, FS)** ▪ Upon filing of petition with clerk of court, court shall immediately determine if respondent has attorney or if appointment of counsel is appropriate ▪ Court scheduled hearing w/i 10 days. ▪ Copy of petition and notice of hearing provided to respondent; attorney, spouse or guardian if applicable, petitioner, (parent, guardian or custodian of a minor), and other persons as the court may direct; and ▪ Issue a summons to respondent.

Baker Act	Marchman Act
Burden of Proof by Clear and Convincing Evidence	
Evidence that is precise, explicit, lacking in confusion, and of such weight that it produces a firm belief or conviction, without hesitation, about the matter at issue (Standard Jury Instructions – Criminal Cases, published by the Supreme Court of Florida, No. SC95832, June 15, 2000).	Evidence that is precise, explicit, lacking in confusion, and of such weight that it produces a firm belief or conviction, without hesitation, about the matter at issue (Standard Jury Instructions – Criminal Cases, published by the Supreme Court of Florida, No. SC95832, June 15, 2000).
Appointment of Counsel	
The Baker Act sets the time for appointing a Public Defender within 1 court working day, unless the person is otherwise represented by private counsel. The State Attorney's Office is appointed as the "real party in interest" to represent the state.	The Marchman Act requires that the court immediately determine whether the respondent is represented by counsel or whether appointment of an attorney is appropriate. No specific time is specified. Neither the Public Defender nor the State Attorney is assigned responsibility in the Marchman Act or chapter 27, FS.
Hearings for Involuntary Placement / Treatment	
▪ Hearing held within 5 court working days unless continuance requested by person, with concurrence of counsel. No waiver of hearing. ▪ Held as convenient to person as consistent with orderly procedure and not likely to be injurious to person's condition ▪ Judge or magistrate presides ▪ Person's attendance at hearing -- any waiver of right to be personally present at hearing must be knowing, intelligent, and voluntary. Witnesses: ▪ 1 of the 2 examining professionals who executed placement certificate must be a witness ▪ Anyone else that has fact testimony to support continued detention. (staff, family, case manager, others) ▪ Person may refuse to testify at the hearing ▪ Competence to consent to treatment must be considered – If incompetent, guardian advocate appointed	**Marchman Act (397.6957, FS)** ▪ The hearing must occur within 10 days of the petition with no possibility of a continuance. ▪ All relevant evidence, including results of all involuntary interventions must be considered ▪ Judge or magistrate presides ▪ Client to be present unless injurious – if so, court will appoint guardian advocate ▪ Petitioner has burden of proving by clear & convincing evidence that all criteria for involuntary admission are met Court will either dismiss petition or order client to involuntary treatment.
Initial Order	
If a court concludes person meets all criteria for involuntary inpatient placement, it shall order person, for a period of <u>up to</u> 6 months: ▪ Transferred to a treatment facility or, if the person is at a treatment facility, that the person be retained there, or ▪ Treated <u>at</u> any other appropriate receiving or treatment facility, or ▪ Receive services <u>from</u> a receiving or treatment facility	**Marchman Act (397.697, FS)** ▪ Order for involuntary treatment by licensed provider <u>up to</u> 60 days ▪ Order authorizes provider to require client to undergo treatment that will benefit. ▪ Order must include court's requirement for notification of proposed release. ▪ Court may order Sheriff to transport ▪ Court retains jurisdiction over case for further orders.
Hearings on Continued Involuntary Placement / Treatment	
Hearings on petitions for continued placement or extensions are administrative hearings and conducted in accordance with section 120.57(1), F.S. Any order entered by a hearing officer is final and subject to judicial review. Appellate case established that Courts and Division of Administrative Hearings (DOAH) have concurrent jurisdiction within the first six months of an order.	The Marchman Act requires that the petition be filed not more than 10 days prior to the end of the initial period.

Baker Act	Marchman Act
Extension of Order	
Baker Act (394.467(6), FS) The Baker Act provides that petitions on continued placement be filed prior to the expiration of the period the treatment facility is authorized to retain the patient. The Baker Act permits a continued placement extension of up to 6 months. ▪ If person continues to meet criteria for involuntary inpatient placement, administrator shall, 20 days prior to expiration of period during which treatment facility is authorized to retain person, file petition (#3035) requesting authorization for continued involuntary inpatient placement. ▪ The request for continued involuntary placement must be accompanied by: ▪ A statement from person's physician or clinical psychologist justifying the request ▪ A brief description of person's treatment during the time he/she was involuntarily placed ▪ An individualized plan of continued treatment ▪ Waiver of person's presence at hearing may be filed, but no waiver of hearing. The testimony in the hearing must be under oath and the proceedings must be recorded ▪ If previously found incompetent to consent to treatment, testimony and evidence regarding the person's competence must be considered. If person is now competent to consent to treatment, the administrative law judge may issue a recommended order to court that found person incompetent to consent to treatment that person's competence be restored and any guardian advocate previously appointed be discharged. (#3116) ▪ If at hearing person continues to meet criteria for involuntary placement, administrative law judge will sign order (#3031) for continued involuntary inpatient placement for period not to exceed 6 months. Same procedure repeated prior to expiration of each additional period the person is retained. ▪ If person is found not to meet criteria for involuntary inpatient placement, he/she must be released or transferred to voluntary status	Marchman (397.6975, FS) When criteria still exists, a renewal of involuntary treatment order may be requested if filed at least 10 days prior to the end of the 60-day period. ▪ Hearing scheduled within 15 days of filing ▪ Copy of petition to all parties ▪ If grounds exist, may be ordered for up to 90 additional days. ▪ Further petitions for 90 day periods may be filed if grounds for involuntary treatment persist.

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Baker Act	Marchman Act
Release from Involuntary Placement / Treatment & Notices	
At any time a person is found to no longer meet the criteria for involuntary placement, the administrator shall: ■ Discharge person, unless under a criminal charge, in which case the person shall be transferred to the custody of law enforcement; or ■ Transfer person to voluntary status if willing and competent to provide express and informed consent, unless the person is under criminal charges or adjudicated incapacitated; or ■ Place improved person, unless under a criminal charge, on convalescent status in the care of a community facility. ■ Notice of discharge/transfer shall be given (#3038).	After 60-day involuntary treatment, client automatically discharged unless petition timely filed with court. ■ Person may be released by a qualified professional without court order. ■ Notice of release provided to applicant for a minor or to petitioner and court if court-ordered. ■ Release of minor must be to parent or guardian, DCF or DJJ. ■ An involuntarily admitted client may, upon giving written informed consent, be referred to a service provider for voluntary admission when the provider determines that the client no longer meets involuntary criteria. ■ When a court ordering involuntary treatment includes requirement in court order for notification of proposed release, provider must notify the original referral source in writing. **Early Release:** Client must be released when: (397.6971, FS) ■ Basis for involuntary treatment no longer exist ■ Converts to voluntary upon informed consent ■ No longer in need of services ■ Client is beyond safe management of the provider ■ Further treatment won't bring about further significant improvements. Notification shall comply with legally defined conditions and timeframes and conform to federal and state confidentiality regulations.

Baker Act	Marchman Act

Responsibilities of Providers

Baker Act (394.461, FS and 65E-5.350 and 65E-5.180(5), FAC)

- Provide onsite emergency reception, screening & inpatient treatment services 24 hours a day, 7 days a week, regardless of ability to pay
- Accept any person brought by law enforcement for involuntary examination (hospitals must accept regardless of leagal status).
- Accept persons of all ages
- Assess all persons for clinical safety, co-occurring disorders, substance abuse, physical/sexual abuse or trauma
- Comply with all EMTALA requirements, if a hospital
- Public receiving facilities affiliated with community mental health centers must ensure the centralized provision and coordination of acute care services for eligible persons with acute mental illnesses. (394.459(11), FS and 65E-5.1304, FAC)
- Failure to have the original form initiating involuntary admission or an original signature on the form is not a basis for refusing an admission.
- The hospital licensing law requires all hospitals that examine or treat an individual of any age who is held under the Baker Act must adhere to all requirements as it applies to that individual, as follows:
- 395.003(5)(a), FS "Adherence to patient rights, standards of care, and examination and placement procedures provided under part I of chapter 394 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment".
- 395.003(5)(b), FS "Any hospital that provides psychiatric treatment to persons under 18 years of age who have emotional disturbances shall comply with the procedures pertaining to the rights of patients prescribed in part I of chapter 394".
- 395.1041(6), FS Rights of Persons being Treated.-- A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s.394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s.394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.
- 395.1055(5), FS "The agency (AHCA) shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment".

Marchman Act (397.6751, FS and65D-30.004, FAC)

Person must be admitted when sufficient evidence exists that:

- Person is substance abuse impaired
- Setting Is the least restrictive and most appropriate
- Within licensed capacity
- Medical & behavioral conditions can be safely managed
- Within financial means of person (Other than licensed hospitals per EMTALA)

Providers receiving state funds for substance abuse services can't deny access based on inability to pay if space and sufficient state resources are available.

Access cannot be denied based on race, gender, ethnicity, age, sexual preference, HIV status, disability, use of prescribed medications, prior service departures against medical advice, or number of relapse episodes.

If admission is refused (397.6751, FS) the provider must, in compliance with federal confidentiality regulations:

1. Attempt to contact referral source to discuss circumstances and assist in arranging alternate intervention.
2. Provider must within 1 workday of refusal, report in writing to referral source:
   - Basis for refusal
   - Documentation of provider's efforts to contact the referral source and assist person to access more appropriate services.
3. If medical or behavior can't be safely managed, provider must discharge and assist to secure more appropriate services. Within 72 hours, report to referral source basis for discharge and provider's efforts to assist client.

Persons on involuntarily status can only be placed in licensed service providers in components authorized to accept involuntary clients.

Providers accepting person on involuntary status must provide a description of the eligibility and diagnostic criteria and the placement process to be followed for each of the involuntary placement procedures

Each person involuntarily admitted shall be assessed by a qualified professional to determine need for additional treatment and most appropriate services.

Decision to refuse to admit or to discharge shall be made only by a qualified professional.

Failure to have the original form initiating involuntary admission or an original signature on the form is not a basis for refusing an admission.

Baker Act	Marchman Act
Rights: General	
▪ Written copy of rights at admission ▪ Signed by person ▪ Copies to significant others ▪ Discussion of rights during hospitalization ▪ Posting of rights & phone numbers near phone: ▪ Abuse Registry / Hotline ▪ Disabilities Rights Florida, Inc. ▪ ADA ▪ Copy of Baker Act statute & rules on each unit	**Marchman Act (397.501, FS and 65D-30.004, FAC)** Clients receiving substance abuse services from any service provider are guaranteed protection of fundamental human, civil, constitutional and statutory rights including those specified in the Marchman Act unless otherwise expressly provided, and service providers must ensure the protection of such rights. Basic client rights include provisions for informing the client, family member, or authorized guardian of their rights and responsibilities, assisting in the exercise of those rights, and an accessible grievance system for resolution of conflicts;
Rights: Individual Dignity	
Baker Act (394.459(1), FS and 65E-5.150 FAC) ▪ All Constitutional Rights ▪ Freedom of Movement – no restraint or seclusion except for safety of person or others (imminent danger) ▪ Outdoors & Exercise – at least ½ hour per day out of doors unless prohibited by physician's order when suitable area is immediately adjacent to unit ▪ Special Clothing – prohibited for identification purposes ▪ Procedures, facilities, vehicles, and restraining devices used for criminals not be used with persons who have a mental illness, except for protection of the person or others	**Marchman Act 397.501(1), FS** ▪ Guaranteed the protection of all fundamental human, civil, constitutional, and statutory rights. ▪ Respect at all times, including when admitted, retained, or transported. ▪ Cannot be placed in jail unless accused of a crime except for adults under protective custody. ▪ Must permit grievances to be filed for any reason
Rights: Treatment	
Baker Act (394.459(2), FS and 65E-5.160, FAC) ▪ No denial or delay of treatment due to inability to pay – may collect appropriate reimbursement ▪ Least restrictive appropriate & available treatment required ▪ Physical examination within 24 hours by authorized health care practitioner ▪ Posted schedule of daily activities ▪ Individualized treatment plan within 5 days. Person must have had opportunity to assist in preparing and reviewing plan. Form must have space for person's comments	**Marchman Act** ▪ See right to quality services below ▪ Services suited to client's needs, administered skillfully, safely, humanely, with full respect for dignity/integrity, and in compliance with all laws and requirements. ▪ Opportunity to participate in formulation & review of individualized treatment / service plan.

Baker Act	Marchman Act
Treatment Planning (394.459(2)(d), FS and 65E-5.160 (2), FAC) must include: ▪ Advance directives-person's preferences for mental health care ▪ Diagnostic testing ▪ Person's treatment goals ▪ Housing ▪ Social supports ▪ Financial supports ▪ Health, including mental health ▪ Observable, measurable & time-limited objectives ▪ Progress notes ▪ Periodic reviews ▪ Integrated approach to treatment ▪ Updates & physician summary every 30 days	"Treatment Plan" means an individualized, written plan of action that directs all treatment services and is based upon information from the assessment and input from the client served. The plan establishes client goals and corresponding measurable objectives, time frames for completing objectives, and the type and frequency of services to be provided. Each client shall be afforded the opportunity to participate in the development and subsequent review of the treatment plan. The treatment plan shall include: ▪ Goals and related measurable behavioral objectives to be achieved by the client, ▪ Tasks involved in achieving those objectives, ▪ Type and frequency of services to be provided, and ▪ Expected dates of completion. The treatment plan shall be signed and dated by the person providing the service, and signed and dated by the client. If the treatment plan is completed by other than a qualified professional, the treatment plan shall be reviewed, countersigned, and dated by a qualified professional within 10 calendar days of completion.
Rights: Express and Informed Consent	
Baker Act 394.459(3), FS and 65E-5.170, FAC Competence is well reasoned, willful & knowing decision-making. Prior to requesting consent to treatment, the following must be provided and explained in plain language: ▪ The reason for admission or treatment, ▪ Proposed treatment, including psychotherapeutic medications ▪ Purpose of treatment ▪ Alternative treatments ▪ Specific dosage range for medications ▪ Frequency and method of administration ▪ Common risks, benefits and short-term/long-term side effects ▪ Contraindications ▪ Clinically significant interactive effects with other medications, ▪ Similar information on alternative medication which may have less severe or serious side effects. ▪ Potential effects of stopping treatment ▪ Approximate length of care ▪ How treatment will be monitored, and that ▪ Any consent for treatment may be revoked orally or in writing before or during the treatment period by the person legally authorized to make health care decisions for the person.	Informed consent required, but not separately defined or described in Marchman Act.

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Baker Act	Marchman Act
Who can give consent? ▪ Competent adult ▪ Guardian of a child ▪ Court Appointed Guardian ▪ Court Order ▪ Letters of Guardianship ▪ Guardian advocate / court order ▪ Health care surrogate or proxy / Advance Directive If competent to consent, person is competent to refuse or revoke consent! If incompetent to consent, person is incompetent to refuse or revoke consent and a substitute decision-maker must be appointed.	**Who can give consent?** ▪ Adults ▪ Minors
Authorization for Treatment 65E-5.170(2), FAC **General Authorization for Treatment (#3042a)** ▪ Routine medical care ▪ Psychiatric assessment ▪ Assessment/treatment other than medications **Specific Authorization for Psychotropic Medications (#3042b)** ▪ Disclosure by qualified personnel ▪ Completed prior to administration ▪ By authorized decision-maker	No corresponding provisions
Emergency Treatment Orders 394.463(2)(f), 394.4625(5), FS and 65E-5.1703, FAC ▪ Document specific nature & extent of imminent danger to self or others (not just "agitated" or "disruptive") ▪ Must attempt to contact guardian, guardian advocate or health care surrogate / proxy to obtain consent ▪ Medical review of person's condition for causal medical factors ▪ Written order of a physician required-Initial order by phone ▪ Written order signed within 24-hours ▪ No PRN or standing orders ▪ Each order valid not to exceed 24-hours; daily renewal by physician if dangerousness continued	No corresponding provisions
Petition for Guardian Advocate: ▪ Petition must be initiated within 24 hours of ETO & submitted to court within 2 court working days thereafter unless only single ETO is needed. ▪ If 2nd ETO written within 7 days, petition must be filed with court within 1 court working day thereafter requesting appointment of a guardian advocate.	No corresponding provisions

Baker Act	Marchman Act
Rights: Quality Treatment / Services	
Baker Act 394.459(4), FS and 65E-5.180, FAC Receiving and treatment facilities are required to maintain in a form accessible to and readily understandable: ▪ Criteria, procedures, & staff training required for any use of & procedures for documenting, monitoring, and requiring clinical review of: ▪ Close or elevated levels of supervision ▪ Use of bodily control and physical management techniques ▪ Restraint, seclusion or isolation ▪ Emergency treatment orders ▪ Procedures for documenting and reviewing incidents resulting in injury. ▪ A system for investigating, tracking, managing, and responding to complaints by persons or others acting on their behalf.	**Marchman Act 397.501(3), FS** Least restrictive and most appropriate services, based on needs and best interests of client. Services suited to client's needs, administered skillfully, safely, humanely, with full respect for dignity/integrity, and in compliance with all laws and requirements. Methods used to control aggressive client behavior that pose an immediate threat to the client or others – used by staff trained & authorized to do so – in accordance with rule. Opportunity to participate in formulation & review of individualized treatment / service plan.
Emergency Orders Facilities must comply with the most stringent standards that apply to their facility, including ETO's, restraints, seclusion, and other emergency interventions. These may include: ▪ Baker Act law and rules --Baker Act rules governing restraints & seclusion rewritten in 2008. ▪ Joint Commission on Accreditation of Healthcare Organizations or CARF ▪ Federal Conditions of Participation (CMS) ▪ Facility policies and procedures	

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Rights: Confidentiality

Baker Act

Variety of federal/state statutes and case law govern confidentiality:

- Baker Act
- Psychotherapist / patient privilege
- Substance Abuse
- HIPAA (treatment, operations and payment exempted)
- Substitute Decision-Makers
- Communicable Diseases
- Duty to report abuse, neglect & exploitation of children & vulnerable adults
- Foreign Nationals – Consular Notification & Access

Unless person, guardian, guardian advocate, or surrogate/proxy waives by express and informed consent, confidentiality of record shall not be lost.

Information from record may be released:

- By court order after good cause hearing
- After declaration of intent to harm – may release sufficient information to adequately warn person threatened. Tarasoff warning not required in Florida
- Inform guardians of threats by minors
- Warn of threats of future harm, but not confessions of past crimes

Person has right of reasonable access to own clinical record unless determined by physician to be harmful. If restricted:

- Recorded, with reasons, in clinical record
- Notice to person, attorney, and others
- Expires in 7 days but can be renewed

Facility policies should identify:

- What is reasonable access?
- Is this all "persons" – minors? incapacitated?
- Who will review for harmfulness?
- How, where & with whom actual review will take place?

Marchman Act

Identity, diagnosis, prognosis, and service provision to any client is confidential.

- Disclosure requires written consent of client, except:
- Medical personnel in emergency
- Provider staff on "need to know" to carry out duties to client.
- DCF Secretary/designee for research (non-identifying)
- Audit or evaluation by federal, state, local governments, or 3rd party payor
- Court order for good cause based on whether public interest/need for disclosure outweigh potential injury to client or provider to authorize disclosure but subpoena then required.to compel.

Other Confidentiality Considerations:

- Restrictions inapplicable to reporting of suspected child abuse.
- Minor may consent to own disclosure – consent can only be given by the minor
- If consent of guardian required to obtain services for minor, both minor & guardian must consent to disclosure
- 42 CFR (Code of Federal Regulations) and HIPAA also control how information can be released – most stringent prevails.

Release to Law Enforcement directly related to commission of a crime on premises or against staff or threat to do so. Limited to:

- Client's name and address
- Circumstances of incident
- Client status
- Client's last known whereabouts.

Court can authorize for criminal investigation or prosecution only if all the following criteria are met:

- Crime is extremely dangerous
- Records will be of substantial value
- No other methods available or effective
- Potential injury to client or program outweighed by public interest and need to know

Confidentiality and the Court:

- Court order authorizes but does not compel disclosure of client identifying data.
- Subpoena must then be issued to compel disclosure.
- Client and provider must be given notice and opportunity to respond or to appear to provide evidence.
- Oral argument, review of evidence or hearing in chambers.

Baker Act	Marchman Act
Patient and personnel records in hospitals; copies; examination	
Baker Act (395.3025(2), FS) This section of the hospital statute does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615.	Marchman 395.3025(3), FS This section of the hospital statute does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.
Rights: Communication, Abuse Reporting & Visitation	
Baker Act 394.459(5), FS and 65E-5.190, FAC Guaranteed regardless of age or development, but facility shall establish reasonable rules governing visitors and use of telephones Visits: Immediate access by family, guardian, guardian advocate, representative, or attorney, unless found to be detrimental Telephone: ▪ Free local calls / Access to long-distance ▪ Private and confidential communication ▪ Phone located near posters giving advocate phone numbers ▪ Unlimited telephone for abuse reporting, attorney, & Disability Rights Florida, Inc. Correspondence ▪ Stationery/stamps/gifts ▪ Send / receive unopened correspondence without delay ▪ Reasonable examination of suspected contraband & disposal Restriction of Communication (#3049) ▪ Written notice with reasons to person, attorney, guardian, guardian advocate, or representative ▪ Reviewed every 7 days Waiver: Competent adults may waive the confidentiality of their presence in a receiving or treatment facility	**Marchman Act 397.501(4), FS** ▪ Free & private communication within limits imposed by provider policies. ▪ Close supervision of all communication & correspondence required. ▪ Reasonable rules for mail, telephone & visitation to ensure the well-being of clients, staff & community. ▪ Clients and families must be informed about provider rules related to communication and correspondence
Rights: Care & Custody of Personal Effects	
Baker Act 394.459(6), FS and 65E-5.200, FAC Right to possess clothing / personal effects except for medical and safety reasons. Receiving and treatment facilities must develop policies and procedures governing: ▪ What will be removed for reasons of personal or unit safety ▪ How it will be safely retained by the facility ▪ How/when it will be returned ▪ How contraband will be addressed when not returned Inventory: ▪ Witnessed by person and two staff ▪ At time of admission and when amended	**Marchman Act 397.501(5), FS** ▪ Right to possess clothing and other personal effects. ▪ Provider may take temporary custody of personal effects only when required for medical or safety reasons. ▪ If removed, reasons for taking custody and a list of the personal effects must be recorded in clinical record.

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Baker Act	Marchman Act

Rights: Non-Discrimination

Baker Act

No corresponding provision.

Marchman Act (2)

Service providers may not deny a client access to substance abuse services solely on the basis of race, gender, ethnicity, age, sexual preference, HIV status, prior service departures against medical advice, disability, or number of relapse episodes. Service providers may not deny a client who takes medication prescribed by a physician access to substance abuse services solely on that basis. Service providers who receive state funds to provide substance abuse services may not, provided space and sufficient state resources are available, deny a client access to services based solely on inability to pay.

Rights: Voting in Public Elections

Baker Act 394.459(7), FS and 65E-5.210, FAC

- A person in a facility who is eligible to vote has the right to vote in the primary and general elections
- Receiving and treatment facilities shall have voter registration forms and applications for absentee ballots readily available at the facility (or in accordance with the procedures established by the County supervisor of elections), and shall assure that each person who is eligible to vote and wishes to do so, may exercise his or her franchise
- Each designated facility shall develop policies and procedures governing how persons will be assisted in exercising their right to vote

Marchman Act

No corresponding provisions

Rights: Right to Counsel

Baker Act (394.467(4), FS)

The Public Defender is responsible for representing all persons on involuntary placement status unless represented by private counsel

Marchman Act 397.501(8), FS

- Client must be informed of right to counsel at every stage of involuntary proceedings.
- May be represented by counsel in any involuntary proceeding for assessment, stabilization, or treatment.
- Person (or guardian of a minor) may immediately apply to court to have attorney appointed, if unable to afford one.
- No reference to Public Defender in Marchman Act or Chapter 27, FS.

Rights: Habeas Corpus

Baker Act 394.459(8), FA and 65E-5.220, FAC

Each person (any age or legal status) admitted to a receiving or treatment facility must have written notice of right to petition (#3036) for writ:

- Cause and legality of detention
- Unjustly denied a right or privilege
- Abuse of procedure authorized in law

Petition (#3090) filed any time/without notice by:

Individual	Guardian Advocate
Relative	Representative
Friend	Attorney
Guardian	DCF

Facility files petition (any format preferred by the individual) with clerk of court on next working day. No fee charged

Marchman Act 397.501(9), FS

- Filed at any time and without notice
- Filed by client involuntarily retained or parent, guardian, custodian, or attorney on behalf of client
- May petition for writ to question cause and legality of retention and request the court to issue a writ for client's release

Baker Act	Marchman Act
Rights: Separation of Children from Adults	
Baker Act 394.4785, FS and 65E-12, FAC Hospitals: ▪ Age 0-13 no contact with adults ▪ Age 14-17 share common areas with adults but share bedroom with adult only if doctor documents medical or safety issues daily ▪ Children and adolescents can be mixed CSUs: ▪ Age 0-13 can share common areas with adult when under direct visual observation by staff but cannot share bedroom with an adult ▪ Age 14-17 share common areas with adults but share bedroom with adult only if doctor daily documents medical or safety issues	No corresponding provisions
Rights: Education of Minors	
No corresponding provision.	Each minor client in a residential service component is guaranteed education and training appropriate to his or her needs. The service provider shall coordinate with local education agencies to ensure that education and training is provided to each minor client in accordance with other applicable laws and regulations and that parental responsibilities related to such education and training are established within the provisions of such applicable laws and regulations. Nothing in this chapter may be construed to relieve any local education authority of its obligation under law to provide a free and appropriate education to every child.
Special Issues *Sexual Misconduct Prohibited*	
Baker Act 394.4593, FS ▪ Sexual Misconduct means any sexual activity between an employee and a patient, regardless of the consent of the patient. ▪ An employee engaging in sexual misconduct with patient in DCF custody or in a receiving/treatment facility commits a felony. ▪ An employee who witnesses, knows of, or has reasonable cause to suspect sexual misconduct must immediately report to the Abuse Registry and to law enforcement. Failure to do so is a misdemeanor. ▪ Employee must prepare, date, sign independent report describing nature of the sexual misconduct, location/time of incident, and persons involved. Report must be given to program director for submitting to DCF Inspector General who will immediately investigate.	**Marchman Act** No corresponding provisions

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Baker Act	Marchman Act
Complaints and Grievances	
Baker Act 394.459(4)(b)3, FS and 65E-5.180 FAC Policy/procedures required to receive, review, investigate, track, manage and respond to formal/informal complaints by person or others. ▪ Process explained verbally at orientation and provided in writing: ▪ How complaints can be addressed informally and formally with staff ▪ Informed of Abuse Registry, Advocacy Center or others to request assistance ▪ Process, including phone numbers for above posted next to phones. ▪ Life-safety issues acted upon immediately Formal complaints: ▪ Person not named in complaint will assist. ▪ Will include date/time of complaint and detail issue/remedy sought ▪ Forward to staff assigned to track/monitor All formal complaints must contain: ▪ Name of complainant ▪ Name of person receiving services ▪ Nature of complaint ▪ Date/time received by staff ▪ Date/time received by person who will track ▪ Name of person assigned to investigate ▪ Date person notified of who will investigate ▪ Due date for written response Written disposition of formal complaint. ▪ Written response provided to person within 24 hours of disposition. If complainant other than patient, not given details of disposition without consent, unless having right to information. Disposition can be appealed to administrator who will review and make final decision within 5 working days and provide written response within 24 hours thereafter.	**Marchman Act (65D-30.004 (29) FAC)** Grievance procedure must include: ▪ Provisions assuring that a grievance may be filed for any reason with cause; ▪ The prominent posting of notices informing clients of the grievance system; ▪ Access to grievance submission forms; ▪ Education of staff in the importance of the grievance system and client rights; ▪ Specific levels of appeal with corresponding time frames for resolution; ▪ Timely receipt of a filed grievance; ▪ The logging and tracking of filed grievances until resolved or concluded by actions of the provider's governing body; ▪ Written notification of the decision to the appellant; and ▪ Analysis of trends to identify opportunities for improvement.
Client Responsibility for Cost of Care	
Chapter 394, Part I, FS, the Baker Act, makes no reference to payment for care and treatment. However, the Florida Attorney General has issued opinions stating that DCF (with county matching funds) is responsible for establishing public receiving facilities but that persons served in private receiving facilities are responsible for their own cost of care.	**Marchman Act (397.431, FS)** ▪ Publicly funded providers must have a fee system based upon a client's ability to pay, and if space and sufficient state resources are available, may not deny a client access to services solely on the basis of client's inability to pay. ▪ Full cost and fee charged must be disclosed to client ▪ Client (or guardian of minor) required to contribute toward costs, based on ability to pay ▪ Guardian of minor not liable if services provided without parent consent unless guardian ordered to pay

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Baker Act	Marchman Act
Parental Responsibility	
No corresponding provisions other than the consent to treatment for the minor and the application for voluntary admission must be filed by the parent or guardian with the agreement *(assent)* of the minor.	**Parental Participation (397.6759, FS)** A parent, legal guardian, or legal custodian who seeks involuntary admission of a minor to substance abuse treatment is required to participate in all aspects of treatment as determined appropriate by the director of the licensed service provider.
Designated Representative	
Voluntary: No notice except emergency Involuntary: Name/address/phone # of guardian, guardian advocate & attorney in record. If no guardian, person selects own representative. Only if person unable/unwilling to select, facility must select from list, in order of listing: ▪ Health care surrogate ▪ Spouse ▪ Adult child ▪ Parent ▪ Adult next of kin ▪ Adult friend The following shall not be designated: ▪ Licensed professional serving the person ▪ Employee of facility serving the person ▪ DCF employee ▪ Person in professional/business services ▪ Creditor of person Role of Designated Representative: ▪ To receive notice of individual's admission; ▪ To receive notice of proceedings affecting the individual; ▪ To have immediate access to the individual held or admitted for mental health treatment, unless such access is documented to be detrimental to the individual; ▪ To receive notice of any restriction of the individual's right to communicate or receive visitors; ▪ To receive copy of the inventory of personal effects upon the individual's admission and to request amendment to the inventory at any time; ▪ To receive disposition of the individual's clothing and personal effects, if not returned to the individual, or to approve an alternate plan; ▪ To petition on behalf of the individual for a writ of habeas corpus ▪ To apply for a change of venue for the individual's involuntary placement hearing for the convenience of the parties or witnesses or because of the condition of the individual; ▪ To receive written notice of any restriction of the individual's right to inspect his or her clinical record; ▪ To receive notice of release of the individual from a receiving facility where an involuntary examination was performed; ▪ To receive a copy of any petition for the individual's involuntary placement filed with the court; and ▪ To be informed by the court of the individual's right to an independent expert evaluation, pursuant to involuntary placement procedures.	No corresponding provisions in the Marchman Act

Baker Act	Marchman Act
Guardian Advocate	
Baker Act 394.4598, FS and 65E-5.230, FAC Duties begin after appointment by court and completion of training Duties terminate upon person's discharge, transfer to voluntary status, restoration of competency, or expiration of involuntary placement order.	**Marchman Act** No corresponding provisions in the Marchman Act
Prior to appointment: ▪ Receive information about duties/ethics of medical decision-making ▪ Agree to serve Prior to decision-making: ▪ Full disclosure of treatment information ▪ Attend 4-hour training course approved by court (GA manual and/or DCF on-line course) ▪ Successfully pass test ▪ Meet and talk with individual and physician in person if possible; by telephone if not Authority: ▪ Mental health decisions and court may also authorize medical decisions.	
Extraordinary decisions after separate hearing (#3108-3109) for the following: ▪ Electroconvulsive treatment ▪ Experimental treatments not approved by IRB ▪ Sterilization ▪ Abortion ▪ Psychosurgery Decisions by guardian advocate may be reviewed by court, upon petition of person's attorney, family or facility administrator Replacement guardian advocate can be appointed by the court	

Baker Act	Marchman Act
Health Care Surrogates & Proxies	
Baker Act 765 FS and 65E-5.2301, FAC Advance Directive: instruction given by a person expressing his/her desires about health care, including the designation of a health care surrogate Surrogate: Selected by the person, when competent, in an advance directive. Person can designate an alternative surrogate, or a separate surrogate for mental health than one for other medical care Proxy: In the absence of an advance directive, selected in priority order from statutory list: ▪ Guardian ▪ Spouse ▪ Adult child ▪ Parent ▪ Adult sibling ▪ Adult relative ▪ Close friend* ▪ Clinical Social Worker* Incapacity may not be inferred from the person's voluntary or involuntary hospitalization for mental illness or intellectual disability. Policy: On interim basis, between time person is determined by a physician to be incapacitated to consent to treatment and time guardian advocate is appointed by court to provide express and informed consent to treatment, a health care surrogate or proxy may provide or refuse consent.	**Marchman Act** No corresponding provisions in the Marchman Act. However, a health care surrogate or proxy provided under chapter 765, FS is authorized to make any and all health care decision for an individual who has been found by a physician to be incompetent/incapacitated to make his/her own health care decisions. Substitute Judgment required if preference of individual is known.

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Baker Act	Marchman Act
Authority: ▪ To make all health care decisions, including mental health, based on the decisions the person would have made if competent to do so – "Substitute Judgment" ▪ Apply for benefits ▪ Access person's clinical record ▪ Authorize release of information and clinical records ▪ Authorize transfer to another facility. Prohibited Procedures: ▪ Voluntary admission to MH facility ▪ Consent to treatment for persons on voluntary status ▪ ECT ▪ Experimental treatment not approved by IRB ▪ Sterilization ▪ Abortion ▪ Psychosurgery Process: ▪ Attending physician documents incapacity of person ▪ Surrogate or proxy notified in writing that authority has commenced (#3122) ▪ Proxy signs Affidavit (#3123) ▪ Authority in effect until determination that person has regained capacity ▪ Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of Guardian Advocate (#3106) filed within 2 court working days of physician determination ▪ Provide to surrogate or proxy same information required to be given to guardian advocate and make same training available ▪ Ensure surrogate or proxy talks with individual and physician in person if possible, if not, by telephone ▪ Surrogate or proxy given full disclosure prior to requesting authorization for treatment ▪ Advance Directives can be revoked at any time by a competent person Decisions of a health care surrogate or proxy may be reviewed by a judge at the request of the persons' family, the facility, or physician, or other interested person	

Baker Act	Marchman Act
Restraints & Seclusion	
Baker Act 394.459(4), FS65E-5.180(7), FAC Restraint is a physical device, method, or drug used to control behavior. Physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to individual's body so he/she cannot easily remove the restraint and which restricts freedom of movement or normal access to one's body. Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint. Drug used as a restraint is medication to control person's behavior or restrict freedom of movement & is not part of standard treatment regimen of a person with a diagnosed mental illness. (ETO not necessarily a chemical restraint) Restraint excludes physical devices or other physical holding when necessary for routine physical examinations and tests; or for purposes of medical treatment; used to provide support for body position or proper balance; or when used to protect a person from falling out of bed. Seclusion means physical segregation of person in any fashion or involuntary isolation of person in an area person is prevented from leaving by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent person from leaving.	**Marchman Act (65D-30.005(14), FAC)** Restraint means: ▪ Any manual method used or physical or mechanical device, material, or equipment attached or adjacent to a client's body that he or she cannot easily remove and that restricts freedom of movement or normal access to one's body; and ▪ A drug used to control a client's behavior when that drug is not a standard treatment for the client's condition. Seclusion means the use of a secure, private room designed to isolate a client who has been determined by a physician to pose an immediate threat of physical harm to self or others.
Prohibitions ▪ Can't be based on person's history or on PRN or standing order ▪ Can't be restrained in prone position unless required to prevent imminent serious harm ▪ Objects impairing respiration can't be placed over person's face -- staff may wear protective gear when needed. ▪ Hands can't be secured behind back except to prevent serious injury ▪ Walking restraints prohibited except for off-unit transportation under direct observation of staff ▪ Simultaneous S/R not used for minors ▪ Can't locate restrained person in areas subject to view by anyone other than involved staff or where exposed to potential injury by other persons. ▪ Can't be placed in S/R in nude or semi-nude state.	
Prior to Restraint or Seclusion ▪ Staff must be trained as part of orientation and on annual basis. Specific required training itemized in rule. ▪ Personal Safety Plan (3124) address individual triggers leading to psychiatric crisis completed ASAP after admission and filed in the person's record. ▪ Plan reviewed by team & updated as needed after each S/R. Specific intervention techniques from personal safety plan offered or used prior to S/R event documented in record. ▪ Each person must be searched for contraband before or immediately after being placed into seclusion or restraints	

Baker Act	Marchman Act
Initiating Restraint or Seclusion ▪ RN or highest level staff permitted by policy, immediately available & trained in S/R may initiate in emergency when danger is imminent. S/R order obtained from physician, ARNP, or PA, if permitted by the facility & stated within professional protocol. If treating physician didn't order S/R, must be consulted ASAP. ▪ Examination conducted within 1 hour by physician or delegated to an ARNP, PA or RN, if authorized by facility & trained in S/R including: ▪ Face-to-face assessment of person's medical/behavioral condition ▪ Review of record for pre-existing medical condition contraindicating use of S/R ▪ Review of person's medication orders including an assessment of the need to modify such orders during the period of S/R, and ▪ Assessment of need or lack of need to elevate person's head and torso during restraint.	
Orders for Restraint or Seclusion ▪ Each written order for S/R limited to: ▪ 4 hours for adults, age 18 and over ▪ 2 hours for minors age 9 - 17; or ▪ 1 hour for children under age 9 ▪ All orders signed within 24 hours of initiation. S/R order may be renewed up to total of 24 hours, after consultation/review by physician, ARNP, or PA in person, or by telephone with a RN who has physically observed/evaluated person. ▪ When order has expired after 24 hours, physician, ARNP, or PA must see/assess person before S/R can be re-ordered. Results of assessment documented. Administrator notified of S/R use exceeding 24 hours. ▪ Order shall include specific behavior prompting use of S/R, the time limits, & behavior necessary for release. Restraint orders must contain type of restraint ordered & positioning of person, considering age, physical fragility & physical disability.	

Baker Act	Marchman Act
During Restraint and Seclusion ▪ Each person immediately informed of behavior resulting in S/R and criteria necessary for release. ▪ Facility must notify guardian of minors in S/R ASAP, but no later than 24 hours and document notice in record, including date/time of notification & name of staff providing notification. ▪ For each use of S/R, following information shall be documented in record: ▪ The emergency situation resulting in S/R; Alternatives/other less restrictive interventions attempted or clinical determination that less restrictive techniques could not be safely applied; ▪ Name/title of staff initiating S/R ▪ Date/time of initiation & release; ▪ Person's response to S/R, including rationale for continued use of the intervention; and ▪ That the person was informed of behavior resulting in S/R & criteria necessary for release. ▪ When restraint initiated, nurse must assess person ASAP but no later than 15 minutes after initiation and at least every hour thereafter. Assessment includes person's circulation/respiration, including vital signs ▪ Seclusion of persons over age 12 must be observed by trained staff every 15 minutes. At least one observation an hour conducted by nurse. Restrained persons must have continuous observation by trained staff. Secluded children age 12 and under must be monitored continuously by face-to-face observation or by direct observation through the seclusion window for first hour and at least every 15 minutes thereafter.	
During Restraint and Seclusion (continued) ▪ Monitoring physical/psychological well-being of R/S person by trained staff must include: respiratory and circulatory status; signs of injury; vital signs; skin integrity & any special requirements specified in facility policies. ▪ During each period of S/R, person must be offered reasonable opportunities to drink & toilet as requested and restrained person must be offered opportunities for range of motion at least every 2 hours. ▪ Documentation of observations & staff's name recorded at each observation.	

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Baker Act	Marchman Act
Release from Restraint and Seclusion ▪ Release must occur as soon as person no longer an imminent danger to self/others, followed by debriefing to decrease risk of future S/R event & to provide support. ▪ Review incident with person, giving opportunity to process the S/R event ASAP – at least within 24 hours of release. ▪ Review incident with all staff involved and supervisors ASAP after the event and address: ▪ Circumstances leading to the event, ▪ Nature of de-escalation efforts and alternatives to seclusion and restraint attempted, ▪ Staff response to the incident, ways to effectively support the person's coping in the future and avoid the need for future S/R. ▪ Review documented for continuous performance improvement/ monitoring. Review findings forwarded to Oversight Committee, and within 2 working days, team meets to review circumstances preceding initiation, review the person's treatment plan and Personal Safety Plan to determine if changes are needed to prevent the further use of R/S. ▪ Team will assess impact event had on person & provide counseling, services, or treatment needed as a result. Team must analyze person's record for patterns relating to conditions, events, or presence of other persons immediately before or upon onset of behavior warranting S/R. Team must review effectiveness of emergency intervention & develop more appropriate therapeutic interventions. ▪ Seclusion and Restraint Oversight Committee must conduct timely reviews of each use of S/R and monitor patterns of use to assure least restrictive approaches are used to prevent/reduce frequency / duration of use.	
Reporting Restraints and Seclusion ▪ All facilities must electronically report monthly S/R events to DCF - Webinar training to be scheduled when reporting process is finalized ▪ All facilities subject to CoP's must report by telephone by next business day to CMS (written report to DCF) any death that occurs: ▪ While a person is restrained or secluded; ▪ Within 24 hours after release from R/S; or ▪ Within one week after S/R, where it is reasonable to assume that use of the S/R contributed directly or indirectly to the person's death.	Not Applicable
Immunity (consult with your attorney)	
▪ Any person who acts in good faith in compliance with the Baker Act is immune from civil or criminal liability for his or her actions in connection with the admission, diagnosis, treatment, or discharge of a person to or from a facility. However, this section does not relieve any person from liability if such person commits negligence. (394.459) ▪ No professional is required to accept persons for treatment of mental, emotional, or behavioral disorders. Such participation is voluntary (394.460)	▪ A LEO acting in good faith pursuant to the Marchman Act protective custody provisions may not be held criminally or civilly liable for false imprisonment. ▪ All persons acting in good faith, reasonably, and without negligence in connection with the preparation of petitions, applications, certificates, or other documents or the apprehension, detention, discharge, examination, transportation or treatment under the Marchman Act shall be free from all liability, civil or criminal, by reason of such acts

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Baker Act	Marchman Act
Training Resources	
Baker Act http://myflfamilies.com/service-programs/substance-abuse/baker-act-manual ▪ Copy of Baker Act law (394, Part I, FS) and rules (65E-5, FAC and 65E-12, FAC) ▪ Baker Act forms – mandatory and recommended ▪ Selected forms in Spanish & Creole ▪ 2014 Baker Act Handbook ▪ Baker Act monitoring/survey instruments ▪ Frequently Asked Questions (FAQ's) on 21 subject areas ▪ List of all public and private receiving facilities throughout the state ▪ Mental Health Advance Directives ▪ Other relevant materials Online Training www.bakeracttraining.org ▪ On demand - at your convenience ▪ Up-to-date material ▪ No fee ▪ Certificate of Achievement ▪ CEC's offered @ low cost Courses Offered: ▪ Introduction to the Baker Act ▪ Emergency Medical Conditions & the Baker Act ▪ Law Enforcement & the Baker Act ▪ Long Term Care Facilities & the Baker Act ▪ Consent for Minors ▪ Rights of Persons in Mental Health Facilities ▪ Guardian Advocacy ▪ Suicide Prevention ▪ Why People Die by Suicide ▪ Trauma Series	**Marchman Act** http://myflfamilies.com/service-programs/substance-abuse/marchman-act Contents include: 2003 Marchman Act User Reference Guide includes among other issues: ▪ Statute & Rules ▪ History & Overview ▪ Marchman Act Model Forms ▪ Law Enforcement and Protective Custody ▪ Quick Reference Guide for Involuntary Provisions ▪ Flow Charts for Involuntary Provisions ▪ Admission & Treatment of Minors ▪ Where to Go for Help ▪ Marchman Act Pamphlet ▪ Substance Abuse Program Standards ▪ Common Licensing Standards Marchman Act PowerPoint Presentation Array of substance abuse related courses funded by DCF and offered through FADAA, FADAA@FADAA.org.

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Resources

The following sites may contain information that may be of interest to you in a professional or advocacy capacity. This list does not constitute endorsement. Information accurate as of December 15, 2013.

Many communities have adopted the "211" toll-free information programs that can guide a person in seeking any type of health and social service program. Some of these programs are operated on a 24-hour a day, 7-day a week basis.

There are several resources that you may turn to for help in implementing the Baker Act and in protecting the rights of persons served under the Act. In most instances, problems can be resolved with facility staff and ultimately, the facility administrator. However, any one of the following may be helpful.

Department of Children & Family Services

The Department (DCF) is designated by the Florida Legislature as the State's Mental Health Authority. It is responsible for designating receiving facilities to serve persons under the Baker Act. It shares responsibility with the Agency for Health Care Administration to supervise all mental health facilities, programs and services. DCF office phone numbers can be found at the front of this Handbook. Visit http://www.dcf.state.fl.us/programs/samh/mentalhealth/index.shtml/

Managing Entities

The Florida Legislature amended Chapter 394.9082, FS in 2008 authorizing behavioral health managing entities under contract with DCF to manage the day-to-day operational delivery of behavioral health services through an organized system of care. This is accomplished through "Provider networks" that are the direct service agencies that are under contract with a managing entity and that together constitute a comprehensive array of emergency, acute care, residential, outpatient, recovery support, and consumer support services. While private receiving facilities are generally overseen directly by DCF, those designated as public receiving facilities that benefit from legislatively appropriated Baker Act funds are overseen by the local Managing Entity.

Baker Act Website

The primary DCF website is **http://www.MyFlorida.com**. To access extensive Baker Act information, visit http://www.dcf.state.fl.us/programs/samh/mentalhealth/laws/index.shtml.

Updated information about the Baker Act can also be found at the Baker Act Reporting Center website (http://bakeract.fmhi.usf.edu).

Receiving Facility List

The Baker Act Receiving Facility List and table describing Transportation Exception Plans are no longer contained within the manual. This is because of the changing nature of this information and the desire to make the most up to date information available. Documents containing this information can be found online at http://bakeract.fmhi.usf.edu

Baker Act Training Online

As a substitute for attending a face to face training, you may wish to take the online courses instead. Continuing Education credits are available for licensed professionals for a fee. There is NO FEE for this training! To get started, please visit: http://www.bakeracttraining.org

Florida Abuse Registry

The Registry, operated by the Department of Children and Families, accepts calls reporting abuse, neglect or exploitation of vulnerable persons, including children, elders, and disabled adults. The statewide toll-free Registry is available at all times at 1-800-96-ABUSE.

Agency for Health Care Administration

AHCA is responsible for licensing all hospitals, crisis stabilization units, and residential treatment facilities in Florida, as well as other types of health care facilities and programs. It is also responsible to the federal Centers for Medicare and Medicaid Services (CMS) for ensuring hospitals' compliance with all applicable federal laws and regulations. AHCA's statewide toll-free complaint telephone number is 1-888-419-3456.

Professional Regulation

Reports on physicians, psychologists, social workers, and other mental health professionals can be directed to The Florida Department of Health, Office of Medical Quality Assurance, at a statewide, toll-free number 1-888-419-3456. Reports on nurses can be directed to The Florida Board of Nursing in Jacksonville at 1-850-245-4125, press #6.

Other State Agencies

Official Portal for the State of Florida
http://www.myflorida.com

State of Florida Agencies
http://www.myflorida.com/directory/

Department of Mental Health Law & Policy
Louis de la Parte Florida Mental Health Institute
USF College of Behavioral & Community Sciences
813-974-4510
http://mhlp.fmhi.usf.edu

Baker Act Reporting Center
http://bakeract.fmhi.usf.edu/

Florida Department of Corrections
http://www.dc.state.fl.us

Florida Department of Elder Affairs
4040 Esplanade Way, Tallahassee, FL 32399-7000
850-414-2000
http://elderaffairs.state.fl.us

Florida Department of Juvenile Justice
850-488-1850
http://www.djj.state.fl.us

Federal Agencies

The Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/

Center for Substance Abuse Treatment (CSAT)
http://csat.samhsa.gov/

Federal Food and Drug Administration
MedWatch is a service of the federal FDA Medical Products Reporting Program for professionals and consumers to report problems with medications and other products.
5600 Fishers Lane
Rockville, MD 20857-9787
1-800-FDA-1088
http://www.fda.gov/Safety/MedWatch/default.htm

National Coalition of Hispanic Health & Human Services Organizations
1501 16th Street NW
Washington, DC 20036
202-387-5000
http://www.cossmho.org

National Criminal Justice Reference Service
http://www.ncjrs.org

National Domestic Violence Hotline
800-799-SAFE (7233)
http://www.thehotline.org/

National Health Information Center
P.O. Box 1133
Washington, DC 20013-1133
240-453-8280
email: info@nhic.org
http://www.health.gov/nhic

National Institute on Justice
http://www.nij.gov/Pages/welcome.aspx

National Institute of Mental Health
http://www.nimh.nih.gov

Office of Juvenile Justice and Delinquency Prevention
http://www.ojjdp.gov/

Social Security Administration
http://www.ssa.gov

Society for Prevention Research
http://www.preventionresearch.org

Substance Abuse and Mental Health Service Administration
U.S. Department of Health and Human Services
http://www.samhsa.gov
Treatment locator: www.findtreatment.samhsa.gov

U.S. Department of Health and Human Services
http://www.hhs.gov

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Advocacy Organizations

Disability Rights Florida, Inc.

The Disability Rights Florida, Inc. is a private non-profit organization that receives federal funding to protect and advocate for the rights of persons of all ages who have disabilities. The Center provides a wide range of services to persons who have mental illnesses who believe they have experienced serious incidents of abuse or neglect, or civil rights violations related to their disabilities. The Center prioritizes services to people in institutional, inpatient, or residential treatment settings, but also provides services to individuals living in their communities, as resources allow. The Center has offices in Tallahassee, Tampa, and Ft. Lauderdale, from which it serves the entire state of Florida. The statewide toll-free phone number is 1-800-342-0823. http://www.disabilityrightsflorida.org/

Bazelon Center for Mental Health Law

The Bazelon Center for Mental Health Law is a nonprofit organization devoted to improving the lives of people with mental illnesses through changes in policy and law.

The Bazelon Center envisions an America where people who have mental disabilities exercise their own life choices and have access to the resources that enable them to participate fully in their communities. http://www.bazelon.org

Florida Partners in Crisis

Florida Partners in Crisis is a unique statewide organization. Membership includes judges, law enforcement, prosecutors, public defenders, mental health and substance abuse providers, hospital administrators, people recovering from mental illnesses and/or substance use disorders and their families and loved ones. Membership in Partners is a way to stay informed of mental health, substance abuse and criminal justice system policy developments and funding decisions. It also offers members opportunities for effective advocacy on behalf of mental health and substance abuse services for people in need. http://www.flpic.org/

Family Support

National Alliance on Mental Illness of Florida

NAMI has its state office in Tallahassee, which can be reached at 850-671-4445. Local chapters of NAMI are located throughout the state. www.nami.org

Al-Anon/Alateen Family Group

http://www.al-anon.alateen.org/

Bi-Polar and Depressive Alliance

Check phone book for chapter in your area. www.dbsalliance.org/

Families Anonymous

http://www.familiesanonymous.org

Florida's Center for the Advancement of Child Welfare Practice

The Center's mission is to support and facilitate the identification, expansion, and transfer of expert knowledge and best practices in child welfare case practice, direct services, management, finances, policy, and organizational development to child welfare and child protection stakeholders throughout Florida. http://centerforchildwelfare.fmhi.usf.edu

Mental Health America (formerly: National Mental Health Association)

From its inception in 1909, MHA has been dedicated to improving the lives of individuals and families affected by mental illness. http://www.mentalhealthamerica.net/

Florida Affiliates

- MHA of Broward County
  http://www.mhabroward.org/
- MHA of Central Florida, Inc.
  http://www.mhacf.org/
- MHA of Greater Tampa Bay, Inc.
  http://www.mhagreatertampabay.org/
- MHA of Indian River County
  http://www.mhairc.org/
- MHA of Northeast Florida, Inc.
  http://www.mhajax.org/
- MHA of Okaloosa & Walton Counties
  http://www.mhaow.org/
- MHA of Palm County
  http://www.mhapbc.org/index.cfm
- MHA of Southwest Florida
  http://www.mhaswfl.org/
- MHA of Volusia and Flagler Counties
  http://www.mhavolusia.org/
- MHA of West Florida, Inc.
  http://www.mhawfl.org/

Older Adults

AARP Health Advocacy Services

601 E Street, NW
Washington, DC 20049
1-888-OUR-AARP (1-888-687-2277)

AARP Policy & Research

AARP's staff of policy analysts, economists, attorneys, researchers and industry experts specializes in a vast range of topics relating to older adults and aging both domestically and globally.
http://www.aarp.org/research/

Aging Related Web Sites

http://www.publichealth.uga.edu/geron/

Area Agencies on Aging (Aging Resource Center)

http://elderaffairs.state.fl.us/doea/aaa.php

Clearinghouse on Abuse and Neglect of the Elderly (CANE)

Department of Consumer Studies and Research
University of Delaware
297 Graham Hall
Newark, DE 19716
http://www.cane.udel.edu/

Elder Helpline

1-800-96-Elder (1-800-963-5337)

Institute for Memory Impairments and Neurological Disorders

http://www.alz.uci.edu

National Center on Elder Abuse

Part of the federal Administration on Aging, the National Center on Elder Abuse (NCEA) serves as a national resource center dedicated to the prevention of elder mistreatment.
http://www.ncea.aoa.gov/

National Institute on Aging Information Center

Building 31, Room 5C27
31 Center Drive, MSC 2292
Bethesda, MD 20892
800 222-4225
http://www.nia.nih.gov/

Senior Citizens' Resources

Official information and services from the U.S. government
http://www.usa.gov/Topics/Seniors.shtml

Addictions

Alcoholics Anonymous World Services Inc

475 Riverside Drive at West 120th St.
New York, NY 10115
212 870-3400
http://www.aa.org

Center for Substance Abuse Treatment

National Drug & Alcohol Treatment Referral Service
800 662-HELP (4357)
http://beta.samhsa.gov/about-us/who-we-are/offices-centers/csat

Florida Alcohol and Drug Abuse Association

http://www.fadaa.org

National Association of Drug Court Professionals (NADCP)

http://www.nadcp.org/

Gamblers Anonymous

P.O. Box 17173, Los Angeles, CA 90017
626-960-3500
http://www.gamblersanonymous.org/

Narcotics Anonymous

http://www.na.org/index.php

National Families in Action

http://www.nationalfamilies.org

National Institute on Alcoholism and Alcohol Abuse (NIAAA)

http://www.niaaa.nih.gov/

Overeaters Anonymous

http://www.oa.org

Other Resources

Criminal Justice/Mental Health Justice Center
The Council of State Governments

CSG Center: http://csgjusticecenter.org/mental-health/

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation

http://gainscenter.samhsa.gov/

National Association of State Mental Health Program Directors (NASMHPD)

http://www.nasmhpd.org/index.aspx

Center for the Study and Prevention of Violence (CSPV)

The CSPV, a research program of the Institute of Behavioral Science at the University of Colorado at Boulder, was founded in 1992 to provide informed assistance to groups committed to understanding and preventing violence, particularly adolescent violence. Since that time, our mission has expanded to encompass violence across the life course.
http://www.colorado.edu/cspv/index.html

Florida Council for Community Mental Health

The Florida Council for Community Mental Health (FCCMH) is a statewide association of 70 community-based mental health and substance abuse agencies.
http://www.fccmh.org/

National Strategy for Suicide Prevention

A collaborative effort of
SAMHSA, CDC, NIH, HRSA, HIS
http://www.samhsa.gov/prevention/suicide.aspx

National Suicide Prevention Lifeline

1-800-273-TALK (8255)
http://www.suicidepreventionlifeline.org/

Baker Act Online Training

Training is available online. This training was developed by the Louis de la Parte Florida Mental Health Institute staff and faculty at the University of South Florida with funds from the Florida Department of Children and Families. The online training consists of seven training modules, as well as four Web Events that were recorded and are available for viewing online.

The online training is free. Continuing education credits are available for a wide variety of professionals. There is a fee for the administration of the continuing education credits.

Training is available at http://www.bakeracttraining.org/

Online Training Modules

- Introduction to the Baker Act
- Emergency Medical Conditions
- Individual Rights & the Bake Act
- Law Enforcement & the Baker Act
- Long Term Care & the Baker Act
- Minors and the Baker Act
- Suicide Prevention

Recorded Web Events Available Online

Seclusion & Restraint
Kevin Huckshorn, PhD, RN, MSN, CAP, ICADC

Trauma Series
Norin Dollard, PhD., & Victoria Hummer, LCSW

Why People Die by Suicide
Thomas Joiner, PhD

Baker Act & Marchman Act Comparison & Co-Occurring Disorders
Martha Lenderman, MSW & Holly Hills, PhD

Online Guardian Advocate Training

This training was developed by the same faculty/staff who developed the Baker Act online training mentioned above. As of December 2013, this Guardian Advocate training has been approved for Florida Judicial Circuits 2, 3, 5, 7, 8, 9, 11, 12, 13, 14, 17 and 20. The Guardian Advocate Training is available at this site: http://flguardianadvocate.org/.

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Military Service Members and Veterans

Some people subject to various aspects of the Baker Act, such as involuntary examination or inpatient placement, may be serving or may have served in the US military. Services, benefits and information available to veterans may be considered for these individuals. Some of the resources mentioned below may also be relevant to those who are still in the military. Although, with a few exceptions, services offered by the Veterans' Health Administration are not available to those who have not yet separated from the military.

There are many services, exemptions and designations available to veterans. However, these usually require proof of veteran status. How people, various agencies, and particular laws or rules define the term "veteran" varies. Not all people who served in the US Armed Forces are considered veterans based on the definition some use for the term "veteran." Further, not all veterans are eligible for VA Benefits, such as pensions or VA health care. Eligibility for such services is based on a set of complicated factors, including length of service, nature of service, era of service, income, disability status according to the VA, and discharge status. Discharge status can be:

- Honorable
- General (Honorable Conditions)
- General (Without Honorable Conditions)
- Other than Honorable
- Bad Conduct
- Dishonorable

Just because a person does not have an Honorable discharge does not mean he/she has a Dishonorable discharge. There are some VA funded services available to people with less than an Honorable, but more than a Dishonorable discharge status. Further, there is a process that can be pursued to try to get a person's discharge status reclassified. The Real Warrior site describes this reclassification process: http://www.realwarriors.net/veterans/discharge/upgrade.php

DD-214

Getting access to benefits and other offers available to veterans usually requires proof of veteran status. This often means having a DD-214 – the "Report of Separation." This document lists, among other things, the person's discharge status. DD-214s may be requested via the National Archives in St. Louis (see http://www.archives.gov/veterans/). The process for emergency requests is described here: http://www.archives.gov/veterans/military-service-records/#emergency.

Identifying Veterans

Providers would ideally have a systematic way to identify veterans. The question "are you a veteran?" is not the best question to ask in order to determine if someone is a veteran. Rather, asking "have you ever served in the US Armed Force?" is a better question. This is because some people who are veterans may not consider themselves veterans. This may be because they think they must access benefits or health care at the VA to be considered a veteran. Some people also may have discharge statuses that are not Honorable, so do not consider themselves veterans because of their discharge status.

Asking if a person has served in the US Armed Forces is the broadest question. It will allow agency staff to determine if a person is currently in the armed forces or if he/she has ever been in the armed forces. For people who say they served in the US armed forces in the past, then asking about discharge status, if they have a DD-214, if they have accessed VA services, and where they access these VA services may be helpful. If the person does not have a DD-214 assisting him/her to order one may be helpful. One suggestion is to keep copies of the form used to request a DD-214 on hand to give to veterans, and if needed, to assist them to fill it out and fax it. For form see: http://www.archives.gov/veterans/military-service-records/

A GAINS Center report that focuses on justice involved veterans has a helpful set of suggested questions to gather information about veteran status. It is available at: http://gainscenter.samhsa.gov/pdfs/veterans/CVTJS_Report.pdf

Organizations

It is helpful to establish contacts with various agencies/organizations to address issues for veterans. Some of these organizations are listed below.

Florida Department of Veterans Affairs (FDVA)

- Mission: "To advocate with purpose and passion for Florida veterans and link them to superior services, benefits and support."
- Vision: "FDVA is the premier point of entry for Florida veterans to accessed earned services, benefits and support."
- The FDVAs Florida Veterans' Benefits Guide may be found here: http://floridavets.org/?page_id=110. The FDVA website has a wealth of information that can be helpful to veterans and their families.

- The “Resources” section of the FDVAs website a wealth of information: http://floridavets.org/?page_id=31
- Locations and phone numbers for FDVAs 24 Claim Examiner Sites can be found here: http://floridavets.org/?page_id=91

US Veterans’ Administration

- The US Veterans’ Administration is composed of three organizational parts: a) VBA (Veteran Benefit Administration), VHA (Veteran Health Administration), and the VA National Cemetery Administration. Vet Centers, discussed later in this appendix, are separate from the US Veterans’ Administration.
- A list of and links to a variety of services offered by the United States Department of Veterans’ Affairs is available at http://www.va.gov/directory/guide/fac_list_by_state.cfm?State=FL&dnum=1&isflash=0. This includes
  - » VA Medical Centers
  - » Outpatient Clinics
  - » Community Service Programs
  - » Community Based Outpatient Clinics
  - » Vet Centers

  Links to the VBA or Veteran Benefit Administration Offices in Florida are also listed on this web page.
- An interactive search to find services offered by the VA can be done here: http://www.va.gov/directory/guide/home.asp?isflash=1. This will search locations for the following services:
  - » VHA Facilities (Health Care, as well as Homeless programs)
  - » VBA Facilities (Benefits)
  - » Vet Centers
  - » PTSD Programs
  - » Substance Use Disorder (SUD) Programs
- Facilities in Florida are listed here: http://www2.va.gov/directory/guide/fac_list_by_state.cfm?State=FL

County Veteran Service Officers

Each of Florida’s 67 counties has a Veteran Service Office. A list of these may be found at: http://floridavets.org/wp-content/uploads/2013/10/CVSO_Directory_1-October-2013.pdf

Florida’s Veteran Service Organizations

Florida has several congressionally designated Veteran Service Organizations. These organizations have departments, posts and chapters in Florida. They serve Florida’s veterans in a variety of ways. Below is a list of some of these organizations. This list can also be found at the Florida Department of Veteran Affairs website at http://floridavets.org/?page_id=52

- American Gold Star Mothers
  http://www.goldstarmoms.com/Depts/AllDepts/AllDepts.htm
- American Legion
  http://floridalegion.org/
- AMVETS
  http://amvets.org/
- Disabled American Veterans
  http://www.davmembersportal.org/fl/
- Korean War Veterans Association
  http://dfl.kwva.org/
- Military Officers Association of America
  http://www.moaafl.org/
- Military Order of the Purple Heart
  http://www.floridapurpleheart.org/
- Paralyzed Veterans of America
  http://www.pva.org/site/c.ajIRK9NJLcJ2E/b.6463495/k.C5D5/Florida.htm
- Veterans of Foreign Wars
  http://myfloridavfw.org/
- Vietnam Veterans of America
  http://vvafsc.org/

Specific Populations

Combat Veterans

- Vet Centers offers services, but are separate from the VA Health Administration, including VA Health Centers. Vet Centers focus their services on “War Zone Veterans” (see http://www.vetcenter.va.gov/Eligibility.asp for eligibility).
- Vet Centers also offer assessment and referral for Military Sexual Trauma Counseling offered by VA Health Centers. This assessment and referral service is available at Vet Centers not just War Zone Veterans, but for any veteran who has experienced this type of trauma (see http://www.vetcenter.va.gov/Military_Sexual_Trauma.asp).
- Vet Centers also offer services to family members who meet certain eligibility requirements.
- Vet Center information during normal business hours is available at 1-800-905-4675.

- Information in Spanish is available at: http://www.vetcenter.va.gov/Servicios.asp

Women

- The Women Veterans Call Center number is 1-855-VA-WOMEN or 1-855-829-6636
- Woman Veterans Program Information can be found at http://www.va.gov/womenvet/

Justice Involved Veterans

- Each VA Medical Center has at least one Veteran Justice Outreach (VJO) specialist. If a person has justice system involvement, the VJO may be a resource. Additional information about justice involved veterans, as well as contact information for VJOs is available at http://www.va.gov/HOMELESS/VJO.asp

In 2012, language was added to the Florida Statutes specific to military veterans and service members court programs.

394.47891 Military veterans and service members court programs

The chief judge of each judicial circuit may establish a Military Veterans and Service members Court Program under which veterans, as defined in s. 1.01, and service members, as defined in s. 250.01, who are convicted of a criminal offense and who suffer from a military-related mental illness, traumatic brain injury, substance abuse disorder, or psychological problem can be sentenced in accordance with chapter 921 in a manner that appropriately addresses the severity of the mental illness, traumatic brain injury, substance abuse disorder, or psychological problem through services tailored to the individual needs of the participant. Entry into any Military Veterans and Service Members Court Program must be based upon the sentencing court's assessment of the defendant's criminal history, military service, substance abuse treatment needs, mental health treatment needs, amenability to the services of the program, the recommendation of the state attorney and the victim, if any, and the defendant's agreement to enter the program.

OEF/OIF/OND Veterans

- Links to VA resources and other information for people who served in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and/or Operation New Dawn (OND) are available at http://www.oefoif.va.gov/
- VA Medical Centers have people working as OEF/OIF Coordinators. Links to the OEF/OIF resources at each of Florida's six VA Medical Centers can be found here: http://www.oefoif.va.gov/map.asp

Veterans who Experienced Trauma

- The National Center for PTSD has many resources related to trauma (see: http://www.ptsd.va.gov/index.asp)

Veterans Who Experienced Military Sexual Trauma

- Information about many resources for veterans who experienced Military Sexual Trauma are available here: http://www.mentalhealth.va.gov/msthome.asp

Veterans Who Are Homeless or Who Are At Risk for Homelessness

- Over the past several years the VA has put a great deal of focus on ending homelessness among veterans. Several programs – such as HUD-VASH and Grants-Per-Diem are available to veterans (see http://www.va.gov/homeless/index.asp or call 1-877-424-3838).

Veterans Health Initiative

- While most of the resources in this appendix address information, referral, assessment and service provision for veterans, the VHI focuses on training for professional.
- The VHI website states that the "VA developed the Veterans Health Initiative (VHI) independent study courses to increase VA providers' knowledge of military service-related diseases and illnesses. The VHI study guides are useful as well for non-VA providers, VA employees (through the VA Talent Management System), Veterans and the public. The courses are accredited and meet medical licensure requirements" (see http://www.publichealth.va.gov/vethealthinitiative/index.asp).
- This includes information on a variety of topics:
  - » Agent Orange
  - » Traumatic Brain Injury (TBI)
  - » Traumatic Amputation
  - » Military Sexual Trauma
  - » Hearing Impairment
  - » Visual Impairment
  - » Gulf War
  - » War Wounded (OEF/OIF/OND)
  - » Post-Traumatic Stress Disorder

Veterans' Crisis Line

The Veterans' Crisis Line's website has text stating that it "connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline, online chat, or text. Veterans and their loved ones can call 1-800-273-8255 and Press 1, chat online, or send a text message to 838255 to receive confidential support 24 hours a day, 7 days a week, 365 days a year." (See http://veteranscrisisline.net/)

Support for deaf and hard of hearing individuals is available.

- TTY Number: 1-800-799-4889

Key Phone Numbers

Veterans' Crisis Line	1-800-799-4899; TTY 1-800-799-4889
VA Benefits	1-800-827-1000
VA Homeless Programs	1-877-424-3838
VA Women Veterans Call Center	1-855-VA-WOMEN or 1-855-829-6636
Vet Centers	1-800-905-4675
Florida Department of Veterans Affairs (FDVA)	1-805-487-1533

Veteran's Issues and the Baker Act

There are two sections of the Baker Act that directly address issues specific to veterans. Information on the Military Veterans and Service Members Court Program (394.47891, F.S.) was mentioned on page Q-3. Below is the other section of the Baker Act that addresses veterans.

394.4672 Procedure for placement of veteran with federal agency.

(1)Whenever it is determined by the court that a person meets the criteria for involuntary placement and it appears that such person is eligible for care or treatment by the United States Department of Veterans Affairs or other agency of the United States Government, the court, upon receipt of a certificate from the United States Department of Veterans Affairs or such other agency showing that facilities are available and that the person is eligible for care or treatment therein, may place that person with the United States Department of Veterans Affairs or other federal agency. The person whose placement is sought shall be personally served with notice of the pending placement proceeding in the manner as provided in this part, and nothing in this section shall affect his or her right to appear and be heard in the proceeding. Upon placement, the person shall be subject to the rules and regulations of the United States Department of Veterans Affairs or other federal agency.

(2)The judgment or order of placement by a court of competent jurisdiction of another state or of the District of Columbia, placing a person with the United States Department of Veterans Affairs or other federal agency for care or treatment, shall have the same force and effect in this state as in the jurisdiction of the court entering the judgment or making the order; and the courts of the placing state or of the District of Columbia shall be deemed to have retained jurisdiction of the person so placed. Consent is hereby given to the application of the law of the placing state or district with respect to the authority of the chief officer of any facility of the United States Department of Veterans Affairs or other federal agency operated in this state to retain custody or to transfer, parole, or discharge the person.

(3)Upon receipt of a certificate of the United States Department of Veterans Affairs or such other federal agency that facilities are available for the care or treatment of mentally ill persons and that the person is eligible for care or treatment, the administrator of the receiving or treatment facility may cause the transfer of that person to the United States Department of Veterans Affairs or other federal agency. Upon effecting such transfer, the committing court shall be notified by the transferring agency. No person shall be transferred to the United States Department of Veterans Affairs or other federal agency if he or she is confined pursuant to the conviction of any felony or misdemeanor or if he or she has been acquitted of the charge solely on the ground of insanity, unless prior to transfer the court placing such person enters an order for the transfer after appropriate motion and hearing and without objection by the United States Department of Veterans Affairs.

(4) Any person transferred as provided in this section shall be deemed to be placed with the United States Department of Veterans Affairs or other federal agency pursuant to the original placement.

Frequently Asked Baker Act Questions

Frequently Asked Questions can be found on the States Baker Act internet site located at www.dcf.state.fl.us/programs/samh/mentalhealth/laws/index.shtml.

Nearly a thousand pages of Frequently Asked Questions about the Baker Act and related issues categorized in 21 major groups and up to 17 subgroups are posted to the DCF Mental Health Program website. These FAQs may provide significant guidance, but do not represent legal advice. These are all real questions that have been asked and answered over the years with all identifiers removed.

Baker Act Forms

Clinical Records & Confidentiality

- Clinical Record
- Confidentiality
- HIPAA
- Public Records

Discharge Planning

Emergency Medical Conditions, EMTALA, Hospital Transfers

- Emergency Medical Condition Defined
- Medical Conditions of Persons under the Baker Act
- EMTALA Applicability
- Medical Clearance
- EMTALA / Medical Screening
- Baker Act Involuntary Examination
- Stabilization
- Informed Consent for Transfer
- Forms / Paperwork
- Transfers
- Nearest Facility for Transfer
- Transfers under the Baker Act
- Crisis Stabilization Units (CSU's)
- EMTALA / Reverse Dumping
- EMTALA / Insurance
- Transportation
- Law Enforcement

Emergency Treatment Orders

- Restraints
- Chemical Restraints
- Initiation of Emergency Treatment
- Emergency Medications
- Guardian Advocates & Other Substitute Decision-Makers
- PRN & Standing Orders Prohibited
- Forms
- Involuntary Placement Petition
- ETO's for Medical Treatment

Express and Informed Consent

- Competence to Consent
- Incompetence to Consent
- Disclosure
- Consent to Treatment
- Initiation of Psychiatric Treatment
- Mental Health Advance Directives
- Electroconvulsive Therapy
- Consent to Medical Treatment

Guardian Advocates & Other Substitute Decision Makers

- General
- Court Appointed Guardians (Chapter 744, FS)
- Guardian Advocates
- Health Care Surrogates & Proxies
- Other Substitute Decision Makers
- Medical Consent

Involuntary Examinations

- Professional Credentials
- Criteria
- Initiation
- Transport
- Acceptance
- Examination
- Conversion to Voluntary Status
- Release from Involuntary Examination
- Transfers
- Baker Act Reporting
- Nursing Home / ALF Initiations
- Notices
- Medical Conditions
- Elopement
- Miscellaneous

Involuntary Inpatient Placement

- Criteria
- Initiation & Filing of Petitions
- Public Defender & State Attorney
- Witnesses
- Continuances
- Waiver of Hearings
- Conversion to Voluntary Status
- Hearings
- Involuntary Placement Orders
- Continued Involuntary Inpatient Placement
- Baker Act Forms
- Elopements
- Transfers of Persons under Involuntary Placement
- State Treatment Facilities & Transfer Evaluations
- Discharge of Persons under Involuntary Placement
- Convalescent Status

Involuntary Outpatient Placement

Law Enforcement

- Definition of Law Enforcement Officer
- Voluntary Admissions
- Initiation of Involuntary Examination
- Execution of Involuntary Examination
- Criminal Charges
- Restraining Devices
- Receiving Facility Responsibilities
- Paperwork Required
- Rights of Persons
- Consular Notification & Access
- Training
- Warrantless Entry

Long-Term Care Facilities

- Alternatives to the Baker Act
- Voluntary Admissions
- Involuntary Examination
- Transportation
- Transfers
- Refusal to Accept Back

Marchman Act

- General
- Protective Custody – Law Enforcement
- Transportation
- Licensed Substance Abuse Facilities
- Responsibilities of Licensed Facilities
- Emergency Medical Conditions
- Involuntary Admissions
- Involuntary Treatment
- Appellate Cases

Minors

- Minority Defined
- Informed Consent for Treatment
- Voluntary Admissions
- Involuntary Examinations
- Transportation & Transfers
- Involuntary Placement
- Separation of Minors from Adults
- Juvenile Delinquency
- Receiving Facilities

Professional Credentials

- General
- Physicians
- Physician Assistants
- Psychologists
- Psychiatric Nurses
- Chapter 491 Professionals
- Veteran's Affairs
- Involuntary Placement

Receiving Facilities

- General
- Designation
- Public Receiving Facilities & CSU's
- Involuntary Status
- Inducements
- State Hospital Transfers

Rights of Persons in Mental Health Facilities

- General
- Right to Dignity & Privacy
- Advance Directives
- Right to Treatment
- Communication Restrictions
- Clinical Records & Confidentiality
- Custody of Personal Possessions
- Designated Representatives
- Habeas Corpus
- Right to Discharge

Training

Transportation under the Baker Act

- General
- Transportation Exception Plans
- Voluntary Status
- Responsibility of Receiving Facilities & Hospitals
- Nearest Receiving Facility
- Criminal Charges
- Delegation of Transportation to Medical Transport
- Transfers
- EMTALA/Transportation
- Transport to State Hospitals (Treatment Facilities)
- Juvenile Justice
- Transport for Involuntary Placement
- Marchman Act

Voluntary Admissions – Adults

- Requirements for Voluntary Admission
- Competence to Provide Express & Informed Consent
- Right to Request Release
- Guardians & Other Substitute Decision-Makers
- Transfers in Legal Status
- Requirements for Voluntary Admission
- Access to State Mental Health Facilities

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- Weapons in Field
- Weapons at Psychiatric Hospitals
- Contraband

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* Recommended   **Mandatory

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* Recommended **Mandatory

IN THE CIRCUIT COURT OF THE _______________ JUDICIAL CIRCUIT

IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ____ CASE NO.: __________________________

Ex Parte Order for Involuntary Examination

Pursuant to Section 394.463(2)(a)1, Florida Statutes, this Court having received sworn testimony, states that the above-named person, presently within the county, appears to meet the following criteria for involuntary examination:

1. There is reason to believe the above-named person has a mental illness as defined in Section 394.455 (18), F.S., and because of this mental illness said person:
   - ☐ (a) has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **or**
   - ☐ (b) is unable to determine for himself/herself whether examination is necessary, **AND**

2. Either (Check a and/or b)
   - ☐ (a) without care or treatment the above-named person is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **OR**
   - ☐ (b) There is substantial likelihood that without care or treatment the above-named person will cause serious bodily harm to ☐ himself or herself or ☐ another person in the near future, as evidenced by recent behavior.

One or more Petitions and Affidavits Seeking Order Requiring Involuntary Examination (CF-MH 3002 or equivalent) on which the above conclusion is based is attached.

Additional information upon which this order is based is: ____

____

____

Therefore, it is

ORDERED

That a law enforcement officer, or designated agent of the Court take the above-named person into custody and deliver or arrange for the delivery of said person to the **nearest** receiving facility for involuntary examination, and that this order and petition be made part of said person's clinical record. A law enforcement officer or agent may serve and execute this order on any day of the week, at any time of the day or night. A law enforcement officer or agent may use such reasonable physical force as is necessary to gain entry to the premises, and any dwellings, buildings, or other structures located on the premises, and to take custody of the person who is the subject of this ex parte order.

This order expires in ____________ days. If no time limit is specified in this order, the order shall be valid for 7 days after the date that the order was signed.

ORDERED THIS _____________ day of ______________________________, ____________

Date Month Year

____ ____

Printed Name of Circuit Court Judge Signature of Circuit Court Judge

See s. 394.463, Florida Statutes

CF-MH 3001, Jan 98 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT

IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ______________________________ CASE NO.: ___________________________

Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination

I, _______________________________________ , being duly sworn, am filing this sworn statement requesting a court order for the
Print Name of Petitioner
involuntary examination of ____ (hereinafter referred to as PERSON).
Print Name of Person

This petition and affidavit will be included in the PERSON's clinical record and may be viewed by the PERSON.

I understand that by filling out this form, the PERSON may be taken by law enforcement to a mental health facility for an examination.

I SWEAR that the answers to the following questions are given honestly, in good faith, and to the best of my knowledge.

1. a. I live at: (Print Your Full Residence Address and Phone Number) Phone: (_______) ____________________________

   Street Address: ____ City ________________ ST _____ Zip_______

   b. I work as a: (Occupation) ___________________________________ Work Phone: (_______) ___________

   Work Street Address: ____ City ____________ ST _____ Zip _______

   c. The PERSON lives at, or may be found at, the following address(es):

   Street Address: ____ City __________________

   Street Address: ____ City __________________

   Street Address: ____ City __________________

2. I have the following relationship with the PERSON: ____

   ____

3. (Check the one box that applies)

   ☐ a. I or a family member ☐ have or ☐ have not previously made allegations to law enforcement involving this PERSON on _____________ (Date) such as domestic violence, trespassing, battery, child abuse or neglect, Baker Act, neighborhood disputes, etc. as described: ____

   ____

   ____

   ☐ b. This PERSON ☐ has or ☐ has not previously made allegations to law enforcement about me or my family on _______________ (Date) such as domestic violence, trespassing, battery, child abuse or neglect, Baker Act, etc. as described:____

   ____

CONTINUED OVER

Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination (Page 2)

4. (Check the one box that applies)
   ☐ a. I or a family member are not now, and have not in the past, been involved in a court case with the PERSON.
   ☐ b. I or a family member am now, or was, involved in a court case with the PERSON. This case is/was a

   ________________________________ in ________________________
   Type of Case   When

   Explain:____

   ____

5. I am on good terms with the PERSON at the present time. (Check one box) ☐ Yes ☐ No If "no", please explain:

   ____

   ____

6. I have known the PERSON for ____________________ (how long).
   ☐ a. The PERSON has only recently displayed unusual kinds of behavior.
   ☐ b. The PERSON has, over a period of time, always acted in a strange manner.
   ☐ c. The PERSON's behavior has developed over a period of time.

COMPLETE THE FOLLOWING ONLY IF THE SECTION APPLIES TO THIS CASE:

7. I have seen the following behavior, which causes me to believe that there is a good chance that the PERSON will cause serious bodily harm to himself/herself or others. On ______________ at approximately __________ am pm,
   Date   Time
   I saw the PERSON: ____

   ____

   ____

8. Other similar behavior I have personally seen is as follows: ____

   ____

   ____

   ____

9. ☐ To my knowledge or belief, ☐ I do ☐ I do not believe these actions were a result of retardation, developmental disability, intoxication, or conditions resulting from antisocial behavior or substance abuse impairment.

CHECK AND/OR ANSWER APPLICABLE SECTIONS

10. ☐ a. I have attempted to get the PERSON to agree to seek assistance for a mental or emotional problem(s). I explained the purpose of the examination (describe when, who was present, and whether you or another person explained the need for the examination): ____

    ____

    ____

    ☐ b. I did not try to get the PERSON to agree to a voluntary examination because: ______________________

    ____

    ☐ c. The PERSON refused a voluntary examination because: ______________________________

    ____

CONTINUED

11. The following steps were taken to get the PERSON to go to a hospital for mental health care: ____________________

____

____

____

These steps did not work because: ____

____

____

12. I believe that the PERSON is unable to determine for himself/herself, why the examination is necessary because:

____

____

____

13. I believe that the PERSON has a mental illness which will keep the PERSON from being able to meet the ordinary demands of living because: ____

____

____

____

14. I believe that without care or treatment, the PERSON is likely to suffer from neglect or refuse to care for himself/ herself, because: ____

____

____

15. I believe that this lack of care or neglect will lead to the PERSON hurting himself or herself because:

____

____

____

16. Can family or close friends now provide enough care to avoid harm to the PERSON? ☐ Yes ☐ No, If not, why?

____

____

____

____

CONTINUED OVER

Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination (Page 4)

Provide the following identifying information about the person (if known) if it is determined necessary to take the person into custody for examination:

County of Residence: Social Security No.: Date of Birth:

Sex : ☐ Male ☐ Female Race: Attach a picture of the PERSON if possible. Picture attached: ☐ No ☐ Yes

Height: Weight: Hair Color: Eye Color:

Does the PERSON have access to any weapons? ☐ No ☐ Yes If yes, describe:

Is the PERSON violent now? ☐ No ☐ Yes Has the person been violent in the recent past? ☐ No ☐ Yes If Yes, Describe:

Does the PERSON have any pending criminal charges against him/her? ☐ No ☐ Yes If yes, describe:

GUARDIANSHIP:

1) Does the PERSON have a legal guardian? ☐ No ☐ Yes

2) Is there a pending petition to determine the PERSON's capacity and for the appointment of a guardian? ☐ No ☐ Yes
If YES to either of the above, provide the name, address and phone number of the current or proposed guardian.

Name: ______________________ Phone: (__________) ______________________

Address: ______________________ City: ______________________ Zip: __________

____

PHYSICIAN: Name: Phone: ( )

MEDICATIONS: Provide name of medications if known.

CASE MANAGEMENT: Provide name and phone number of case manager or case management agency, if known.

I understand that this sworn statement is given under oath and will be treated as though it was made before a judge in a court of law. I understand that any information in this sworn statement which is not to the best of my knowledge and done in good faith may expose me to a penalty for perjury and other possible penalties under the statutes of the State of Florida.

Under penalties of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

Signature of Affiant/Petitioner: ______________________________

SWORN TO AND SUBSCRIBED before me

this __________ day of ______________________, ____________
Day Month Year

by ______________________________ who is personally known

to me or presented ______________________________ as identification.

____
Notary Public - State of Florida

My Commission expires: Date____________________

OR

SWORN TO AND SUBSCRIBED before me

this __________ day of ______________________, ____________
Day Month Year

Clerk of Circuit Court

______________________________ County, Florida

By: ______________________________
Deputy Clerk

A copy of the petition(s) must be attached to an Ex Parte Order for Involuntary Examination and accompany the person to the nearest receiving facility.

See s. 394.463, Florida Statutes
CF-MH 3002, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT

IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ___________________________________ CASE NO.: __________________________

Order for Involuntary Inpatient Placement

This matter came to be heard pursuant to a Petition for Involuntary Inpatient Placement filed herein on the issue of whether the above-named person should be involuntarily placed in a mental health treatment or receiving facility, and the Court being fully advised in the premises, finds by clear and convincing evidence, as follows:

1. Said person has been represented by counsel; Said person ☐ appeared at the hearing, or
   ☐ said person's presence at the hearing was waived, without objection of said person's counsel.

2. Said person meets the following criteria for involuntary inpatient placement pursuant to s. 394.467(1), F.S. :
   (a) He or she is mentally ill and because of a mental illness:
      (1) has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or
      (2) is unable to determine for himself or herself whether placement is necessary; **AND**
   (b) Either
      (1) He or she is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or
      (2) There is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
   (c) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

3. The nature and extent of the above-named person's mental illness is as follows: ____
   ____
   ____

4. The Court considered testimony and evidence regarding the person's competence to consent to treatment. The person was found to be ☐ competent ☐ incompetent to consent to treatment. If found to be incompetent, ____________________________________
   ____ was appointed as guardian advocate.
   (name and address)

5. If the petition was referred to and heard by a general master, the Master's Report and Recommendation are attached, incorporated by reference, and/or adopted by the Court.

ORDERED

That the above-named person be placed in a designated mental health receiving or treatment facility on an involuntary basis for a period of up to ___________________________, not to exceed 6 months from the date of this order, or until discharged by the administrator or transferred to voluntary status.

DONE AND ORDERED in __________________ County, Florida, this ______ day of __________________, ____________.

_______________________________________ ____

Printed Name of Circuit Court Judge Signature of Circuit Court Judge

This form must accompany person to the treatment facility.

See s. 394.467(1), Florida Statutes

CF-MH 3008, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT

IN AND FOR __________________________ COUNTY, FLORIDA

IN RE: ___________________________________ CASE NO.: ______________________________

Notice of Petition for Involuntary Placement

YOU ARE HEREBY NOTIFIED that a petition for a hearing has been filed with the _______ Circuit Court in __________________ County, Florida where the above-named person is hospitalized on the question of whether he/she should be ordered or confined for:

- ☐ Involuntary Inpatient Placement
- ☐ Involuntary Outpatient Placement
- ☐ Continued Involuntary Outpatient Placement

Said person will be represented by the Public Defender if he/she is not otherwise represented by counsel.

A hearing has been scheduled by the court and will be conducted pursuant to Section 394.467, F.S., on ____________ at ______ am pm
Date Time

at ____ .
Place/address

At least one of the following examining experts will testify in support of continued detention:

_________________________________ _________________________________

In addition to at least one of the professionals listed above, the following persons are also expected to testify in support of involuntary inpatient placement or involuntary outpatient placement or continued involuntary outpatient placement:

	Guardian or Representative	**Other Witness**	**Other Witness**
Name:	____________________	____________________	____________________
Relationship	____________________	____________________	____________________
Address	____________________	____________________	____________________
	____________________	____________________	____________________
Telephone:	(______)______________	(______)______________	(______)______________

The person, the person's guardian, or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the person.

The person has a right to an independent expert examination and if he/she cannot afford such an examination the Court shall provide for one.

_________________________________ ______________ _________ am pm
Signature of Court Date Time

____
Printed Name of Court

Certificate of Mailing

I hereby certify that I mailed the above and foregoing notice to the named parties by depositing the same in the United States Post Office on the _____________ day of ________________, __________. In addition, I sent this notice by registered or certified mail to each person listed below who was not given a copy by hand delivery.

_________________________________ ______________ _________ am pm
Signature of Court Date Time

This form may be completed and mailed by the Receiving Facility instead of the Court, with the court's concurrence.

cc: ☐ Person ☐ Guardian ☐ Representative ☐ Public Defender or ☐ Private Attorney

See s. 394.4599(2)(a), (c), Florida Statutes

CF-MH 3021, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT

IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ____________________________________ CASE NO.: __________________________

Application for Appointment of Independent Expert Examiner

I, ____ hereby petition the Court to order an independent expert examination pursuant to:

- ☐ Involuntary Inpatient Placement (s.394.467(6)(a)2, FS)
- ☐ Involuntary Outpatient Placement (s.394.4655(6)(a)2, FS)
- ☐ Continued Involuntary Outpatient Placement (s.394.4599(2)(c)5, FS)

____ ______________________

Signature of Person or Representative Date

____

Typed or Printed Name of Person or Representative

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Representative		am pm	

See s. 394.467(6)(a)2, Florida Statutes

CF-MH 3022, Feb 05 (obsoletes previous editions) (Recommended Form)

IN RE: ____ CASE NO.: _________________________

Notice of Petition for Continued Involuntary Inpatient Placement

YOU ARE HEREBY NOTIFIED that a petition for a hearing has been filed with the State Division of Administrative Hearings on the question of whether ____ who is hospitalized at ____ should be ordered for continued involuntary inpatient placement.

The person will be represented by the Public Defender if the person is not otherwise represented by counsel.

A hearing will be conducted pursuant to Section 394.467 (7), F.S., at __________ am pm on ____________ (date) at____

The following physician(s) or clinical psychologist(s) are expected to testify in support of continued detention:

____ ____

In addition, the following persons are also expected to testify in support of continued involuntary inpatient placement:

Name:	______________________________	______________________________	______________________________
Relationship	______________________________	______________________________	______________________________
Address	______________________________	______________________________	______________________________
	______________________________	______________________________	______________________________
Telephone:	(_____)_____________________	(_____)_____________________	(_____)_____________________

The person, the person's guardian, or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the person.

The person has a right to an independent expert examination and if he/she cannot afford such an examination, one shall be provided for him or her.

____ __________________ ______________ am pm
Signature of Administrative Law Judge Date Time

____
Typed or Printed Name of Administrative Law Judge

Certificate of Mailing

I hereby certify that I mailed the above and foregoing notice to the named parties by depositing the same in the United States Post Office on the __________ day of ________________, __________ . In addition, I sent this notice by registered or certified mail to each person listed below who was not given a copy by hand delivery.

____
Signature of Administrative Law Judge

cc: Check when applicable ☐ Person ☐ Guardian ☐ Guardian Advocate ☐ Representative ☐ Public Defender or ☐ Private Attorney

See s. 394.4599(2)(a), (c), 394.467(7), Florida Statutes
CF-MH 3024, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

IN RE: ______________________________ CASE NO.: ____________________

Order for Continued Involuntary Inpatient Placement or for Release

This matter coming on to be heard, pursuant to the requirements of Section 394.467(7), Florida Statutes, that the mental status and necessity to continue involuntary inpatient placement of persons be periodically reviewed, and the person having ☐ appeared in person ☐ appeared through counsel, the following findings of fact are made from the evidence designated:

1. The person, on ______________________ (Date), was involuntarily placed on a Court order.

2. The person ☐ does ☐ does not continue to meet the criteria for involuntary inpatient placement. This finding is determined from the testimony of ______________________________
and ______________________________. As evidenced by:
____
____
____

Based on the above findings of fact, the Administrative Law Judge makes the following conclusions:

On the basis of the above, it is hereby

ORDERED

- ☐ The person be returned to involuntary inpatient placement pending the next periodic review required by Section 394.467, Florida Statutes.
- ☐ The person be processed for release from involuntary inpatient placement and be completely discharged from the facility.
- ☐ The person is eligible for and has applied for voluntary status.

ORDERED at

this __________ (Date) day of ______________ (Month), __________ (Year).

______________________________ Printed Name of Administrative Law Judge

______________________________ Signature of Administrative Law Judge

cc: Check when applicable
☐ Person ☐ Guardian ☐ Guardian Advocate ☐ Representative ☐ Public Defender ☐ Facility Administrator

See s. 394.467(7), Florida Statutes
CF-MH 3031, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT

IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ____________________________________ CASE NO.: __________________________

Petition for Involuntary Inpatient Placement

COMES NOW the Petitioner, ____ , and alleges:

1. That Petitioner is Administrator of ________________________ ______________________________________
   Name of Facility Facility Address

2. That (Name of Person) ____ , is a patient of said facility and has been examined at such facility.

3. The person's social security number is________________________ and date of birth is:____________________.
   Date

4. That this petition is being filed within the following time frames: (Check one below)

   ☐ A. This person was admitted for involuntary examination and this petition is being filed within the 72-hour examination period, or if the examination period ends on a weekend or legal holiday, on the next court working day
   OR

   ☐ B. This person was transferred to involuntary status after examination or after refusing/revoking consent to treatment or requesting discharge from the facility and this petition is filed within two court working days.

5. That attached hereto and by reference made a part hereof, are two (2) opinions regarding the mental health of said person necessitating involuntary inpatient placement.

6. That based thereon Petitioner recommends that the person/respondent be involuntarily placed in
   ____ , a (public/private) designated receiving or treatment facility.

7. In addition to at least one of the two experts whose opinions are attached, the following persons may testify:

	Guardian or Representative	**Other Witness**	**Other Witness**
Name:	______________________	______________________	______________________
Relationship	______________________	______________________	______________________
Address	______________________	______________________	______________________
	______________________	______________________	______________________
Telephone:	(_____)________________	(_____)________________	(_____)________________

CONTINUED OVER

Petition for Involuntary Placement (Page 2)

COMES NOW THE PETITIONER and further alleges that:

☐ 1. A Guardian Advocate is necessary to act on the person's behalf on issues related to express and informed consent to mental health or medical treatment and a Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate is attached; OR

☐ 2. The person/respondent is competent to provide express and informed consent to his or her own treatment or the person has a guardian authorized to consent to treatment and no Guardian Advocate is requested.

______________________________ ______________________ __________ am pm
Signature of Facility Administrator or Designee Date Time

____
Typed or Printed Name of Administrator or Designee

The person ☐ does or ☐ does not have a private attorney. If so, the name and address of the private attorney is:

Private Attorney Name: ______________________________

Private Attorney Address: ______________________________

cc: The Clerk of the Court shall provide a copy of this petition to the: (Check when applicable and initial/date/time when copy provided)

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Public Defender		am pm	
☐ Representative		am pm	
☐ State Attorney		am pm	
☐ Dept. of Children & Families		am pm	

CONTINUED / SUPPORTING OPINIONS ON PAGE 3

Petition for Involuntary Placement (Page 3)

First Opinion Supporting the Petition

I, ______________________ a psychiatrist authorized to practice in the State of Florida, have personally examined

______________________ on ______________ (within 72 hours of the signing hereof) and find from such
Name of Person Date
examination that the person meets the following criteria for involuntary placement:

1. Said person is mentally ill and because of a mental illness (check one):
   - ☐ a. Said person has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; OR
   - ☐ b. Said person is unable to determine for himself/herself whether placement is necessary:

AND

2. Either (Check one or both):
   - ☐ a. Said person is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alliterative services, and without treatment, he/she is likely to suffer from neglect or refuse to care for himself/herself and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; OR
   - ☐ b. There is substantial likelihood that in the near future said person will inflict serious bodily harm on himself/herself or another person as evidenced by recent behavior causing, attempting, or threatening such harm.

AND

All available less restrictive treatment alternatives which would offer an opportunity for improvement of said person's condition have been judged to be inappropriate based on contact with the following programs/agencies: ______________________

____

Observations which support this opinion are:

______________________ ______________ ______________ am pm
Signature of Psychiatrist Date Time

______________________ ______________________
Typed or Printed Name of Psychiatrist License Number

Second Opinion Supporting the Petition

I,______________________, a ☐ psychiatrist, ☐ clinical psychologist, ☐ licensed physician *,
☐ psychiatric nurse *, authorized to provide a second opinion on this petition pursuant to Section 394.467 (2), F.S., have personally examined

______________________ on ______________, (within 72 hours of signing hereof), and
Name of Person Date
find that he/she meets the criteria for involuntary inpatient placement as stated in this petition. Observations which support this opinion are:

______________________ ______________ ______________ am pm
Signature of Examiner Date Time

______________________ ______________ ______________
Typed or Printed Name of Examiner Profession License Number

I certify that the county in which the person is detained has less than 50,000 population and no psychiatrist or psychologist is available to provide the second opinion.

______________________ ______________________
Printed Name and Signature of Administrator or Designee Date

*** A licensed physician or psychiatric nurse may only provide such second opinion in counties of less than 50,000 population in cases where the facility administrator certifies that no psychiatrist or clinical psychologist is available to provide the second opinion (by countersigning above).**

See s. 394.4599(2)(c)3, 394.467, Florida Statutes
CF-MH 3032, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT

IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ____ CASE NO.: __________________________

Notification to Court of Withdrawal of Petition For Hearing on Involuntary Inpatient or involuntary Outpatient Placement

YOU ARE HEREBY INFORMED THAT ____
Name of Person

at ____
Facility Name and Address

☐ has made application by express and informed consent for voluntary admission, due to an improvement in his/her condition.

☐ was discharged on ___________________ to ____
Date Destination (if known)

☐ was transferred on ___________________ to ____
Date Destination (if known)

☐ was converted to Marchman Act on ____________________________________
Date

☐ Other (specify):____

____

Please withdraw my Petition for:

☐Involuntary Inpatient Placement
☐Involuntary Outpatient Placement
☐Continued Involuntary Outpatient Placement

filed on ________________(date). The Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate, if any, is also being withdrawn.

____ _____________ ________ am pm
Signature of Administrator or Designee Date Time

____
Printed Name of Administrator or Designee

cc: ☐ Clerk of the Court (Probate Division) ☐ Person ☐ Guardian
☐ Assistant State Attorney ☐ Representative ☐ Person's Attorney

When a petition for involuntary placement is withdrawn, the court, state attorney, public defender or other attorney for the person, and guardian or representative must be notified by telephone within one business day of the decision, unless such decision is made within 24 hours prior to the hearing. In such cases, the notification must be made immediately.

See s. 394.467, 394.4685, 394.469, Florida Statutes
CF-MH 3033, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

IN RE: ____ CASE NO.: __________________________

Petition Requesting Authorization for Continued Involuntary Inpatient Placement

The petition of ____ who is the Administrator of ____ Facility shows that:

1. The above named person, ______________________________ of ____________________ County, Florida, is currently in the aforesaid facility and was admitted to this facility on _________________________ .
   Date

2. That according to the provisions of Section 394.467 (7), F.S., this person may not be retained after ___________________________, (Date) without an order authorizing continued involuntary inpatient placement.

3. That the person continues to meet the criteria for involuntary inpatient placement pursuant to Section 394.467(1), F.S., and

   ☐ that legally authorized period has nearly expired, or

   ☐ the person was admitted while serving a criminal sentence whose sentence will expire on ______________ , or
   Date

   ☐ the person was placed while a minor and will reach the age of majority on _______________.
   Date

Wherefore, it is requested an Order be issued authorizing this Facility to retain the person for a period not to exceed six (6) months.

____ ___________________ _____________ am pm
Signature of Administrator or Designee Date Time

____
Printed or Typed Name of Administrator or Designee

CONTINUED OVER

Petition Requesting Authorization for Continued Involuntary Placement (Page 2)

Physician's or Clinical Psychologist's Statement

I hereby state that the above named person continues to meet the criteria for involuntary placement. Behavior which supports this opinion is: ______________________________

____

____

Person's treatment during placement was: ______________________________

____

____

Less restrictive settings which were investigated and the reasons they were ruled out are as follows: ______________

____

____

____

☐ Support for facts in this statement is attached.
☐ The individualized treatment plan for the person is attached.

______________________________ Signature of ☐ Physician ☐ Clinical Psychologist

______________ Date

__________ Time am pm

______________________________ Printed Name of Physician/Clinical Psychologist

______________________________ License Number

File this completed form with the Administrative Law Judge.

Person ☐ does or ☐ does not have a private attorney. If so, the name and address of the private attorney is:

Private Attorney Name: ______________________________

Private Attorney Address: ______________________________

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ Public Defender or ☐ Private Attorney		am pm	

See s. 394.467(7), Florida Statutes
CF-MH 3035, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances

To: ____

PLEASE BE ADVISED that you may petition the Circuit Court for a Writ of Habeas Corpus to question the cause and legality of your detention. Furthermore, a petition may be filed in the Circuit Court in the county in which you are placed for Redress of Grievances alleging that you are being unjustly denied a right or privilege or that an authorized procedure is being abused.

A Petition for Writ of Habeas Corpus and Redress of Grievances (CF MH Form 3090) may be used for this purpose. A petition must be signed by either you, your relative, friend, guardian, guardian advocate, representative, attorney, or the Department of Children and Families.

Staff of this facility will provide a copy of the Writ form to you immediately upon your request. Staff will assist you in completing this Writ form if you request such help. The Petition for a Writ will be submitted by the staff to the Circuit Court no later than the next working day after you submit the form.

______________________________________ ________________ __________ am pm
Signature of Administrator or Designee Date Time

This completed form must be given to all persons admitted to a facility and to those individuals listed below as applicable.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ Health Care Surrogate/Proxy		am pm	

See s. 394.459(8), Florida Statutes
CF-MH 3036, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Notice of Release or Discharge

IN RE: ____ CASE NO. ____________________________

YOU ARE HEREBY NOTIFIED that ____ , admitted for

- ☐ Involuntary examination
- ☐ Involuntary inpatient placement
- ☐ Involuntary outpatient placement

has this ________ day of __________________ , 20__ been released or discharged from this facility and or order.

Any guardian advocate appointed to provide express and informed consent to treatment on the person's behalf, if any, has been discharged from his or her duties, unless the person was released from involuntary inpatient placement to involuntary outpatient placement and the appointment of the guardian advocate was continued by the court.

____ ______________________ __________ am pm
Signature of Administrator or Designee | Date | Time

____ ____
Printed Name of Administrator or Designee | Name of Facility

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ Person's Attorney		am pm	
☐ Initiating Person		am pm	
☐ Circuit Court		am pm	
☐ Person's Clinical Record		am pm	

See s. 394.4599, 394.463(3), Florida Statutes
CF-MH 3038, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Application for Voluntary Admission of an Adult
(Receiving Facility)

I, ____ do hereby apply for admission to
Full printed name of person whose admission is being requested

____
Fill in name of facility

for observation, diagnosis, care, and treatment of a mental illness, and I certify that the information given on this application is true and correct to the best of my knowledge and belief.

I am making this application for voluntary admission after sufficient explanation and disclosure to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. The reason for my admission to this facility is:

____

____

____.

I am a competent adult with the capacity to make well-reasoned, willful, and knowing decisions concerning my medical or mental health treatment. I do not have a guardian, guardian advocate, or currently have a health care surrogate/proxy making health care decisions for me.

I ☐ have ☐ have not provided a copy of advance directive(s).

If so, the advance directives include my:
- ☐ Living Will
- ☐ Health Care Surrogate,
- ☐ Mental Health Care Surrogate,
- ☐ Other as specified:

I have been provided with a written explanation of my rights as a person on voluntary status and they have been fully explained to me. **I understand that this facility is authorized by law to detain me without my consent for up to 24 hours after I make a request for discharge**; unless a petition for involuntary inpatient placement or involuntary outpatient placement is filed with the Court within two (2) court working days of my request for discharge in which case I may be held pending a hearing on the petition.

I understand that I may be billed for the cost of my treatment.

______________________	____________	________ am pm
Signature of Competent Adult	Date	Time

______________	______________	__________	________ am pm
Printed Name of Witness	Signature of Witness	Date	Time

No notice of this admission is to be made without the consent of the person except in case of an emergency. The use of this form for a voluntary admission requires that a "Certification of Person's Competence to Provide Express and Informed Consent" be completed within 24 hours and if the form is used for a transfer of a person from involuntary to voluntary status, the "Certification" must be completed prior to the "Application". The "Application" and "Certification" must be placed in the person's clinical record.

See s. 394.455(9), 394.459, 394.4625, Florida Statutes
CF-MH 3040, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

General Authorization for Treatment Except Psychotropic Medications

I, the undersigned, a ☐ competent adult, ☐ guardian, ☐ guardian advocate, or ☐ health care surrogate/proxy hereby authorize the professional staff of this facility to administer assessment and treatment specified below.

☐ Routine medical care ___________ (Initials of Person or Authorized Decision Maker)

☐ Psychiatric Assessment __________ (Initials of Person or Authorized Decision Maker)

☐ Other (Specify & Initial) ____

____

____

I understand that more information will be provided to me before my informed consent will be requested for the administration of any psychotropic medications.

I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.

I have read and had this information fully explained to me and I have had the opportunity to ask questions and receive answers about the treatment.

_______________________________ _______________ ___________ am pm
Signature of Competent Adult Date Time

_______________________________ _______________ ___________ am pm
Signature of Witness for Person Date Time

_______________________________ _______________ ___________ am pm
Signature of: (check one when applicable) Date Time
☐ Guardian ☐ Guardian Advocate
☐ Health Care Surrogate ☐ Health Care Proxy

If I am the guardian advocate, health care surrogate, or health care proxy for the person, I certify that I have met and talked with the person and the person's physician in person, if at all possible, and by telephone, if not about the proposed treatment prior to signing this form.

Talked to person on:_________(date) ☐In person ☐By telephone. If not in person, explain why not.________________________
____

Talked to person's physician on: _____(date) ☐ In person ☐By telephone. If not in person, explain why not.____________________

_______________ ___________ am pm
Signature of: (check one when applicable) Date Time
☐ Guardian ☐ Guardian Advocate
☐ Health Care Surrogate ☐ Health Care Proxy

_______________________________ _______________ ___________ am pm
Signature of Witness for Substitute Decision-Maker Date Time

The person shall always be asked to sign this authorization form. However, if the person is a minor, is incapacitated, or is incompetent to consent to treatment, the consent of his or her guardian, guardian advocate, or health care surrogate/proxy is required. Court orders, letters of guardianship, or advance directives must be retained in the clinical record if an individual other than the person signs the consent to treatment. The guardian, guardian advocate, or health care surrogate/proxy must agree to keep the facility informed of their whereabouts during the term of the hospitalization.

See s. 394.459(3), Florida Statutes
CF-MH 3042a, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Specific Authorization for Psychotropic Medications

Discussion of psychotropic medication should occur within the context of the person's medical history and current overall medication regimen.

I, the undersigned, a ☐ competent adult, ☐ guardian, ☐ guardian advocate, or ☐ health care surrogate/proxy hereby authorize the professional staff of this facility to administer treatment, limited to mental health medications, as follows:

____

____

____

I have been given detailed information about:

1. The proposed medications and dosage range and frequency;
2. The purpose of my treatment;
3. Common short- and long-term side effects of my proposed medication, including contraindications and clinically significant interactions with other medications;
4. Alternative medications;
5. Approximate length of care

I further understand that a change of medication dosage range from that listed above or on the attached will require my express and informed consent.

I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.

The information I have relied upon to make the decision to consent to treatment, including full disclosure of each of the above subjects, is attached to this authorization and signed by me. I have read and had this information fully explained to me and I have had the opportunity to ask questions and receive answers about the treatment.

____________________________ _______________ _________ am pm
Signature of Person Date Time

____________________________ _______________ _________ am pm
Signature of Witness for Person Date Time

____________________________ _______________ _________ am pm
Signature of: (check one when applicable) Date Time
☐ Guardian ☐ Guardian Advocate
☐ Health Care Surrogate ☐ Health Care Proxy

If I am the guardian advocate, health care surrogate, or health care proxy for the person, I certify that I have met and talked with the person and the person's physician in person, if at all possible, and by telephone, if not about the proposed treatment prior to signing this form.

Talked to person on:_________(date) ☐In person ☐By telephone. If not in person, explain why not.____________________________

____

Talked to person's physician on: _____(date) ☐ In person ☐By telephone. If not in person, explain why not.____________________

____

____________________________ _______________ _________ am pm
Signature of: (check one when applicable) Date Time
☐ Guardian ☐ Guardian Advocate
☐ Health Care Surrogate ☐ Health Care Proxy

____________________________ _______________ _________ am pm
Signature of Witness for Substitute Decision-Maker Date Time

* The person shall always be asked to sign this authorization form. However, if the person is a minor, is incapacitated, or is incompetent to consent to treatment, the consent of his or her guardian, guardian advocate, or health care surrogate/proxy is required. Court orders, letters of guardianship, or advance directives must be retained in the clinical record if a person other than the person signs the consent to treatment. The guardian, guardian advocate, or health care surrogate/proxy must agree to keep the facility informed of their whereabouts during the term of the hospitalization. Facilities may devise unique disclosure forms or use commercially prepared forms, but in either case, the material must include all statutorily required elements.

See s. 394.459(3), Florida Statutes
CF-MH 3042b, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Inventory of Personal Effects

The following person ______________________________ has retained these articles in his or her own custody:

________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________

The person has, for medical and safety reasons, placed the following articles in the temporary custody of this facility. (Attach additional sheets if necessary)

________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________

This is a correct listing of my personal effects and belongings which I hereby place in custody of the facility.

______________________________ ______________ ________ am pm
Signature of Person Date Time

______________________________ ______________ ________ am pm
Signature/Title of Witness to Inventory Date Time

______________________________ ______________ ________ am pm
Signature/Title of Witness to Inventory Date Time

If the person is unable or unwilling to sign the above, the reason(s) are as follows: ______________________________
____
____.

Amendment to the above inventory shall be made on a separate Inventory form, signed by the person, and witnessed by two persons.

This inventory must be amended upon the request of the person, guardian, guardian advocate or representative. All effects held by the facility shall be returned to the person immediately upon the person's discharge or transfer from the facility, unless such return would be detrimental to the person. If not returned to the person, the reason must be documented in the clinical record along with the disposition of the personal effects. The inventory form must be filed in the person's clinical record.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initial of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	

See s. 394.459(6), Florida Statutes
CF-MH 3043, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Authorization for Release of Information

I hereby request and authorize:

____
Name of Person(s) or Agency Holding the Information

____
Address

to release written or verbal information specified below:

____

____

To:____
Name of Person(s) or Agency Requesting the Information

____
Address

For the purpose of: ____

I understand that this form may be used to release information related to mental health treatment, including assessments and lab reports. Any release of substance abuse information must be pursuant to 42 CFR. There are other special restrictions which apply to the release of information regarding HIV, abuse reports, etc.

I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information.

Expiration Date: ________________ Social Security Number of Person: ____________________________

Signature of Competent Adult	Printed Name of Competent Adult	Date	Time am pm
When applicable, Signature of: ☐ Guardian, ☐ Guardian Advocate, ☐ Health Care Surrogate/Proxy, or ☐ Personal Representative/Equivalent (if deceased)	Printed Name of Substitute Decision Maker	Date	Time am pm
Signature of Witness	Printed Name of Witness	Date	Time am pm

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the person provides specific written consent for the subsequent disclosure of this information. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

Any release of information must be in compliance with the federal HIPAA law and state laws governing such releases.

See s. 394.4615(1), Florida Statutes
CF-MH 3044, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Notice of Person's Admission for Involuntary Examination

Name of Guardian or Representative: ______________________________

YOU ARE HEREBY NOTIFIED THAT ______________________________
Printed Name of Person Admitted for Examination

Was admitted to: ______________________________ (Name of Facility)

____
Facility Address City State Zip Code

(_____)___________________on ____________________for an involuntary examination.
Facility Telephone Number Date

You are notified of this admission because you have been designated as the person's ☐ representative and the person did not object to you being notified or as his or her ☐ guardian. Prompt notice by ☐ telephone or ☐ in person was given to you within 24 hours of the person's arrival at the facility.

You will be informed of his/her legal proceedings, rights and any restriction of these rights, and of the person's discharge or transfer to another facility. You have the legal right to petition the Court on the person's behalf, question the cause and legality of his/her detention in a facility or if you believe the person is being unjustly denied a right or privilege.

______________________________ ____________________ ________________ am pm
Signature of Administrator or Designee Date Time

____
Printed or Typed Name of Administrator or Designee

Notice to the local Florida Local Advocacy Council must be given for all persons on involuntary status; such notice may not be waived. A person may choose his or her representative. Only if the person is unable to unwilling to designate a representative, the facility shall select a representative. When the facility selects the representative, the selection shall be made from the following list in the order of listing:

1. Health Care Surrogate
2. Person's Spouse
3. Person's Adult Child
4. Person's Parent
5. Person's Adult Next of Kin
6. Person's Adult Friend
7. Florida Local Advocacy Council

The person shall be consulted with regard to the selection of a representative by the receiving or treatment facility and shall have authority to request that any such representative be replaced. The following shall not be appointed as the person's representative: a licensed professional providing services to the person, an employee of a facility providing direct services to the person, an employee of the Department of Children and Families, an individual providing other substantial services to a person in a professional or business capacity, or a creditor of the person.

Distribution: Check when applicable and initial/date/time when copy is provided.

Individual	Date Copy Provided	Method Copy Provided	Time Copy Provided	Initials of Person Providing Copy
☐ Guardian			am pm	
☐ Representative			am pm	
☐ Florida Local Advocacy Council			am pm	
☐ Person's clinical record			am pm	

See s. 394.4597, 394.4599, Florida Statutes
CF-MH 3045, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

IN RE: ____

Application for and Notice of Transfer to Another Receiving or Treatment Facility

Part I - Application for Transfer

I, ____, hereby apply for transfer from

______________________ to __________________________

on or before ____________, ________

I understand that in transfers:

☐ From a public receiving facility to a private receiving facility, I am responsible for the cost of transportation and personnel required to assist with the transfer.

☐ From a private receiving facility to a public receiving facility, the cost of transfer is the responsibility of the private facility if the transfer is requested by the private facility.

______________________________ ____________ ________ am pm
Signature of ☐ Person, ☐ Guardian, ☐ Guardian Advocate Date Time
☐ Health Care Surrogate ☐ Health Care Proxy

Part II - Notice of Transfer to Another Facility

YOU ARE HEREBY NOTIFIED that ____________________________ will be transferred from

______________________, to __________________________ located at

____ on ____________.
Date

______________________________ ____________ ________ am pm
Signature of Administrator or Designee Date Time

Part I is to be completed by the person or other authorized person to request a transfer. Part II is completed by the sending facility administrator prior to the date of transfer. Only Part II is completed when the transfer is initiated by the facility administrator rather than by the person or other person authorized to act on the person's behalf.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ Attorney		am pm	

See s. 394.4685, Florida Statutes
CF-MH 3046, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Confidentiality Agreement

While receiving services at ____ Facility, you have the right to decide who may and who may not receive information about your presence and treatment in this facility. This form is for you to document your choices. Please initial indicating your choice in the following areas:

Visitors:

_____ I choose to have visitors

_____ I choose to limit the specific visitors to the following:

____

_____ I choose to have no visitors

Telephone Use:

_____ I choose to receive all phone calls

_____ I choose to limit my calls to specific callers, including:

____

_____ I choose to receive no phone calls

Medical Records:

_____ I choose not to limit access to my medical records

_____ I choose to limit access to my medical records to the following:

____

_____ I choose that my records be accessible only by staff and people in the profession involved in my treatment

Other:

_____ I understand that federal and state laws, courts, and medical conditions may limit any of the above decisions

_____ I understand that though these are my present choices, I may change this document at any time, and that it will be placed in my clinical record while treatment continues.

______________________________	______________________________
Signature of Person	Printed Name of Person
______________________________	______________________________
Date	Name of Witness

See s. 394.459(5), Florida Statutes
CF-MH 3048, Feb 05 (Recommended Form) **BAKER ACT**

Restriction of Communication or Visitors

Notice is hereby given to ____
Full Name of Person

this date, that under the provisions of s.394.459(5)(c), Florida Statutes, a restriction on communications has been placed for a period of ________ days, starting at ____________ am pm on (Date) ___________________ and ending at ____________ am pm on (Date) ________________

The nature of the restriction is as follows: ____

____

____

____

____

The restriction has been ordered because ____

____

____

____

____

This restriction of communication shall be reviewed at least every 7 days and lifted as soon as possible.

________________________________ ________________ ____________ am pm
Signature of Administrator or Designee Date Time

A person's right to report an alleged abuse or to contact and to receive communication from his/her attorney shall not be limited. This completed form must be placed in the person's clinical record as individualized justification for depriving the person of his/her right to communicate with others. Any renewal of this restriction shall be justified. A copy of this form and any renewal of the restriction shall be provided to all persons listed below, as applicable. The right to communicate or receive visitors shall not be restricted as a means of punishment.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initial of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ Attorney		am pm	
☐ Health Care Surrogate/Proxy		am pm	

See s. 394.459(5)(c), Florida Statutes
CF-MH 3049, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Part I
Notice of Right of Person on Voluntary Status To Request Discharge From a Receiving Facility

A person on voluntary status or a relative, friend, or attorney of the person may request discharge either orally or in writing at any time following admission to the facility. If the request for discharge is made by a person other than the person, the discharge may depend on the express and informed consent of the person.

If you request discharge, your doctor will be notified and you will be discharged within 24 hours after your request for discharge unless you withdraw your request or you meet the criteria for involuntary inpatient placement or involuntary outpatient placement. If you meet the criteria for involuntary inpatient or outpatient placement, the facility administrator may file a petition with the court for your continued detention within two (2) court working days and you will be detained without your consent, pending a court hearing.

If you wish to request discharge at any time during your stay at this facility, complete the Application for Discharge on the reverse side of page. No action on your part is required, unless you wish to make arrangements for release.

The procedure for requesting discharge has been explained to me and I have had the opportunity to ask questions and receive answers about my right to request discharge.

Printed Name of Person	Signature of Person	Date	Time am pm
Printed Name of Guardian of Minor	Signature of Guardian of Minor	Date	Time am pm
Printed or Typed Name of Witness	Signature of Witness	Date	Time am pm

cc: Check when applicable and provide date/time/initial when copy provided:

☐ Person	Date:	Time: am pm	Initial:
☐ Guardian of Child	Date:	Time: am pm	Initial:

Parts II and Part III are continued on back

Part II Application for Discharge

Pursuant to Section 394.4625 (2), Florida Statutes, I, ________________________________

hereby apply for my release or that of ________________________________

who is a voluntary patient at (Name of Facility) ________________________________.

My relationship to the said person is that of (Relationship) ________________________________.

________________________________ ________________ ____________ am pm
Signature of Person or Authorized Individual on his or her behalf Date Time

---

An oral request for discharge was made by ________________ on ____________ ________ am pm
Name of Requester Date Time

________________ ________________ ____________ ________ am pm
Signature of Staff Printed Name of Staff Date Time

If this request for discharge was made by someone other than me, I concur with the above request for my discharge. If not, I have completed Part III below.

________________________________ ____________ ________ am pm
Signature of Adult Date Time

________________________________ ____________ ________ am pm
Signature of Guardian of Minor Date Time

________________________________ ____________ ________ am pm
Signature of Witness Date Time

cc: Check when applicable and date/time/initial when copy provided:

☐ Person	Date:	Time: am pm	Initials:
☐ Guardian of Minor	Date:	Time: am pm	Initials:

Part III Withdrawal of Application for Discharge

I, ________________________________, freely and voluntarily rescind my previous oral or written Application for Discharge or do not concur with the request for discharge made by another person. No force, fraud, deceit, duress, or other form of constraint or coercion were used to obtain this withdrawal of my Application for Discharge.

________________________________ ____________ ________ am pm
Signature of Person Date Time

________________ ________________ ____________ ________ am pm
Signature of Witness Credentials of Witness Date Time

cc: Check when applicable and date/time/initial when copy provided:

☐ Person	Date:	Time: am pm	Initials:
☐ Guardian of Minor	Date:	Time: am pm	Initials:

See s. 394.455(9), 394.4625(2), (3), Florida Statutes
CF-MH 3051a, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Notice of Right of Person on Voluntary Status To Request Discharge from a Treatment Facility

Part I

A person on voluntary status or a relative, friend, or attorney of the person may request discharge either orally or in writing at any time following admission to the facility. If the request for discharge is made by an individual other than the person, the discharge may depend on the express and informed consent of the person.

If you request discharge, your doctor will be notified and you will be discharged within 3 days, not including weekends and holidays, after your request for discharge unless you withdraw your request or you meet the criteria for involuntary inpatient placement or involuntary outpatient placement. If you meet the criteria for involuntary placement, the facility administrator may file a petition with the Court for your continued detention within two (2) court working days and you will be detained without your consent, pending a court hearing.

If you wish to request discharge at any time during your stay at this facility, complete the Application for Discharge on reverse side of page. No action on your part is required, unless you wish to make arrangements for release.

______________________	______________________	____________	______ am pm
Printed or Typed Name of Person	Signature of Person	Date	Time

______________________	______________________	____________	______ am pm
Printed or Typed Name of Witness	Signature of Witness	Date	Time

cc: Check when applicable and date/time/initial when copy provided:

☐ Person	Date:	Time: am pm	Initials:

Parts II and III are continued on back

Part II Application for Discharge

Pursuant to Section 394.4625 (2), Florida Statutes, I, ____________________

hereby apply for my release or that of ____________________

who is on voluntary status at (Name of Facility) ____________________.

My relationship to the said person is that of (Relationship) ____________________.

____________________ Signature of Person or Authorized Individual ____________ Date ________ Time am pm

---

An oral request for discharge was made by ____________________ Name of Requester on ____________ Date ________ Time am pm

____________________ Signature of Staff ____________________ Printed Name of Staff ____________ Date ________ Time am pm

---

If this request was made by someone other than me, I concur with the above request for my discharge. If not, I have completed Part III below.

____________________ Signature of Person ____________ Date ________ Time am pm

____________________ Signature of Witness ____________ Date ________ Time am pm

cc: Check when applicable and date/time/initial when copy provided:

☐ Person	Date:	Time: am pm	Initials:

Part III Withdrawal of Application for Discharge

I, ____________________, freely and voluntarily rescind my previous oral or written Application for Discharge. No force, fraud, deceit, duress, or other form of constraint or coercion were used to obtain this withdrawal of my Application for Discharge.

____________________ Signature of Person ____________ Date ________ Time am pm

____________________ Signature of Witness ____________ Credentials of Witness ____________ Date ________ Time am pm

cc: Check when applicable and date/time/initial when copy provided:

☐ Person	Date:	Time: am pm	Initials:

See s. 394.455(9), 394.4625(2), (3), Florida Statutes
CF-MH 3051b, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Report of Law Enforcement Officer Initiating Involuntary Examination

State of Florida, County of ______________________, Florida

I,____, am a law enforcement officer certified by the State of Florida. In my opinion

____ appears to meet the following criteria for involuntary examination:

1. I have reason to believe said person has a mental illness pursuant to Section 394.455 (18), F.S., and because of the mental illness (check a or b):

   ☐ a. Person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **OR**

   ☐ b. Person is unable to determine for himself/herself whether examination is necessary, **AND**

2. Either (check all that apply)

   ☐ a. Without care or treatment said person is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his/her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; AND/**OR**,

   ☐ b There is substantial likelihood that without care or treatment the person will cause serious bodily harm to (check one or both) ☐**self** ☐**others** in the near future, as evidenced by recent behavior.

Circumstances supporting this opinion, including specific information about the person's behavior, threats and actions and information offered by others:

____

____

____

____

____

____

____

____

____

____

____

Signature of Law Enforcement Officer

__________ / __________ / 20________

________ am pm
Time

____

Printed Name of Law Enforcement Officer

____

Full Name of Law Enforcement Agency (printed)

____

Badge or ID Number

____

Law Enforcement Case Number

By Authority of s. 394.463(2)(a) 2, Florida Statutes
CF-MH 3052a, Sept 06 (obsoletes previous editions) (Mandatory Form)

BAKER ACT

Certificate of Professional Initiating Involuntary Examination

All sections of this form must be completed and legible (please print)

I have personally examined (printed name of person) ____ at time _________ am pm (time must be within the preceding 48 hours) on ________/ _______/ 20 ______ in ______________________________ **County** and that person appears to meet criteria for involuntary examination **OR** I am a physician who has determined that (printed name of person) ______________________________ has failed or has refused to comply with the treatment ordered by the court, and, in my clinical judgment, efforts were made to solicit compliance and the person appears to meet the criteria for involuntary examination. Section IV of this form is completed to document the requirements of the law.

This is to certify that my **professional license number** is: [   ] and I am a *(check one box)*

☐ Psychiatrist ☐ Physician (non-psychiatric) ☐ Clinical Psychologist ☐ Psychiatric Nurse ☐ Clinical Social Worker

☐ Mental Health Counselor ☐ Marriage and Family Therapist Each as defined in s.394.455, F.S.

Section I: CRITERIA

There is reason to believe person has a mental illness as defined in Section 394.455(18), Florida Statutes (excludes retardation or developmental disabilities, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment).

Diagnosis of Mental Illness is: List all mental health diagnoses applicable to this person		DSM Code(s) (if known)

AND BECAUSE OF MENTAL ILLNESS

☐ A. Person has refused voluntary examination after conscientious explanation of disclosure of the purpose of examination

OR
Statute requires that at least one be checked, but both may be checked if both apply

☐ B. Person is unable to determine for himself/herself whether examination is necessary

☐ A. Without care and treatment the person is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services

AND EITHER
(A and/or B)

☐ B. There is substantial likelihood that without care or treatment the person will cause serious bodily harm to (check one or both):

☐ self ☐ others

in the near future, as evidenced by recent behaviors (describe behaviors at top of page 2)

Section II: SUPPORTING EVIDENCE

A. My observations supporting these criteria including the person's behaviors and statements, specifically those related to suicidal ideation, previous suicide attempts, homicidal ideation or self-injury are as follows:

[   ]

CONTINUED OVER

Certificate of Professional Initiating Involuntary Examination (Page 2)

Section III: OTHER INFORMATION

Other information, including source relied upon to reach this conclusion is as follows. If information is obtained from other persons, describe these sources (e.g., reports of family, friends, other mental health professionals or law enforcement officers, as well as medical or mental health records).

Section IV: NON-COMPLIANCE WITH INVOLUNTARY OUTPATIENT PLACEMENT ORDER

Complete this section if you are a physician who is documenting non-compliance with an involuntary outpatient placement order: This is to certify that I am a physician, as defined in Florida Statutes 394.455(21), F.S. and in my clinical judgment, the person has failed or has refused to comply with the treatment ordered by the court, and the following efforts have been made to solicit compliance with the treatment plan:

Section V: INFORMATION FOR LAW ENFORCEMENT

Provide identifying information (if known) if needed by law enforcement to find the person so he/she may be taken into custody for examination:
Age: ___________ ☐ Male ☐ Female Race/ethnicity: ________________________ Other details (such as height, weight, hair color, clothing worn when last seen, where last seen): If relevant, information such as access to weapon, recent violence or pending criminal charges:
This form must be transported with the person to the receiving facility to be retained in the clinical record. Copies may be retained by the initiating professional and by the law enforcement agency transporting the person to the receiving facility.

Section VI: SIGNATURE

Signature of Professional:	Date Signed
Typed or Printed Name of Professional:	Phone ( )
Address of Professional:	

By Authority of s. 394.455(18), 394.463(2)(a)3, 394.4655, Florida Statutes
CF-MH 3052b, Sept 06 (obsoletes previous editions) (Mandatory Form) BAKER ACT

Authorization for Electroconvulsive Treatment

As the physician for this person, I have recommended a series of ____________ electroconvulsive treatments and have provided sufficient information to ensure express and informed consent to the treatment.

______________________________ ______________________________ ______________ ________ am pm
Signature of Physician Printed Name of Physician Date Time

I have agreed with the need for this series of __________ electroconvulsive treatments after
☐ examination of the person or ☐ review of the person's treatment records. I am not directly involved with the person.

______________________________ ______________________________ ______________ ________ am pm
Signature of Second Physician Printed Name of Second Physician Date Time

I, the undersigned, ☐ competent adult, ☐ guardian, ☐ guardian advocate, ☐ health care surrogate

authorize ____________________________ **Electroconvulsive Treatments** for ____.
Number of treatments authorized Name of Person to Receive Treatment

a person in ____
Name of Facility

The information provided to the person to make the decision to consent to electroconvulsive treatment (which must include the purpose of the procedure, the common side effects, alternative treatments, and the approximate number of procedures considered necessary and that my consent may be revoked prior to or between treatments) is:
____
____
____

I have read and understood the information provided to me above and have been given an opportunity to ask questions and receive answers about the procedures. Knowing the above, I hereby consent to the treatment described.

____ ______________ ________ am pm
Signature of Competent Adult Date Time

____ ______________ ________ am pm
Signature, * as appropriate, of: Date Time
☐ Guardian, ☐ Guardian Advocate,
☐ Parent of a Minor, ☐ Health Care Surrogate

____ ______________ ________ am pm
Signature of Witness Date Time

Facility should attach information about or copies of educational materials provided to the person and/or substitute decision maker.

*** A guardian shall produce letters of guardianship prior to authorizing ECT to demonstrate authority to provide consent. A guardian advocate requires express Court approval to provide consent to this procedure. A health care surrogate requires an advance directive expressly delegating such authority to the surrogate. In the absence of such an advance directive, a health care surrogate or proxy require express court approval to consent to ECT. The authorizing documentation must be validated by staff and filed in the person's clinical record.**

See s. 394.459(3)(b), 458.325, Florida Statutes
CF-MH 3057, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Baker Act Service Eligibility

Public Receiving Facility Name: ____

1. **IDENTIFYING INFORMATION:**
   Person's Name: ______________________________
   Date of Birth: ______________________________ Gender: ☐ Male ☐ Female Race: ______________

2. **FINANCIAL INFORMATION:** Prospective monthly income (6-month average) $__________________
   Number of Family Members: _________________ Title XX Eligible: ☐ Yes ☐ No

3. **LEGAL STATUS:** ☐ Voluntary Admission ☐ Involuntary Examination

4. **CRITERIA:** (check the appropriate criteria)
   ☐ There is reason to believe the above-named person has a mental illness, as defined in 394.455(18), **AND**
   ☐ Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself, such neglect or refusal poses a real and present threat of substantial harm to his or her well-being, and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services,
   OR
   ☐ There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

5. **MOST RECENT DSM OR ICD ADMISSION DIAGNOSIS AND CODE NUMBER**: __________________________

6. **SUMMARY**: Behavioral manifestations justifying diagnosis. (A completed CF-MH 3052a or 3052b or Ex Parte Order may be attached for persons on involuntary status)

7. **RECOMMENDED DISPOSITION / PLACEMENT**:

8. **WHY IS A LESS RESTRICTIVE PLACEMENT NOT BEING UTILIZED?**

9. **APPROVAL OF DISPOSITION/PLACEMENT** ☐ does ☐ does not include authorization for payment of contracted 24-hour care.

____ __________________ ___________ am pm
Signature of Administrator or Designee Date Time

____
Printed Name of Administrator or Designee

By authority of s. 394.74, 394.875, 394.879, Florida Statutes
CF-MH 3084, Feb 05 (obsoletes previous editions) (Mandatory Form for Public Receiving Facilities) **BAKER ACT**

Transfer Evaluation
(To a State Mental Health Treatment Facility)

I, ______________________________ ☐ concur ☐ do not concur
Full Name of Mental Health Center/Clinic Director or Chief Clinical Officer

that ______________________________, residing at ______________________________
Full Name of Person Name and Address of Receiving Facility

meets statutory criteria for ☐ voluntary or ☐ involuntary admission to a state mental health treatment facility.
I find that less restrictive community based treatment alternatives have been considered for this person and were determined to be (Check one): ☐ inappropriate ☐ unavailable ☐ appropriate and available.

If placement at a State Mental Health Treatment Facility is recommended, specify the reason for the recommendation:

____

____

____

If it is determined that the person does not meet criteria for admission to a state mental health treatment facility, and consequently a diversion to a less restrictive voluntary community-based service is appropriate, specify the recommended facility and type of service:

____

____

____

______________	______________	______________	______________ am pm
Signature of Evaluator	Printed Name and Title of Evaluator	Date	Time of Evaluation

______________ Original Signature of ☐ Executive Director or ☐ Chief Clinical Officer

______________ Date

______________ am pm Time

______________________________ Name and Address of Community Mental Health Center or Clinic

(______)______________ Telephone Number

This form is to be completed by a designated staff member employed by a Community Mental Health Center or Clinic whenever a person is being considered for admission to a state mental health treatment facility either on a voluntary or involuntary basis. In the case of potential involuntary admission, the original copy of this form shall be provided for the Court's consideration prior to the hearing on the petition for involuntary placement. The evaluator or another knowledgeable person from the center or clinic shall be present at the court hearing to provide testimony as desired by the court.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Circuit Court		am pm	
☐ District DCF Mental Health Office		am pm	

By Authority of s. 394.455(29), 394.461, Florida Statutes
CF-MH 3089, Feb 05 (obsoletes previous editions) (Mandatory Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT

IN AND FOR ____________________________ COUNTY, FLORIDA

IN RE: ____ CASE NO.: ______________________

__________________________________,
Petitioner,

vs.

__________________________________,
Administrator,

__________________________________,
Facility Respondent.

Petition for Writ of Habeas Corpus or for Redress of Grievances

1. This Court has jurisdiction pursuant to Section 394.459 (8), Florida Statutes.
2. Petitioner is being held by ____ , (Administrator) in ____, (Facility), in ________________________ (City), Florida.
3. ☐ Petitioner believes that he/she is being deprived of her/his freedom for invalid and illegal reasons. Petitioner believes that her/his confinement is illegal because: ____
____
____
____
and/or
4. ☐ Petitioner believes that he/she is being unjustly denied a right or privilege or that a procedure authorized by law is being abused. Petitioner believes that he/she is being unjustly denied a right or privilege or that a procedure authorized by law is being abused because: ____
____
____
____
5. Petitioner is unable to afford counsel and would like the Office of the Public Defender or other counsel to be appointed to represent her/him in the above captioned matter.

CONTINUED OVER

Petition for Writ of Habeas Corpus or for Redress of Grievances (Page 2)

WHEREFORE, Petitioner respectfully requests that this Court:

☐ Appoint the Office of Public Defender or other counsel to represent your Petitioner in these proceedings; and

☐ Enter an Order setting a return hearing on this Petition for Writ of Habeas Corpus for respondent to show by what legal authority he/she holds petitioner, and/or

☐ Set a hearing for the purpose of a judicial inquiry into the allegations of this Petition for Redress of Grievances and for ordering a correction of abuse of rights or privileges granted under Chapter 394, Part I, F.S.

I HEREBY CERTIFY that the above stated matters In the Petition for Writ of Habeas Corpus and Redress of Grievances are true and correct to the best of my information, knowledge, and belief.

_______________________________ _______________ __________ am pm
Signature of Petitioner Date Time

____
Printed Name of Petitioner

There ☐ is or ☐ is not a petition for involuntary placement pending.

The person ☐ is or ☐ is not currently represented by counsel.

Facilities must provide this form to any person making a verbal request for access to the Court. The completed form must be filed with the Clerk of the Court no later than the next working day and a copy retained in the person's clinical record. A copy of the completed Petition for Writ must be provided immediately to the person and copies of the Petition provided to those listed below, as applicable.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ Attorney		am pm	
☐ Health Care Surrogate/Proxy		am pm	

See s. 394.459(8), Florida Statutes
CF-MH 3090, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Application for Voluntary Admission - Minors

I ____ do hereby apply on behalf of
Full printed name of guardian of minor whose admission is being requested

______________________________ for admission to ______________________________
Full printed name of minor   Name of facility

for observation, diagnosis, care, and treatment of a mental illness, and I certify that the information given on this application is true and correct to the best of my knowledge and belief.

I am making this application for voluntary admission after sufficient explanation and disclosure so me and the minor so we can make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. The reason for admission to this facility is: ____

____

____

____

As guardian of this minor, I am a competent adult with the capacity to make well-reasoned, willful, and knowing decisions concerning medical or mental health treatment. I understand that I must keep the facility informed of my whereabouts during the time of this admission.

The minor and I have been provided with a written explanation of rights of a person on voluntary status and they have been fully explained to us. I understand that this facility is authorized by law to detain the minor without my consent for up to 24 hours after I or the minor make a request for discharge from a receiving facility; unless a petition for involuntary placement is filed with the Court as required by law within two (2) court working days of the request for discharge.

I understand that I may be billed for the cost of the minor's treatment.

Printed Name of Guardian	Signature of Guardian	Date	Time am pm
Printed Name of Witness	Signature of Witness	Date	Time am pm

I agree with the decision for me to be voluntarily admitted to this facility. This agreement is being given without any element of force, fraud, deceit, duress, or other form of constraint or coercion. I have been provided with a written explanation of my rights and they have been fully explained to me.

Printed Name of Minor	Signature of Minor	Date	Time am pm
Printed Name of Witness	Signature of Witness	Date	Time am pm

No notice of this admission is to be made without the consent of the minor's guardian except in case of an emergency. The original of this signed form must be filed in the clinical record.

See s. 394.459, 394.4625, Florida Statutes
CF-MH 3097, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Application for Voluntary Admission
(State Treatment Facility)

I, ____ do hereby apply for admission to
Full printed name of person whose admission is being requested

____
Fill in name of facility

for observation, diagnosis, care, and treatment of a mental illness, and I certify that the information given on this application is true and correct to the best of my knowledge and belief.

I am making this application for voluntary admission after sufficient explanation and disclosure to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. The reason for my admission to this facility is:

____

____

____.

I am a competent adult with the capacity to make well-reasoned, willful, and knowing decisions concerning my medical or mental health treatment. I do not have a guardian, guardian advocate, or currently a health care surrogate/proxy making health care decisions for me.

I ☐ have ☐ have not provided a copy of advance directive(s). If so, the advance directives include my
- ☐ Living Will,
- ☐ Health Care Surrogate,
- ☐ Mental Health Care Surrogate, or
- ☐ Other as specified: _________________.

I have been provided with a written explanation of my rights as a person on voluntary status and they have been fully explained to me. I understand that this facility is authorized by law to detain me without my consent for up to 3 days, not including weekends and holidays, after I make a request for discharge unless a petition for involuntary placement is filed with the Court within two (2) court working days of my request for discharge.

I understand that I will be asked to complete a financial disclosure form and may be billed for the cost of my treatment.

I understand that the facility is authorized by law to transfer me to another departmental facility when it is necessary to meet my medical needs or for the efficient use of the department's facilities. I understand that prior to transfer, the administrator of the facility will give me written notice.

______________________________ ______________ ____________ am pm
Signature of Adult Date Time

______________________ ______________________ ______________ ____________ am pm
Printed Name of Witness Signature of Witness Date Time

No notice of this admission is to be made without the consent of the person except in case of an emergency. The use of this form for a voluntary admission requires that a "Certification of Person's Competence to Provide Express and Informed Consent" be completed within 24 hours and if the form is used for a transfer of a person from involuntary to voluntary status, the "Certification" must be completed prior to the "Application". The "Application" and "Certification" must be placed in the person's clinical record.

See s. 394.455(9), 394.459, 394.4625, Florida Statutes
CF-MH 3098, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Certification of Ability to Provide Express and Informed Consent For Voluntary Admission and Treatment of Selected Persons From Facilities Licensed under Chapter 400, F.S.

On ___________________________, at _______________ (a.m.) (p.m.) ____,
Date | Time | Print Name of the Person

who resides at ____
Person's Residence Name and Address

made application by express and informed consent for voluntary admission to ____________________________________

facility located at ____.
Address of Facility

He or she is: (Check the box that applies)

☐ A person 60 years of age or older diagnosed with dementia for whom transfer is being sought from nursing home, assisted living facility, adult day-care center, or adult family-care home.

☐ A person 60 years of age or older for whom emergency transfer is being sought from a nursing home pursuant to s. 400.0255(6).

☐ A person for whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy designated under Chapter 765, F.S.

He/she ☐ does or ☐ does not have the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.

He/she ☐ has or ☐ has not consented in writing, after sufficient explanation and disclosure of the need for admission, without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

The observations on which I have reached this conclusion are:

____

____

____

_____________________________________ ___________________________ _______________ am pm
Signature of Assessor * | Date of Assessment | Time of Assessment

_____________________________________ ___________________ ______________________
Typed or Printed Name of Assessor | Profession | License Number (if any)*

*** If publicly funded assessor is not licensed, specify the name, profession and license number of supervising professional:**
Name: ____________________________________ Profession: ________________________ License #: ________________

Name of Mental Health Overlay Program (a service provided under contract with the Department of Children & Families and attached to a public receiving facility): ____

Name of Mobile Crisis Response Service (a service provided under contract with the Department of Children & Families and attached to a public receiving facility): ____

Name of Community Mental Health Center or Clinic (publicly funded, not-for-profit center under contract with the Department of Children & Families): ____

OVER FOR USE BY INDEPENDENT PROFESSIONAL

Certification of Ability to Provide Express and Informed Consent For Voluntary Admission and Treatment of Selected Persons From Facilities Licensed Under Chapter 400, F.S. (Page 2)

When an initial assessment of the ability of a person to give express and informed consent to treatment is required and a mobile crisis response service does not or cannot respond to the request for an assessment within two (2) hours after the request is made, the requesting facility may arrange for assessment by any licensed professional authorized to initiate an involuntary examination, pursuant to s. 394.463 who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made. I certify that the mobile crisis service, if one exists, has been contacted and cannot respond within the 2-hour period and that I have no conflict of interest as defined above.

NOTICE: Under the provisions of s. 400 F.S. and 394.4625(1)(c), it is unlawful for this assessment to be conducted by any professional who is employed by, under contract with, or who has a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made.

The person applying for voluntary admission ☐ does or ☐ does not have the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.

He/she ☐ has or ☐ has not consented in writing, after sufficient explanation and disclosure of the need for admission, without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

The observations on which I have reached this conclusion are:

____

____

____

____

____

____________________	____________	____________ am pm
Signature of Independent Professional	Date	Time of Assessment
____________________	____________	____________
Typed or Printed Name of Professional	Profession *	License Number

* Physician, Clinical Psychologist, Clinical Social Worker, or Psychiatric Nurse whose education, training, experience, and licensure comply with statutory provisions of s. 394.455, F.S. A Licensed Mental Health Counselor is also authorized to perform this assessment on or after July 1, 2005.

Distribution:
☐ Original to the Receiving Facility for retention in person's clinical record
☐ Facility at which the person was assessed
☐ Assessor

See s. 395.455(9), 394.4625(1)(a), (b), (c), Florida Statutes
CF-MH 3099, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Transportation to Receiving Facility

Part I: General Information

The circumstances, under which (Name of Person) ______________________________ was taken into custody are as follows:

Time: am pm Date:

Place or Facility Name:

Pick Up Address:

Family members or others present when person was taken into custody			
Name	Address	Relationship	Phone Number
Next of Kin (if known)			

Indicate personal knowledge by family members and others about the person's condition.

Delivered to (Nearest Receiving Facility):

Basis for Custody: (Check one) ☐ Ex Parte Order ☐ Certificate of Mental Health Professional ☐ Report of Law Enforcement Officer

Signature of Law Enforcement Officer

Date

Time am pm

Printed Name of Law Enforcement Officer

Full Name of Law Enforcement Agency

Badge or ID Number

Law Enforcement Case Number

CONTINUED OVER

Part II - Used When Law Enforcement Consigns Persons to Contract Transport (Page 2) or to Emergency Medical Personnel

If transport is used due to the medical condition of the person or due to a county-funded contract with a transport company, print the name of the company ______________________________

which will transport the person to the nearest emergency room in the case of a medical emergency or, if not a medical emergency, to the nearest designated receiving facility ______________________________.
(specify facility to which person is to be taken)

The law enforcement agency and the transport service must agree that the continued presence of law enforcement personnel is not expected at the time of consignment to be necessary for the safety of the person or others.

I, ______________________________ of the ______________________________
Printed Name of Law Enforcement Officer — Printed Name of Law Enforcement Agency

and

I, ______________________________ of the ______________________________
Printed Name of Medical Transport Service Representative — Printed Name of Medical Transport Service

agree that the continued presence of the law enforcement agency is not expected to be necessary for the safety of ______________________________ or others. By affixing my legal signature and date/time of signing below, I understand that continued transporting of the person named above to a receiving facility is no longer the responsibility of law enforcement agency. The responsibility is assumed by the medical transport service in accordance with s. 394.462 (1), F.S.

______________________________ ______________________________ ______________ am pm
Signature of Law Enforcement Officer — Date Signed — Time Signed

______________________________ ______________________________ ______________ am pm
Signature of Representative of Medical Transport Service — Date Signed — Time Signed

This form must be delivered with the person to the receiving facility for inclusion in the clinical record. A copy may be retained by the law enforcement agency and by the medical transport service.

By Authority of s. 394.462(18), 394.463, Florida Statutes
CF-MH 3100, Feb 05 (obsoletes previous editions) (Mandatory Form)

BAKER ACT

Hospital Determination That
Person Does Not Meet Involuntary Placement Criteria

☐ I have personally examined ______________________________, a person for whom an involuntary examination has been initiated pursuant to 394.463 who was brought to ______________________ Hospital (**not designated as a Baker Act receiving facility**) for evaluation or treatment of an emergency medical condition.

☐ I have conducted the initial mandatory involuntary examination, including documenting observations of the person's recent behavior, reviewing the form initiating this examination and the transportation form, conducting a brief psychiatric history, and conducting a face-to-face examination of the person.

Check at least one box from each of the two categories below:

I have determined that he/she does **NOT** meet the criteria for involuntary **inpatient** placement pursuant to 394.467 based upon one or more of the following reasons:

- ☐ Does not suffer from a mental illness, as defined in s. 394.455(18)
- ☐ Has not refused placement or is able to determine for himself or herself that placement is necessary
- ☐ Is not likely to suffer from neglect posing a real and present threat of substantial harm nor is there substantial likelihood that in the near future he/she will inflict serious bodily harm on self or others as evidenced by recent behavior causing, attempting, or threatening such harm.
- ☐ There are available less restrictive treatment alternatives offering an opportunity for improvement of his/her condition

AND

I have determined that he/she does **NOT** meet the criteria for involuntary **outpatient** placement pursuant to394.4655 based upon one or more of the following reasons:

- ☐ Person is under age 18;
- ☐ Does not suffer from a mental illness, as defined in s. 394.455(18)
- ☐ Person is likely to survive safely in the community without supervision, based on my clinical determination;
- ☐ Person has no history of lacking compliance with treatment for a mental illness
- ☐ Person has not within the preceding 36 months been involuntarily admitted to a Baker Act receiving or treatment facility, or received mental health services in a forensic correctional facility or engaged in one or more acts of serious violent behavior toward self or other, or attempts at serious bodily harm to self/others;
- ☐ Person has not been found to be unlikely to voluntarily participate in recommended treatment and has not either refused voluntary placement or been found to be unable to determine whether placement is necessary;
- ☐ Person hasn't been found, based on his/her treatment history and current behavior, to need involuntary outpatient placement to prevent a relapse or deterioration that would be likely to result in serious bodily harm to self or others, or a substantial harm to his/her well-being;
- ☐ There has been no finding that it is likely the person will benefit from involuntary outpatient placement; **or**
- ☐ There are less restrictive treatment alternatives available that offer an opportunity for improvement of his/her condition

This examination was conducted at ______________ a.m. p.m. on ______________________.
Time of Examination / Date of Examination

As a physician or licensed clinical psychologist and recognized by this hospital as eligible to perform the involuntary examination, I have: ☐ Offered voluntary placement of this person OR ☐ Approved the direct release of this person from the hospital.

______________________________ ______________ ____________ am pm
Signature of ☐ Physician ☐ Clinical Psychologist Date Time

______________________________ ______________________
Typed or Printed Name of Examiner License Number

If a person is released from a hospital after being evaluated or treated for an emergency medical condition, this completed form or its equivalent must be completed and retained in the person's clinical record and a Notice of Release or Discharge (CF-MH 3038 or equivalent) must be given or sent to the person, the person's guardian, to any person who executed a Certificate, and to any Court which ordered the person's examination.

See s. 394.455(2), (18), (21), 394.463(2)(f), (g), (h), 394.467, Florida Statutes
CF-MH 3101, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Request for Involuntary Examination after Stabilization of Emergency Medical Condition

The following person ________________________________, for whom an involuntary examination has been initiated has been evaluated or treated at ________________________________ Hospital located at ________________________________ for an emergency medical condition.

a. The person arrived at this hospital at: __________ am pm on ____________________, 20_____.
b. The attending physician documented that the person had an emergency medical condition at:
__________ am pm on ______________, 20__.
c. The attending physician documented at __________ am pm on ________________, 20___

☐ That the person's medical condition had stabilized, or
☐ That an emergency medical condition did not exist

This hospital is notifying ________________________________, a designated receiving facility or the psychiatric unit within this hospital, within two (2) hours of the time noted in (c) above that the person must be examined by a designated receiving facility and released; or the person must be transferred to a designated receiving facility in which appropriate medical treatment is available.

Within 12 hours of the time noted in (c) above, the designated receiving facility: (check one or both boxes)

☐ **S**hall perform the involuntary examination at this hospital or,

☐ Shall, if it has available the appropriate medical treatment, accept transfer of the person.

The nature and extent of this person's current medical problems: ________________________________
____
____
____

This hospital, pursuant to federal and state statutes, will provide or secure transport of this person via: ________________________
with expected time of arrival of: __________ am pm on ____________, 20______ unless other methods of transportation have been arranged as specified:
____
____
____

________________________________	________________	________________	__________ am pm
Signature of Administrator or Designee	Credentials	Date	Time

________________________________	________________________________
Typed or Printed Name	Name of Hospital

*** Transfers of persons in a psychiatric emergency must be performed in compliance with the federal EMTALA law. This completed form must be given to the receiving facility with the form initiating the involuntary examination prior to or at the time of the transfer of the person with a copy retained in the clinical record. The person shall not be held for involuntary examination longer than a total of 72 hours plus the period during which an emergency medical condition was declared by the attending physician.**

See s. 394.463(g), (h), Florida Statutes
CF-MH 3102, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Rights of Persons

In Mental Health Facilities and Programs

The following rights are guaranteed to you under Florida law. These will be fully explained to you at the time of and following admission to this facility. A copy of this form will be given to you to keep. You have the right to read the Baker Act law and rules at any time. Your signature on the form, if you choose to sign, only acknowledges that you have had the rights explained and that a copy of this form was provided to you.

Individual Dignity

You have the right to individual dignity and access to all constitutional rights. The federal Americans with Disabilities Act (ADA) applies to persons in this facility.

Right to Request Discharge by Persons on Voluntary Status

If you request discharge, your doctor will be notified and you will be discharged within 24 hours from a designated community facility and within 3 working days from a state hospital, unless you withdraw your request or you meet the criteria for involuntary placement. If you meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the hospital administrator must file a petition with the Court for your continued stay within two (2) working days of your request for discharge.

Designation of Representative

You will be asked to identify a person to be notified in case of an emergency. Further, if you are at this facility for involuntary examination and do not have a guardian appointed by the court, you will be asked to designate a person of your choice to receive notification of your presence in this facility, unless you request that no notification be made. If you do not or cannot designate a representative, a representative will be selected for you by the facility from a prioritized list of persons. You have the right to be consulted about the person selected by the facility and you can request that such a representative be replaced.

Communication

You have the right to communicate openly and privately by phone, mail, or visitation with persons of your choice during your stay at this facility. You have the right to make free local calls and will be given access to a long distance service for collect calls. If communication is restricted, you will be given a written notice including the reasons for the restrictions. This facility is required to develop reasonable rules governing visitors, visiting hours, and the use of telephones but you cannot be limited in your access to your attorney, to a phone for the purpose of reporting abuse, in contacting the Florida Local Advocacy Council or the Advocacy Center for Persons with Disabilities. Several toll-free telephone numbers you may wish to keep are:

Florida Abuse Registry	1 800 96-ABUSE (962-2873) TDD: 1-800-453-5145
Advocacy Center for Persons with Disabilities	1 800 342-0823

Confidentiality of Information and Records

Information about your stay in this facility is confidential and may not be released, except under special circumstances, without your consent (or the consent of your guardian or guardian advocate or health care surrogate/proxy if you have one). Special circumstances include release of information to your attorney, in response to a court order, to an aftercare treatment provider, or after a threat of harm to another person. You have the right of reasonable access to your clinical record unless such access is determined to be harmful to you by your physician.

Treatment

You have the right to receive the least restrictive, available, appropriate treatment in this facility. You will get a physical examination within 24 hours of arrival and you will be asked to help develop a treatment plan to meet your individual needs. The criteria, procedures, and required staff training used by this facility for restraints, seclusion, isolation, emergency treatment orders, close levels of supervision, or physical management are available for your review. Such interventions may never be used for punishment, convenience of staff, or to compensate for inadequate staffing.

Advance Directives

You have the right to prepare an advance directive when competent to do so that specifies the mental health care you want or don't want and to designate a health care surrogate to make those decisions for you at the time of crisis. The facility is required to make reasonable efforts to honor those choices or transfer you to another facility that will honor your choices. The facility must document whether you have an advance directive and inform you of its policies about advance directives. There are organizations that can help you prepare an advance directive.

(Continued Over)

Rights of Persons

In Mental Health Facilities and Programs (page 2)

Informed Consent

Before any treatment is given to you, you will be given information about the proposed treatment, the purpose of the treatment, the common side effects of medication you receive, alternative treatments, the approximate length of care, and that any consent given may be revoked at any time by you, your guardian your guardian advocate, or your health care surrogate/proxy. There are additional disclosures that must be made for mediations you receive. If the treatment for which you have given consent is changed at any time during your stay in this facility, it will be fully explained by the staff prior to asking for your written consent to the revised treatment.

Clothing and Personal Effects

You have the right to keep your clothing and personal effects unless they are removed for safety or medical reasons. If they are taken from you, an inventory of the possessions will be prepared and given to you to sign. The possessions will be immediately returned to you or your representative upon your discharge or transfer from this facility.

Habeas Corpus

You or your representative has the right to ask the Court to review the cause and legality of your detention in this facility or if you believe you have been unjustly denied a legal right or privilege or an authorized procedure is being abused. A petition form will be given to you by staff upon your request. If you wish to file a habeas corpus petition, you can submit it to a facility staff member, and it will be filed with the court for you by the facility no later than the next court working day.

Voting

You have the right to register to vote and to cast your vote in any elections unless the court has removed this right from you. Staff will assist you in arranging for registration or voting.

Discharge

You have the right to seek treatment from the professional or agency of your choice after your discharge from this facility.

______________________________ ______________ ____________ am pm
Person's Signature Date Time

______________________________ ______________ ____________ am pm
Signature, if applicable, of ☐ Guardian ☐ Guardian Advocate Date Time
☐ Representative ☐ Health Care Surrogate/Proxy

______________________________ ______________ ____________ am pm
Witness Signature Date Time

This form must be retained in the clinical record as a receipt that the person received notice of his/her rights at the time of admission. A copy must be given to the person and to any authorized decision-maker for persons incompetent or incapacitated by age or disability.

cc: Check when applicable and initial/date/time when copy provided

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		a m pm	
☐ Representative		am pm	
☐ Health Care Surrogate/Proxy		am pm	

See s. 394.459, 394.4615, Florida Statutes

CF-MH 3103, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Certification of Person's Competence
To Provide Express and Informed Consent

I have personally examined______________________________, a person being served at _________________ ____________________________________facility on __________________, 20____ at ___________ am pm.

Express and informed consent means consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

This person is 18 years of age or older, is not now known to be incapacitated with a guardian, is not now known to be incompetent to consent to treatment with a guardian advocate, and does not have a health care surrogate or proxy currently making medical treatment decisions. I have found this person to be one of the following:

☐ Competent to provide express and informed consent, as defined above, for voluntary admission to this facility and is competent to provide express and informed consent for treatment. He/she has the consistent capacity to make well reasoned, willful, and knowing decisions concerning his or her medical or mental health treatment. The person fully and consistently understands the purpose of the admission for examination/placement and is fully capable of personally exercising all rights assured under section 394.459, F.S.

☐ Incompetent to provide express and informed consent to voluntary admission. and thus is incompetent to provide express and informed consent to treatment. The person must be transferred to involuntary status and a petition for a guardian advocate filed with the Circuit Court. .

☐ Refusing to provide express and informed consent to voluntary admission but is competent to provide express and informed consent for treatment. The person must be discharged or transferred to involuntary status.

____ ______________________________________

Signature of Physician License Number

____ ______________________ __________ am pm

Typed or Printed Name of Physician Date Time

Form shall be completed within 24 hours of a person's arrival at the receiving facility and filed in the clinical record of each person:

1. Admitted on a voluntary basis
2. Permitted to provide express and informed consent to his/her own treatment.
3. Allowed to transfer from involuntary to voluntary status
4. Prior to permitting a person to consent to his or her own treatment after having been previously found incompetent to consent to treatment.

See s. 394.459(3), 394.4625(1)(f), Florida Statutes
CF-MH 3104, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Refusal or Revocation of Consent to Treatment

PART I

_______________________________________, a person in this facility, ☐ refuses consent ☐ revokes previous consent;

OR _______________________________________, the ☐ guardian, ☐ guardian advocate, or ☐ health care surrogate/proxy for

_______________________________________, a person who is incapacitated or incompetent to consent to treatment in this facility,

☐ refuses consent ☐ revokes previous consent for: ☐ All treatment, **or** ☐ The following treatment:

____

____

The reason given for this refusal/revocation, if any, is: _______________________________________

____

_______________________________________ _______________ ___________ am pm
Signature of Competent Adult (or staff if oral refusal) Date Time

_______________________________________ _______________ ___________ am pm
If incompetent, signature of ☐ Guardian, ☐ Guardian Advocate, Date Time
☐ Health Care Surrogate, ☐ Health Care Proxy

PART II Facility Response

A person on voluntary status who has been admitted to a facility and who refuses to consent to or revokes consent to treatment shall be discharged within 24 hours after such refusal or revocation, unless transferred to involuntary status or unless the refusal or revocation is freely and voluntarily rescinded by the person. The guardian, guardian advocate, or health care surrogate/proxy has the right to refuse or revoke consent to treatment. The decision of the guardian, guardian advocate, or health care surrogate/proxy may be reviewed by the court, upon petition of the person's attorney, the person's family, or the facility administrator.

The facility's response to the refusal/revocation of consent was: _______________________________________

____

____

_______________________________________ _______________________________________
Staff Signature Profession

_______________________________________ _______________ ___________ am pm
Typed or Printed Name of Staff Date Time

PART III Withdrawal of Refusal or Revocation of Consent to Treatment

I, _______________________________________, freely and voluntarily rescind my previous refusal or revocation of consent to

treatment for the following reason(s): _______________________________________

____

_______________________________________ _______________ ___________ am pm
Signature of Authorized Decision-Maker Date Time
☐ Person, ☐ Guardian, ☐ Guardian Advocate,
☐ Health Care Surrogate, ☐ Health Care Proxy

_______________________________ _____________ _____________ _________ am pm
Signature of Witness Credentials Date Time

See s. 394.4625(2)(b), Florida Statutes
DCF-MH 3105, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT
IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ____ CASE NO.: __________________________

Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate

PART I

I, ____, Administrator of

____
Name of Facility

____
Facility Address

hereby recommend that ____ be

adjudicated incompetent to consent to:

- ☐ Mental health treatment
- ☐ Medical treatment

and that a guardian advocate be appointed to make such health care decisions for the person. The person is presently placed in the County of _________________________ and has residence in the County of ______________________.

OR

Is presently ordered to involuntary outpatient placement in the County of :___________________________________.

PART II Psychiatric Opinion Supporting the Petition

I,____, a psychiatrist authorized to practice in the State of Florida, have personally examined ______________________________________
Name of Person Examined

on __________________, and found his/her judgment to be so affected by a mental illness that he/she lacks the
Date

capacity to make a well-reasoned, willful, and knowing decision concerning his/her ☐ medical and/or ☐ mental health care. Observations which support this opinion are: ____

____

____

____

____

____

____ ______________________ ______________ am pm
Signature of Psychiatrist | Date | Time

____ ______________________________________
Typed or Printed Name of Psychiatrist | License Number

CONTINUED OVER

Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate (Page 2)

PART III - Proposed Guardian Advocate

____, who resides at

____ and whose

relationship to the person is ______________________, has agreed to serve as guardian advocate.

He/she has been provided with information about the duties and responsibilities of guardian advocates, including the information about the ethics of medical decision-making.

_______________________________ ______________ __________ am pm
Signature of Administrator or Designee Date Time

____
Typed or Printed Name of Administrator or Designee

Complete Parts I, II, and III to Petition for a Guardian Advocate

Complete Part I only to petition the Court to expand a current guardian advocate's authority to provide consent to medical treatment in addition to mental health treatment.

Complete Part I and Part III to request the circuit court to appoint a substitute guardian advocate for one who cannot or will not perform his or her duties.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initial of Who Provided Copy
☐ Person		am pm	
☐ Representative		am pm	
☐ Current Guardian Advocate		am pm	
☐ Prospective Guardian Advocate		am pm	
☐ Person's Attorney		am pm	

See s. 394.4598(1), (2), (3), (4), (5), (6), Florida Statutes
CF-MH 3106, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT

IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ____ CASE NO.: __________________________

Order Appointing Guardian Advocate

This matter came to be heard on the issue of whether the above-named person should be adjudicated incompetent to consent to treatment, and the Court finds by clear and convincing evidence as follows:

1. Said person has been represented by counsel.
2. Said person is not presently adjudicated incapacitated with a duly appointed guardian with authority to consent to treatment.
3. Said person meets the definition for being incompetent to consent to treatment pursuant to Section 394.455 (15), Florida Statutes.

   This finding is determined from the testimony of ____. The court has considered testimony and other evidence regarding said person's competence to consent to treatment and based on such testimony and evidence has concluded that said person is not competent to consent to treatment.

On the basis of these findings, it is hereby,
ORDERED

That the above-named person presently within the county, is incompetent to consent to treatment because his/her judgment is so affected by a mental illness that he/she lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical and/or mental health treatment.

____, whose relationship to the person is:
Name of Guardian Advocate

1. ☐ Health Care Surrogate
2. ☐ Person's Spouse
3. ☐ Person's Adult Child
4. ☐ Person's Parent
5. ☐ Person's Adult Next of Kin
6. ☐ Person's Adult Friend
7. ☐ Adult Trained and Willing to Serve

Has agreed to serve as guardian advocate and:

a. Will obtain from the facility sufficient information in order to decide whether to give express and informed consent to the treatment, including information that the treatment is essential to the care of the person, and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects.
b. Has agreed to meet and talk to the person and the person's physician in person, if at all possible, and by telephone if not, before giving consent to treatment.
c. Has or will undergo a training course approved by this Court prior to exercising this authority, unless waived by this Court.
d. Will be provided access to the appropriate clinical records of the person.

This guardian advocate has been given authority by this Court to consent, refuse consent, or revoke consent for:

☐ mental health treatment ☐ medical treatment

but may not consent to abortion, sterilization, electroconvulsive treatment, psychosurgery, or experimental treatments unless express Court approval in a separate proceeding is given.

This appointment as Guardian Advocate shall terminate upon the discharge of the person from an order for involuntary outpatient placement or involuntary inpatient placement or the transfer of the person to voluntary status, or an order of the court restoring the person's competence.

DONE AND ORDERED this _______________ day of _________________________, _______________

_____________________________________ _____________________________________
Printed Name of Circuit Court Judge Signature of Circuit Court Judge

cc: ☐ Person _____ ☐ Guardian Advocate _____ ☐ Representative _____ ☐ Facility Administrator _____ ☐ Person's Attorney

See s. 394.455(15), 394.4598(1), (2), (3), (4), (6), (7), Florida Statutes
CF-MH 3107, Feb 05 (obsoletes previous editions) (Recommended Form)

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT

IN AND FOR __________________________ COUNTY, FLORIDA

IN RE: ________________________________ CASE NO.: ________________________

Petition Requesting Court Approval for Guardian Advocate to Consent to Extraordinary Treatment

____, guardian advocate appointed on ________________

Name of Guardian Advocate Date

for ____,

Name of Person.

Said person is presently:

☐ Placed on an inpatient basis in ____a receiving or treatment facility in

_____________________ County and has residence in __________________________ County, or

☐ Involuntarily placed on an outpatient basis in _______________County. The service provider is: _____________________

Psychiatric or Medical Opinion Supporting the Petition

I,__________________________, a psychiatric or physician authorized to practice in the State of Florida,

Name of Psychiatrist or Physician

have personally examined ____ on _______________, and found

Name of Person Date

that he/she is in need of the following treatment or procedure: ____

____

Observations which support this opinion are: ____

____

____

This treatment or procedure is essential to the care of the person and the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects.

____ ________________ __________ am pm

Signature of: ☐ Psychiatrist ☐ Physician Date Time

____ ____________________________

Typed or Printed Name of Psychiatrist or Physician License Number

____ ______________ __________ am pm

Guardian Advocate's Signature Date Time

____

Typed or Printed Name of Guardian Advocate

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ Person's Attorney		am pm	
☐ Facility Administrator		am pm	

See s. 394.4598(6), Florida Statutes

CF-MH 3108, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT

IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ___________________________________ CASE NO.: __________________________

Order Authorizing Guardian Advocate to Consent to Extraordinary Treatment

This matter came to be heard on the issue of whether ____ guardian
Name of Guardian Advocate

advocate for the above-named person who is involuntarily placed should be given express court approval for extraordinary treatment. Upon the evidence presented, the Court finds as follows:

1. The petitioner was appointed as the guardian advocate for the above-named person by order previously entered in this cause after an earlier hearing.

2. The person has been represented by counsel.

3. The treatment or procedure approved herein is essential to the care of the person and the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects.

On the basis of these findings, it is hereby,
ORDERED

That the above-named guardian advocate for the above-named person, presently within the county, is authorized to provide consent for:

____.

The Guardian Advocate's appointment shall terminate upon the discharge of the person from an order for involuntary outpatient placement or involuntary inpatient placement, or when the person is transferred to voluntary status, or by order of the court restoring the person's competence.

DONE AND ORDERED this _______________ day of ___________________, _________________.

____ ____
Printed Name of Circuit Court Judge Signature of Circuit Court Judge

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initial of Who Provided Copy
☐ Person		am pm	
☐ Guardian Advocate		am pm	
☐ Person's Attorney		am pm	
☐ Facility Administrator		am pm	

See s. 394.4598(6), Florida Statutes
CF-MH 3109, Feb 05 (obsoletes previous editions) (Recommended Form) **BAKER ACT**

Restriction of Person's Access to Own Record

____, served currently or in the past by this facility made a request on ______________________________ (Date) to inspect his /her clinical record. The clinical record means all parts of the record required to be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by a facility which pertains to the person's hospitalization and treatment. This access was restricted in the following way: ____

____

____

The reasons for this restriction were: ____

____

____

The harm to the person as a result of such access was determined by the person's physician to be: ______________________

____

____

____

This restriction will expire on __________________ (Date) (automatically expires after 7 days but may be renewed after review for subsequent 7 day periods).

____ _________________ ____________ am pm
Signature of Person's Physician Date Time

______________________________________ ___________________________
Typed or Printed Name License Number

This form must be completed and filed in the person's clinical record at any time an oral or written request is made by a person to see his/her record and the facility does not produce the requested information. Facility policies and procedure shall govern criteria for determining what information may be harmful to persons served by the facility, establishing a reasonable time for responding to requests for access, identifying methods of providing access that ensure clinical support to the person while securing the integrity of the record, etc. Any renewal of the restriction of access shall require written justification.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ Attorney		am pm	

See s. 394.455(3), 394.4615(9), Florida Statutes
CF-MH 3110, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT

Cover Sheet to Agency for Health Care Administration

This form must be completed, attached to each of the forms listed below and sent by the receiving/treatment facility or service provider within one working day of the person's arrival at the facility/provider or upon the facility/provider's receipt of a court order for involuntary inpatient placement or involuntary outpatient placement to:

BA Reporting Center FMHI – MHC 2637 13301 Bruce B. Downs Blvd. Tampa, FL 33612-3807	Questions about form completion and receipt may be addressed to bareporting@fmhi.usf.edu or by calling 813-974-9665. Additional information about form completion can be found at http://bakeract.fmhi.usf.edu.

Check the box to indicate the type of form attached:

- ☐ Ex-Parte Order for Involuntary Examination
- ☐ Report of Law Enforcement Officer Initiating Involuntary Examination
- ☐ Certificate of Professional Initiating Involuntary Examination
- ☐ Involuntary Inpatient Placement Order
- ☐ Involuntary Outpatient Placement Order
- ☐ Continued Involuntary Outpatient Placement Order

Identifying Information about the person (if known)

Person's Name (Please Print):

Florida County of Residence: ______________________________ **or** **State (If not FL)** ___________

Florida Zip Code of Residence: _______ _______ _______ _______ _______ ☐ **Homeless (no zip code)**

Social Security Number: _____ _____ _____ - _____ _____ - _____ _____ _____ _____

Date of Birth [ ] [ ] -- [ ] [ ] -- [ ] [ ] [ ] [ ]
M M D D Y Y Y Y

Gender
- ☐ Female
- ☐ Male

Race
- ☐ Caucasian/White
- ☐ African-American/Black
- ☐ Asian
- ☐ Other

Hispanic Origin?
- ☐ Yes
- ☐ No

Immediately prior to this exam and/or placement, was the person in:

Yes	*No*	**Answer for Adults ONLY (18 and over)**
☐	☐	A nursing home?
☐	☐	An assisted living facility?
☐	☐	Jail (i.e., sent for examination from jail)?
Yes	*No*	**Answer for Children Only (under 18)**
☐	☐	Department of Juvenile Justice Custody?
☐	☐	DCF custody (such as shelter or foster care)?
☐	☐	School?

Name of Provider:

Address:

Provider Phone Number (________) __________ - ______________ ext __________

OR ***FMHI Assigned Provider #***

Name of Person Completing Form (Please Print):

Date Person Arrived at Facility: ____________________ **Date Mailed to BA Reporting Center:** _____________________

By Authority of s. 394.463, Florida Statutes
CF-MH 3118, Sept 06 (obsoletes previous editions) (Mandatory Form but name/address/phone number/FMHI number for provider may be preprinted.)

Personal Safety Plan (page 3)

11. Room Checks:

Room checks are done at night to make sure you are okay. In order to make room checks as non-intrusive as possible is there anything that would make room checks more comfortable for you? ______________________________
____
____
____

12. Trauma History:

Do you have any issues regarding abuse such as sexual or physical abuse that you would like to talk about with staff, or with counselor? Yes___ No___

Would you like more information on these issues in classes or support groups? Yes____ No____

13. Anything Else?

Is there anything else that would make your stay easier and more comfortable? For example do you have any special issues like cultural, diet, sexual preference, appearance, etc. that you think could contribute to misunderstandings or cause problems for you? Please describe:

____
____
____
____
____
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____
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____
____
____

The Personal Safety Form Information should be presented to the treatment team and incorporated into the treatment plan for this individual. Each individual shall receive a copy. This form has been adapted from an original form created by the Massachusetts Department of Mental Health

See s. 394.453, and 394.459(4) Florida Statutes
CF-MH 3124, Feb 05 (obsoletes previous editions) (Recommended Form)

Application for Designation as a Receiving Facility

Name of Applicant Facility: ____

Street Address: ____

City: ___________________________________ , FL Zip Code: _____________ - _____________________

Telephone Number: (_____)_________________________________

Administrator: ____

Provide complete responses to the following questions and issues, attaching additional sheets where necessary.

1. Designation requested for:
   - ☐ All populations
   - ☐ Adults Only – Approved Transportation Exception Plan attached
   - ☐ Minors Only – Approved Transportation Exception Plan attached

2. The following are the street addresses for each location at which persons will be received or treated for involuntary examination. Each will operate 24 hours / 7 day a week emergency services and psychiatric licensed beds.

Name of Facility	Street Address	City	Zip Code

3. Psychiatric services, including any distinct programs to be provided to each of the following consumer groups, and the projected numbers of persons to be served in each group are as follows:

	Psychiatric Services	Distinct Programs	Projected Number
Minors below 10 years of age			
Minors between the ages of 10 to 17 years			
Adults			
Persons 60 or more years of age			
Other specialty groups			

CONTINUED OVER

Application For Designation as a Receiving Facility (Page 2)

4. The community need for maintaining or expanding the present level of service to meet the existing need, and why this applicant is best suited for this purpose. Included is information about the public's need for specialty services to specific age or disability groups. Evidence of such need may include certificate of need data and other information published by the Agency for Health Care Administration, the organization's or community's utilization of available or licensed psychiatric bed capacity, geographic accessibility information, input from local governmental agencies. (Attach response on separate sheet(s).)

5. The facility's compliance program, including key facility protocols which will be used to assure all involved practitioners and staff are knowledgeable of, and implement legal rights of persons served by the facilities and providers, key psychiatric care, records standards, complaint reporting, and investigation and reviews, to maintain a consistently high level of compliance with applicable Baker Act laws, ethical principles, and rights protections are as follows: (Attach response on separate sheet(s).)

6. The facility's complaint and grievance system, including any mandatory time frames is as follows. Attach pamphlet used by the facility to educate persons served by the facility and family members about this system. (Attach response on separate sheet(s).)

7. Protocols to prevent the organization, its staff, its contractors, and its privileged professionals from economic exploitation of, trafficking persons among facilities for economic purposes or similar activities prohibited by s. 817.505, F.S., and related statutes are as follows: (Attach response on separate sheet(s).)

8. Frequent, if not daily opportunity for persons to receive exercise, fresh air and sunshine, except as individually restricted and documented in the person's record and within the physical limitations of the facility are assured by the following: (Attach response on separate sheet(s).)

9. The means utilized to create a low stimulation or separate psychiatric emergency reception and triage area that minimizes individual's exposure to undue and exacerbating environmental stresses while awaiting or receiving services is as follows (general hospitals only): (Attach response on separate sheet(s).)

10. Continuing aftercare or post discharge psychiatric care services provided at the receiving facility other than referral or transfer are as follows: (Attach response on separate sheet(s).)

11. The facility's discharge planning policies provide for continuity of medication availability until post-discharge follow-up services are scheduled are as follows. (Attach response on separate sheet(s).)

CONTINUED

Application For Designation as a Receiving Facility (Page 3)

Certifications:
Submission of this application constitutes authorization by the applicant and release for the Department of Children and Families, to make inquiries and obtain information about the conduct of the applicant, its key employees and contractors, and it's psychiatric services management company, to verify the representations and information provided in this application. Application for designation as a receiving facility is agreement to abide by all statutes and rules governing the Baker Act and related laws.

I certify that the above information and information on the attachments is correct:

Signed for the Facility ____ Date __________________

Typed Name: __________________________________ Title: ____________________________________

Attachments:

1. A copy of the facility's license issued pursuant to chapter 394 or 395, F.S., evidencing its eligibility to apply for designation.
2. A copy of the most recent state monitoring or licensing survey report.
3. Copy of the most recent survey report of the organization by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) or, if not JCAHO accredited, by another national accrediting body.
4. A current Certificate of Good Standing for the applicant organization issued by the Florida Secretary of State.
5. Documentation of the applicant's governing authority, authorizing the application for designation.

By Authority of s. 394.461, Florida Statutes
CF-MH 3125, Feb 05 (obsoletes previous editions) (Mandatory Form) **BAKER ACT**

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT

IN AND FOR __________________________ COUNTY, FLORIDA

IN RE: ___________________________________ CASE NO.: _________________________

Petition for Involuntary Outpatient Placement

COMES NOW the Petitioner, ____ , and alleges:

1. That Petitioner is Administrator of: ____
   Name of Receiving or Treatment Facility   Facility Address

2. That __________________________ , is served in said receiving or treatment facility and has been examined at such facility

3. The person's social security number is____________________________ and date of birth is:________________________

4. That this petition is being filed within the following time frames: (Check one below)

☐ A. This person was admitted for involuntary examination and this petition is being filed within the 72-hour examination period, or if the examination period ends on a weekend or legal holiday, on the next court working day **OR**

☐ B. This person was transferred to involuntary status after examination or after refusing/revoking consent to treatment or requesting discharge from the facility and this petition is filed within two court working days.

☐ C. This person is currently on an order for involuntary inpatient placement, and this petition is being filed before the expiration of that order

☐ D. A petition for involuntary inpatient placement has been filed and a hearing is pending.

5. That attached hereto and by reference made a part hereof, are two (2) opinions and supporting facts regarding the mental health of said person necessitating involuntary outpatient placement.

6. In addition to at least one of the two experts whose opinions are attached, the following persons may testify in support of the petition for involuntary outpatient placement:

	Guardian or Representative	**Other Witness**	**Other Witness**
Name:	________________	________________	________________
Relationship	________________	________________	________________
Address	________________	________________	________________
	________________	________________	________________
Telephone:	(______)____________	(______)____________	(______)____________

CONTINUED OVER

Petition for Involuntary Outpatient Placement (Page 2)

COMES NOW THE PETITIONER and further alleges that:

☐ 1. A Guardian Advocate is necessary to act on the person's behalf on issues related to express and informed consent to:

☐ Mental health treatment only, or
☐ Both mental health and medical treatment decisions

And a Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate is attached;

OR

☐ 2. The person/respondent is competent to provide express and informed consent to his or her own treatment or the person has a guardian authorized to consent to treatment and no Guardian Advocate is requested.

____
Signature of Facility Administrator or Designee

____
Date

__________ am pm
Time

____
Typed or Printed Name of Administrator or Designee

Person ☐ does or ☐ does not have a private attorney. If so, the name and address of the private attorney is:

Private Attorney Name: ____

Private Attorney Address: ____

cc: The Clerk of the Court shall provide a copy of this petition to the: (Check when applicable and initial/date/time when copy provided)

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	
☐ Guardian		am pm	
☐ Public Defender		am pm	
☐ Representative		am pm	
☐ State Attorney		am pm	
☐ Dept. of Children & Families		am pm	

CONTINUED / SUPPORTING OPINIONS ON PAGE 3

Petition for Involuntary Outpatient Placement (Page 3)
First Opinion Supporting the Petition

I, ______________________________ a psychiatrist authorized to practice in the State of Florida, have personally examined

_________________________________ on ________________ (within 72 hours of the signing hereof) and find from such
Name of Person Date
examination that the person meets each of the following criteria for involuntary outpatient placement. Each of the following required criterion must be alleged and substantiated by evidence in this petition.

1. The person is 18 years of age or older, corroborated by: ____
1. The person has a mental illness, as substantiated by the following evidence:____________________________________
____
____

2. The person is unlikely to survive safely in the community without supervision, based on a clinical determination, as substantiated by the following evidence: ____
____
____

4. The person has a history of lack of compliance with treatment for a mental illness, as substantiated by the following evidence: _______
____
____
____

5. The person has:

a. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s. 394.455, or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated, as substantiated by the following evidence: __________
____
____
____

or

b. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months, as substantiated by the following evidence : ____________________________________
____
____
____

6. The person is, as a result of a mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary, as substantiated by the following evidence:____
____
____

7. In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient placement in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in the criteria for involuntary examination, as substantiated by the following evidence:_________________
____
____

8. It is likely that the person will benefit from involuntary outpatient placement, as substantiated by the following evidence;____________
____
____
____

AND

9. All available less restrictive treatment alternatives than court-ordered involuntary outpatient placement which would offer an opportunity for improvement of said person's condition have been judged to be inappropriate, based on contact with the following programs/agencies: ____
____
____

____ ________________ ____________ am pm
Signature of Psychiatrist Date Time

____ ____________________________
Typed or Printed Name of Psychiatrist License Number

CONTINUED OVER

Second Opinion Supporting the Petition (page 4)

I,____, a ☐ psychiatrist, ☐ clinical psychologist, ☐ licensed physician *, ☐ psychiatric nurse *, authorized to provide a second opinion on this petition pursuant to Section 394.467 (2), F.S., have personally examined ____ on_____________________________, (within 72 hours of signing hereof), and find
Name of Person Date

that he/she meets the criteria for involuntary outpatient placement as stated in this petition. Observations and supporting evidence which support this opinion are: ____

____

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_______________________________________ ___________________ ___________ am pm
Signature of Examiner Date Time

_______________________________________ ________________________ ______________
Typed or Printed Name of Examiner Profession License Number

*I certify that the county in which the person is detained has less than 50,000 population and no psychiatrist or psychologist is available to provide the second opinion.

____ ________________________________
Printed Name and Signature of Administrator or Designee Date

*** A licensed physician or psychiatric nurse may only provide such second opinion in counties of less than 50,000 population in cases where the facility administrator certifies that no psychiatrist or clinical psychologist is available to provide the second opinion (by countersigning above).**

See s. 394.4599(2)(c)3, 394.467, Florida Statutes
CF-MH 3130, Feb 05 (Recommended Form)

BAKER ACT

Designation of Service Provider for Involuntary Outpatient Placement

Pursuant to chapter 394.4655, Florida Statutes, a petition for Involuntary Outpatient Placement has been filed to require

____________________________________ to comply with a treatment plan approved by the court.

The following service provider has been identified by:

☐ ____, a representative of the Department of Children and Families, **or**

☐____, a representative of a designated receiving facility

Name of Assigned Service Provider:	
Address of Provider:	
Phone Number of Provider:	

The service provider will have primary responsibility for service provision under an order for involuntary outpatient placement. The service provider will prepare a written proposed treatment plan, in consultation with the person or the person's guardian, guardian advocate, or health care surrogate/proxy, if appointed, to be attached to the petition for involuntary outpatient placement for the court's consideration for inclusion in the involuntary outpatient placement order. The Baker Act requires that each person shall have an opportunity to assist in preparing and reviewing such a plan prior to its implementation and that the plan shall include a space for the person's comments.

For purpose of determining whether a person meets the criteria for involuntary outpatient placement or for preparing the proposed treatment plan, the clinical record may be released to the state attorney, the person's attorney, and to the appropriate mental health professionals, including the proposed service provider, in accordance with federal and state law.

The treatment plan must specify the nature and extent of the person's mental illness. The treatment plan must also address the reduction of symptoms that necessitate involuntary outpatient placement and include measurable goals and objectives for the services and treatment that will be provided 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.

Service providers may select and provide supervision to other individuals to implement specific aspects of the treatment plan. The services in the treatment plan must be deemed to be clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker, as defined in s. 394.455, Florida Statutes, who consults with, or is employed or contracted by, the service provider.

The service provider must certify to the court in the proposed treatment plan whether sufficient services for improvement and stabilization are currently available in the local community, whether there is space available to serve this person, that funding is available to finance the care, and whether the service provider agrees to provide those services. If the service provider certifies that the services or funding required by the proposed treatment plan are not available, the petitioner may not file the petition.

A petition for Involuntary Outpatient Placement will be filed with the circuit court no later than __________________________. A copy of the proposed treatment plan developed by the assigned service provider, in consultation with the person, must be attached, including a certification by the service provider that the proposed services and funding are available to support the proposed treatment/service plan. The service provider shall also provide a copy of the of the proposed treatment plan to the person and the administrator of the receiving facility.

The service provider identified above shall prepare a treatment plan, consistent with the above requirements, no later than __________________to be attached to the petition for involuntary outpatient placement, unless the service provider cannot certify the availability of funded services to meet the person's needs.

____   ________________________
Signature of ☐ DCF ☐ Receiving Facility representative   Date

____   ____
Printed Name of Representative   Address and Telephone Number of Representative

See s. 394.4655(2)(a), Florida Statutes
CF-MH 3140, Sept 06 (obsoletes previous edition) (Recommended Form)

Proposed Individualized Treatment Plan for
Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement

Pursuant to chapter 394.4655, Florida Statutes, a petition for Involuntary Outpatient Placement has been filed to require ______________________________ to comply with a treatment plan approved by the court.

The following proposed treatment plan has been developed in consultation with the above named person (or his/her legally authorized substitute decision-maker, if appointed) for the court's consideration by the following service provider designated by ☐ the Department of Children and Families or ☐ a designated receiving facility.

Name of Assigned Service Provider:______________________________
Name & Credentials of Person Developing the Treatment Plan:______________________________
Address:______________________________
Phone Number______________________________

The nature and extent of the person's mental illness is as follows:

____

____

The following specific services are proposed in this treatment plan, including the specific service to be provided, the organization to provide each service, the licensure or other credentials of the organization or professional to provide each service, and the frequency and duration of each service:

1. Services that will reduce symptoms that necessitate involuntary outpatient placement, including measurable goals and objectives for the services and treatment that will be provided to treat the person's mental illness:

____

____

____

2. Services that will reduce symptoms, including measurable goals and objectives for the services and treatment, that are provided to assist the person in living and functioning in the community.

____

____

____

____

____

3. Services that will reduce symptoms, including measurable goals and objectives, for the services and treatment that are provided to attempt to prevent a relapse or deterioration:

____

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____

____

Service providers may select and provide supervision to other individuals to implement specific aspects of the treatment plan. Other individuals than those employed by the above named service provider, and their credentials, who are expected to assist in providing the services described in this proposed treatment plan are:

____

____

____

CONTINUED OVER

Proposed Individualized Treatment Plan for
Involuntary Outpatient Placement and Continued Involuntary Outpatient Placement (page 2)

I am a ☐physician, ☐clinical psychologist, ☐psychiatric nurse, ☐mental health counselor, ☐marriage and family therapist, or ☐clinical social worker, as defined in s. 394.455, F.S. I consult with, or am employed or contracted by, the service provider and I have determined that the services, personnel, and organizations described in this proposed treatment plan are clinically appropriate.

______________________________ __________________________ ______________
Signature of Clinical Professional | Printed Name of Clinical Professional | Date

The service provider certifies to the court that all services described in the proposed treatment plan for person's improvement and stabilization are:

☐ Currently available in the local community
☐ There is space available to serve this person
☐ Funding is available to finance the care, and
☐ The service provider agrees to provide those services.

The nature and extent of the person's involvement in the preparation of this proposed treatment plan is as follows:

____
____
____
____
____

Comments about the proposed treatment plan by the person are as follows:

____
____
____
____

____________________________ __________________________ __________
Signature of Preparer of Plan | Printed Name of Preparer of Plan | Date

---

> The service provider shall also provide a copy of the proposed treatment plan to the person and the administrator of the receiving facility. For persons in state treatment facilities who are ordered to involuntary outpatient treatment, a copy of the state mental health discharge form must be sent by the treatment facility to a department representative in the county where the person will be residing, which is the county where the petition must be filed.

See s. 394.467(6)(c), Florida Statutes
CF-MH 3145, Sept 06 (obsoletes previous edition) (Recommended Form) **BAKER ACT**

Notice to Department of Children and Families of Non-Filing of Petition for Involuntary Outpatient Placement Or Diminished Treatment Plan Due to Non-Availability of Services or Funding

I have evaluated ______________________________Social Security #_________________________ a person referred for:

- ☐ Involuntary Outpatient Placement
- ☐ Continued Involuntary Outpatient Placement

I have found that services needed by the person are:

- ☐ Unavailable in the community
- ☐ Unavailable due to waitlists
- ☐ Unfunded

As a result of this finding,

- ☐ No petition for involuntary outpatient placement or continued involuntary outplacement was filed or
- ☐ A petition for involuntary outpatient or continued involuntary outplacement was filed but omitted services that were unavailable or unfunded.

Please check which of the following services are needed by the person but are unavailable for any of the above reasons:

- ☐ Residential Treatment
- ☐ Psychotropic Medications
- ☐ Counseling
- ☐ Club House
- ☐ FACT or Intensive Case Management
- ☐ Vocational Program
- ☐ Drop-In Center
- ☐ Peer Support Services
- ☐ Others as specified below

The nature of the service unavailability or lack of funding is described as follows:

____

____

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____

____

______________________________	______________________________
Signature of Service Provider Representative	Printed Name of Representative Date
______________________________	______________________________
Name of Service Provider	Address of Service Provider Telephone

See s. 394.4655(2)(a)3, Florida Statutes
CF-MH 3150, Feb 05 (Recommended Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE _______________ JUDICIAL
CIRCUIT, IN AND FOR ___________________ COUNTY, FLORIDA

IN RE: ________________________, Case No.: ____________________

ORDER FOR INVOLUNTARY OUTPATIENT PLACEMENT OR CONTINUED INVOLUNTARY OUTPATIENT PLACEMENT

This matter came to be heard pursuant to s.394.4655, F.S., and on ☐ Petition for Involuntary Outpatient Placement or, ☐ Petition for Continued Involuntary Outpatient Placement, and the Court being fully advised in the premises, finds by clear and convincing evidence as follows:

1. The above-named person has been represented by counsel; said person ☐ appeared at the hearing, or ☐ presence at the hearing was waived, without objection of said person's counsel.
2. The above-named person meets the following criteria for involuntary outpatient placement pursuant to s.394.4655(1), F.S.: the person is 18 years of age or older; has a mental illness; is unlikely to survive safely in the community without supervision, based on a clinical determination; and, has a history of lack of compliance with treatment for a mental illness.
3. The above-named person has: (not applicable to **continued** involuntary outpatient placement)
   ☐ A. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s.394.455, or has received mental health services in a forensic or correctional facility; **or**
   ☐ B. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to self or others, within the preceding 36 months.
4. The above-named person is, as result of mental illness, unlikely to voluntarily participate in the recommended treatment plan and has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment, or is unable to determine whether placement is necessary.
5. The above-named person's treatment history and current behavior mandates the conclusion that the person is in need of involuntary outpatient placement in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to the person or others, or a substantial harm to his or her well-being through neglect or refusal to care for self as set forth in s.394.463 (1), F.S..
6. It is likely that the above-named person will benefit from involuntary outpatient placement. All available less restrictive treatment alternatives which would offer an opportunity for improvement of said person's condition are inappropriate.
7. The treatment plan which is attached hereto specifies the nature and extent of the above-named person's mental illness and specifies the outpatient treatment to be provided. The treatment plan contains a certification to the court that sufficient services for improvement and stabilization are currently available, funded, and that the service provider agrees to provide those services.
8. The services described in the treatment plan are clinically appropriate. This finding is supported by evidence presented, including the testimony of ____.
9. The Court considered testimony and evidence regarding the above-named person's competence to consent to treatment. The person is found to be ☐ competent, ☐ incompetent to consent to treatment. If found to be incompetent, a guardian advocate is appointed by separate order.
10. If the petition was referred to and heard by a Magistrate, the Magistrate's Report and Recommendation are attached, incorporated by reference, and adopted by the Court.

Whereupon, IT IS ORDERED that the above-named person be treated as an outpatient in accordance with the treatment plan attached hereto, for a period ☐ not to exceed 6 months from the date of this order, or
☐ ______________________________, or until discharged by the administrator or transferred to voluntary status.

DONE AND ORDERED in _________________ County, Florida, this _____ day of ______________, 20___.

________________________________ ____
Printed Name of Circuit Court Judge Signature of Circuit Court Judge

See s. 394.4655(6)(c), Florida Statues
CF-MH 3155, Feb 05 (Recommended Form) **BAKER ACT**

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT
IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ___________________________________ CASE NO.: __________________________

Notice to Court of Modification to Treatment Plan for Involuntary Outpatient Placement and/or Petition Requesting Approval of Material Modifications to Plan

This court issued an order on ______________ requiring :

☐ involuntary outpatient placement **OR** ☐ continued involuntary outpatient placement for the above-named person.

Material modifications to the treatment plan previously approved by the Court

☐ For which the person or the person's guardian or guardian advocate, if appointed AGREE have been made.

☐ For which the person or the person's guardian or guardian advocate, if appointed DO NOT AGREE are being proposed for the court's consideration.

☐ A hearing is requested to review the proposed changes for which the person or the person's guardian or guardian advocate, if appointed, do not agree and the reasons for the objections to the proposed changes.

The changes or proposed changes to the currently approved treatment plan, including why the modifications are necessary and appropriate, are as follows: ____
____
____
____

Any objections to the changes or proposed changes to the currently approved treatment plan by the person or the person's guardian or guardian advocate, if appointed, are as follows: ______________________________
____
____
____

If this petition is filed by the service provider, a copy of the complete treatment plan, including proposed changes, is attached to this filing.

____________________________ ____________________________________ _____________
Signature of Petitioner Printed Name of Petitioner Date
☐ Person ☐ Guardian ☐ Guardian Advocate ☐ Service Provider ☐ Attorney for Person

____
Printed Name of Petitioner Printed Address and Telephone Number of Petitioner

ORDERED
That the proposed changes to the currently approved treatment plan are:
☐ Approved
☐ Disapproved

DONE AND ORDERED in _________________ County, Florida, this _____date of __________, 20____

____________________________________ ____________________________
Signature of Circuit Court Judge Printed Name of Circuit Court Judge

Pursuant to 394.4655(6)(b)3, Florida Statutes,
See s. 394.467(6)(c), Florida Statutes
CF-MH 3160, Feb 05 (Recommended Form)

BAKER ACT

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT
IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ___________________________________ CASE NO.: __________________________

Petition for Termination of Involuntary Outpatient Placement Order

COMES NOW the petitioner, ___________________________________ alleging that ______________________
No longer meets one or more of the following criteria for involuntary outpatient placement:

☐ The person is 18 years of age or older;

☐ The person has a mental illness;

☐ The person is unlikely to survive safely in the community without supervision, based on a clinical determination;

☐ The person has a history of lack of compliance with treatment for a mental illness;

The person has:

☐ 1. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s. 394.455, or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated; **or**

☐ 2. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months;

☐ The person is, as a result of a mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary;

☐ In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient placement in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1);

☐ It is likely that the person will benefit from involuntary outpatient placement; and

☐ All available less restrictive treatment alternatives which would offer an opportunity for improvement of said person's condition have been judged to be inappropriate based on contact with the following programs/agencies:

For each criteria checked above that the petition alleges is not currently met, substantiating evidence is provided as follows:

____

____

____

____

____

____

____

Wherefore, it is requested that the Court issue an order terminating its order issued on ______________________
requiring involuntary outpatient placement.

___________________________________ _________________ _____am pm
Signature of Petitioner Date Time

☐ Person ☐ Guardian ☐ Guardian Advocate ☐ Service Provider ☐ Attorney for Person

___________________________________ ___________________________________
Printed or Typed Name of Petitioner Address of Petitioner

See s. 394.467(6)(c), Florida Statutes
CF-MH 3170, Feb 05 (Recommended Form) **BAKER ACT**

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT
IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ___________________________________ CASE NO.: __________________________

Petition Requesting Authorization for Continued Involuntary Outpatient Placement

COMES NOW the Petitioner, ________________________ and alleges:

1. That Petitioner is Administrator of: ____
   Name of Service Provider Address

2. That (Name of Person): ________________________ has been served by said service provider under an order for Involuntary Outpatient Placement entered by this Court on ____________________,

3. That according to the provisions of s.394.4655(7), F.S. this person may not be involuntarily placed after ________________________(Date) without an order authorizing continued involuntary outpatient placement

4. That this petition is being filed within the allowed time frame

5. That the person continues to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1), F.S., as follows:

   a.. The person is 18 years of age or older;

   b. The person has a mental illness

   c. The person is unlikely to survive safely in the community without supervision, based on a clinical determination, as substantiated by the following evidence:____
   ____
   ____
   ____
   ____
   ____

   d. The person has a history of lack of compliance with treatment for a mental illness.

   e. The person is, as a result of a mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary, as substantiated by the following evidence: ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____

Continued (Over)

f. In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient placement in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1), as substantiated by the following evidence:

____

____

____

____

____

____

g. It is likely that the person will benefit from involuntary outpatient placement, as substantiated by the following evidence;

____

____

____

____

____

____

AND

h. All available less restrictive treatment alternatives than court-ordered involuntary outpatient placement which would offer an opportunity for improvement of said person's condition have been judged to be inappropriate, based on contact with the following programs/agencies: ____

____

____

____

______________________________ ______________ ____________ am pm
Signature of Physician or Clinical Psychologist Date Time

______________________________ ______________________
Typed or Printed Name of Physician or Clinical Psychologist License Number

A description of the person's treatment during the time he or she was involuntarily placed on an outpatient basis is attached to this petition, as is a proposed individualized plan of continued treatment, that has been developed in consultation with the person or the person's guardian or guardian advocate, if appointed.

Wherefore, it is requested that an Order be issued authorizing this service provider to continue to treat this person on an involuntary outpatient basis until ________________ or for a period not to exceed six (6) months.

______________________________ ______________ ________am pm
Signature of Administrator or Designee Date Time

____
Printed or Typed Name of Administrator or Designee

See s. 394.467(6)(c), Florida Statutes
CF-MH 3180, Feb 05 (Recommended Form) **BAKER ACT**

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT
IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ___________________________________ CASE NO.: __________________________

Notice to Court of Waiver of Continued Involuntary Outpatient Placement Hearing And Request for an Order

________________________________, a person being treated under an Order for Involuntary Outpatient Placement by __________________________________ (service provider) and who has been found by the court to be competent to consent to make decisions about his or her treatment, has agreed to a period of continued involuntary outpatient placement without a court hearing.

As counsel for this person, I agree to this waiver of hearing and request the issuance of an order for continued involuntary outpatient placement for a period of _____________________________________(up to six months)

_____________________________________ Signature of Person Agreeing to Waiver of Hearing

____________________ Date of Person's Signature

____________________________________ Signature of Counsel

____________________ Printed Name of Counsel

_______________ Date

cc: ☐Person ☐Service Provider ☐State Attorney ☐Guardian ☐Guardian Advocate ☐Representative

See s. 394.4655(7)(d), Florida Statutes
CF-MH 3185, Feb 05 (Recommended Form)

BAKER ACT

Florida Department of Children & Families

State Mental Health Facility Admission Form

(Submit Prior to Pre-Admission Meeting)

A. Client Identifying Information

1. Name ____
   Last Maiden First M.I.
2. Discharge Address ____
3. County of Residence/Referral _________/_________ 4. Last Living Environment ____________
5. Date of Birth ______/ ______ / __________ 6. SSN __________ - ________ - ___________
7. Age _______ yrs. 8. Sex ☐ M ☐ F 9. Race __________________ 10. Religion ____________
11. Birthplace ____________________ 12. USA Citizen? ☐ Yes ☐ No 13. Language ______________
14. Immigration Status ____________________ 15. Country ____________________
16. Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated

B. Client Status Information

17. Legal Status (check one) ☐ Voluntary ☐ Involuntary
18. Competency Status (check one) ☐ Competent ☐ Incompetent ☐ Not Guilty by Reason by Insanity ☐ Incompetent to Proceed
19. Date Competency Hearing Held _______/________/__________ 20. Hearing Site ____________________
21. Has legal guardian been appointed? ☐ YES ☐ NO (If yes, complete following)
    Legal Guardian for ☐ client only ☐ client's property only ☐ both client and property

    Guardian's Name ______________________________ Phone # (_____) ____________

    Guardian's Mailing Address ______________________________

    Guardian Advocate's Name ______________________________ Phone # (_____) ____________

    Guardian Advocate's Mailing Address ______________________________
22. Name of Designated Representative (if any) ____________________ Phone # (_____) ____________
23. Should anyone else be contacted in an emergency? ☐ YES ☐ NO If yes, relationship to client ____________

    Name ______________________________ Phone # (_____) ____________

    Mailing Address ______________________________
24. If Charges Pending Specify ______________________________

    Criminal Statute Number __________ Name of Court ______________ Case Number __________

    Judge's Name ____________________ Probation Officer: ____________________

    Probation Officer Mailing Address ______________________________

    Probation Officer Phone # (______) ____________________

CONTINUED OVER

State Mental Health Facility Admission Form (Page 2)

C. Transferring or Screening Agency Identifying Information

25. Name of Agency ____

26. Agency Contact (Continuity of Care Case Manager) ____________________ Phone # (_____) __________

27. Mailing Address ____

28. Date Case Manager Notified (mm/dd/yyyy) ________/________/________

D. Client Medical Information / History

29. Current Diagnoses (Current edition of DSM and ICD for Axis III): ______________________________

Treating Psychiatrist: ______________________ Treating Physician: ______________________

AXIS I: ____

AXIS II: ____

AXIS III: ____

AXIS IV: ____

AXIS V: ____

(Indicate most recent GAF score & Date Given (mm/dd/yyyy) ______________)

Attached Documents (Assessments, Evaluations, etc.)

Documents	Provided by Case Manager	If No or N/A Indicate Rationale	Provided by Receiving Facility	If No or N/A Indicate Rationale
30. Mental Status and Psychiatric Evaluation	☐ Yes ☐ No ☐ N/A		☐ Yes ☐ No ☐ N/A	
31. Psychiatrist's Notes (Up to 90 days)	☐ Yes ☐ No ☐ N/A		☐ Yes ☐ No ☐ N/A	
32. Diagnostic Summary/ Clinical Impressions & Recommendations	☐ Yes ☐ No ☐ N/A		☐ Yes ☐ No ☐ N/A	
33. Significant Lab and Diagnostic Reports	☐ Yes ☐ No ☐ N/A		☐ Yes ☐ No ☐ N/A	
34. Psychological Evaluation	☐ Yes ☐ No ☐ N/A		☐ Yes ☐ No ☐ N/A	
35. Psychosocial History (Comprehensive if available)	☐ Yes ☐ No ☐ N/A		☐ Yes ☐ No ☐ N/A	
36. Substance Abuse Developmental Disability Other	☐ Yes ☐ No ☐ N/A		☐ Yes ☐ No ☐ N/A	

CONTINUED

State Mental Health Facility Admission Form (Page 3)

D. Client Medical Information / History (continued)

Attached Documents (Assessments, Evaluations, etc.) continued

Documents	Provided by Case Manager	If No or N/A Indicate Rationale	Provided by Receiving Facility	If No or N/A Indicate Rationale
37. Physical Exam and Medical History	☐ Yes ☐ No ☐ N/A		☐ Yes ☐ No ☐ N/A	
38. Medication History including current prescribed medications	☐ Yes ☐ No ☐ N/A		☐ Yes ☐ No ☐ N/A	
39. Appropriate Legal Documents including Court Order, Police Report and Petition for Involuntary Placement, Form 3089, 3052a, 3052b, and ex-parte order when applicable	☐ Yes ☐ No ☐ N/A		☐ Yes ☐ No ☐ N/A	
40. Client Service Plan and/or Treatment Plan	☐ Yes ☐ No ☐ N/A		☐ Yes ☐ No ☐ N/A	
41. Clinician's Progress Notes (Up to past year)	☐ Yes ☐ No ☐ N/A		☐ Yes ☐ No ☐ N/A	
42. Functional Assessments (Most recent)	☐ Yes ☐ No ☐ N/A		☐ Yes ☐ No ☐ N/A	
43. Receiving Facility Admissions Summary, and, if available, Emergency Room Report			☐ Yes ☐ No ☐ N/A	

44. Primary Issues of Strength Checklist: Place scoring code (see key) in appropriate column to indicate extent of strength, or need in each subject area listed below, and briefly describe problem, if any.

*** Key: 0 = No Data; 1 = Minor; 2 = Moderate; 3 = Severe**

	Strength	Issue/Need	Description of Strengths, Issues, Needs (attach information, if necessary)
Health			
Mental Health			
Family			
Social			
Work			
Police, Law			
Violence			
Accidents			
Education			
Other (specify)			

CONTINUED OVER

State Mental Health Facility Admission Form (Page 4)

D. Client Medical Information / History (continued)

45. The issues/needs checked above co-occur with:
☐ Alcohol ☐ Drugs ☐ Psychiatric Disorder ☐ Developmental Disability ☐ Other (Specify) ______________________

46. Reason for transfer to the state facility ____

____

47. What steps have already been taken to explore less restrictive placement ____

____

48. List Previous State Hospital Admissions (attach additional sheets if necessary):

Admission Date (mm/dd/yyyy)	Facility Name	Length of Stay

49. List previous Local Hospitals, Crisis Stabilization Units, or Intensive Residential Treatment Programs serving client prior to admission (include facility/program name and mailing address):

Facility Name	Program Name	Mailing Address

E. Current Financial Information About Client

50. Monthly Income: $________________ 51. Check one: ☐ Owns Home ☐ Rents ☐ Other ____________________________

52. Complete the following charts as appropriate:

	Monthly Benefit	Type of Claim/ Policy Number		If Filed For	Date Filed	I.D. Number	Where Filed	Approved/Denied (Indicate why if denied)
Social Security				Medicare				
S.S.I.				Medicaid				
Veteran's Benefits				Champus				
Pensions				Medical Insurance				
Insurance/ HMO				Hospitaliza-tion				
Other (Specify)				Other (Specify)				

53. List any other financial resources:

CONTINUED

State Mental Health Facility Admission Form (Page 5)

F. Recommendations and Pre-Release Plans (Items 54, 55 and 56 completed jointly by Receiving Facility & Community Case Manager)

54. List expectations of the State Facility

By Client ____________________

By Family ____________________

By Community Services ____________________

55. List ALL potential recommended alternatives for this client's return to the community (include the name, address, and phone number of services/programs to which the client may be referred):

Client ____________________

____

Family ____________________

____

Community Services ____________________

____

56. Describe briefly how the community staff will remain involved in the therapeutic process during this client's hospitalization (to be developed through mutual effort of Hospital and Continuity of Care Facilitator.

____

____

57. Describe briefly how the family will remain involved in the therapeutic process during this client's hospitalization (to be developed through mutual effort of Hospital and Continuity of Care Facilitator:

____

____

G. Receiving Facility's General Referral Comments
(Include statement indicating eligibility for placement in a Mental Health or Developmental Services Facility)

____________________	____________________	____/____/____
Signature of Person(s) Completing Form	Title	Date Signed (mm/dd/yyyy)
____________________	____________________	____/____/____
Signature of Person(s) Completing Form	Title	Date Signed (mm/dd/yyyy)

CONTINUED OVER

State Mental Health Facility Admission Form (Page 6)

Client Name ______________________ SS# ______________________

Receiving Facility ______________________ Phone # ______________________

Signature ______________________ Date Admission Packet Sent (mm/dd/yyyy)

This side to be completed by the Receiving Facility and sent with the admission packet prior to admission	This side to be completed by the State Mental Health Facility Staff Person after receiving admission packet			
	Rating			Notes (Please Note Incomplete And/Or Missing information Items) (Use Back if Necessary)
Check ☒ if included in packet or Circle "NA"	Complete Info	Incomplete Info	No Info	
1. Form 7000 A. Identifying Information ☐ NA	3	2	1	
B. Status Information ☐ NA	3	2	1	
C. Tansfer/Screen Agency ID Info ☐ NA	3	2	1	
D. Medical Info/History 29. Current Diagnosis ☐ NA	3	2	1	
30. Psychiatric Eval/Diag Sum ☐ NA	3	2	1	
31. Psychiatric Notes ☐ NA	3	2	1	
34. Psychological Evaluation ☐ NA	3	2	1	
35. Psychosocial Eval/History ☐ NA	3	2	1	
37. Physical Examination ☐ NA	3	2	1	
39. Appropriate Legal Docs ☐ NA	3	2	1	
40. Service Treatment Plan ☐ NA	3	2	1	
41. Clinicians' Progress Notes ☐ NA	3	2	1	
42. Functional Assessment ☐ NA	3	2	1	
43. Rec Fac Admission Summary ☐ NA	3	2	1	
44. Prim Issue/Strength Ck List ☐ NA	3	2	1	
45. Issues/Needs Co-occuring ☐ NA	3	2	1	
46. Reason for Transfer ☐ NA	3	2	1	
47. Steps taken to explore less restrictive placement ☐ NA	3	2	1	
48. Previous Psychiatric Admis ☐ NA	3	2	1	
49. Previous Other Admissions ☐ NA	3	2	1	
E. Current Financial Information ☐ NA	3	2	1	
F. Recommend./Pre-Release Plan ☐ NA	3	2	1	

2. Joint Review (of admission packet information) (State Mental Health Facility Staff Person Completes)

A. Who Reviewed? State Mental Health Facility ______________________ Receiving Facility ______________________

B. When Reviewed? Date(s) (mm/dd/yyyy) ______________________ ______________________

C. What incomplete/missing information items need to be resolved? (Use back if needed)

Above Item #	Action to Resolve	Who to Resolve	Date Due (mm/dd/yyyy)

3. Satisfaction of the State Mental Health Facility Staff Person (Please Circle Appropriate Rating)	Rating: Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Comments (Please Explain Low Ratings: 3 or Less) (Use Back if Necessary)
A. Overall, I am very satisfied with the admission packet information and process.	5	4	3	2		

B. State Mental Health Facility Staff Person Signature ______________________ Phone # ( ) ______________________

See s. 394.4573 and s. 394.468, Florida Statutes

CF-MH 7000, Jan 98 (Recommended Form)

BAKER ACT

Department of Children & Families

State Mental Health Facility Discharge Form

Instructions: This form will be faxed to the community case manager the day of discharge and to the medical service provider in jail, if appropriate. A copy of this form with the attachments will be mailed by the next working day.

Attach copies of Need/Issue Lists, Service Plan, current status, significant lab reports, physical exam (completed in last 30 days), attach copy of latest clinical summary/competency exam completed within 30 days prior to discharge, and comprehensive social history with latest update.

TO (Agency) ______________________________

Phone # (_______) ______________________ Fax # (_______) ______________________

Mailing Address ______________________________

____

ATTN (Case Manager) ______________________ Phone # (_______) ______________________

A. Social Worker's Section: (Include all relevant demographic information)

1. Client's Name ______________________ Hospital Number ______________________

   Legal Status ______________________ Date of Admission (mm/dd/yyyy) ______/______/______

   Social Security Number ________ - ________ - ________ Date of Birth (mm/dd/yyyy) ______/______/______

   County of Residence ______________________ County of Admission ______________________

   Guardian or First Representative ______________________ Relationship ______________________

   Address ______________________________

   Phone # (_______) ______________________

2. Discharged Status Including Conditional Release Plans: ______________________________

   ____________ ______________________ Discharge To ______________________

   Discharge Address ______________________________

   Phone Number # (_______) ______________________

3. Financial Status: Type of Benefit(s) ______________________________

   Name of Payee ______________________ Amount of Benefits ______________________

   Date Applied For _____/_____/______ (mm/dd/yyyy) Date Accepted/Rejected _____/_____/______ (mm/dd/yyyy) Appeals _____/_____/______ (mm/dd/yyyy)

4. Who takes responsibility for the client upon discharge? (List name, relationship, responsibilities)

______________________ Social Worker's Signature ______/______/______ Date (mm/dd/yyyy) Phone # (_______) ______________________

CONTINUED OVER

State Mental Health Facility Discharge Form (Page 2)

B. Psychiatrist's Section: Current Diagnoses (Current edition of DSM [Axis I, II, IV & V] and ICD [Axis III]):

AXIS I: ________________________ AXIS II: ________________________

AXIS III: ________________________ AXIS IV: ________________________

AXIS V: GAF = __________ On Admission SCI-PANSS = __________ On Admission

GAF = __________ On Discharge SCI-PANSS = __________ On Discharge

Course of Hospitalization:

1. Reason for Admission (Circumstances which brought client to hospital):

____

____

____

____

2. Assessment and Findings (Diagnostic assessments completed and findings including mental status exam):

____

____

____

____

3. Treatment and Response (Types, frequencies, and response from admission to present):

____

____

____

____

____

4. Homicidal/Suicidal History (Address any issues related to these behaviors):

____

____

____

5. Medication History for current admission, including any dosages, court ordered medications, significant labs for psychiatric management, (i.e., lithium levels, etc.), and side effects. (See also Medical Physician's section, page 3).

____

____

6. Prognosis including recommendations for follow up and early warning signs of decompensation (address delusional speech).

____

____

____

______________________ Psychiatrist's Signature

_____/_____/_____ Date (mm/dd/yyyy)

Phone # (_____) ______________

CONTINUED

State Mental Health Facility Discharge Form (Page 3)

C. Medical Physician's Section:
(summary of current hospital course as it relates to medical issues, note special consultations, need for follow up)

Allergies ____ Diet ____

Medical Diagnoses ____

____

Lab and Other Studies including Pap Smear and Blood Levels appropriate for management of medical conditions.

____

____

____

Immunizations: ☐ PPD ☐ DT ☐ Influenza ☐ Pneumovax

Hospital Course, Special Issues/Concerns, Recommendations for Follow-up (List some descriptive items such as important salient treatment modalities, special issues/concerns, successful treatment modalities):

____

____

____

____

____

____

Medication Regime including dosages, significant labs, and side effects. (See also Psychiatrist section page 2)

____

____

____

____

____

____

____ ________/________/________ Phone # (_______) ____________________
Medical Physician's Signature Date (mm/dd/yyyy)

CONTINUED OVER

State Mental Health Facility Discharge Form (Page 4)

D. Nurse's Section:

1. Adaptive Equipment: Indicate below if client has items listed or if client needs items listed.

☐ Has ☐ Needs Dentures (Type) ________________
☐ Has ☐ Needs Wheelchair
☐ Has ☐ Needs Glasses
☐ Has ☐ Needs Prosthesis ____________________
☐ Has ☐ Needs Walker
☐ Has ☐ Needs Hearing Aid
☐ Has ☐ Needs Crutches
☐ Has ☐ Needs Contacts
☐ Has ☐ Needs Cane

2. Describe skin condition: ____

____

____

3. Is client at risk for choking? (check one) ☐ Yes ☐ No
Does the attached Service Implementation Plan contain information related to prevention of aspiration? (check one)
☐ Yes ☐ No

4. Is client is on Blood/Body Fluid Precautions? (check one) ☐ Yes ☐ No

5. Side Effects/Adverse Reactions: ____

____

____

____

6. Current Medications as ordered for separation (include date/time of last dose): ______________________

____

____

____

____

____

Number of days supply sent with client: ________________

7. Medication not sent (per facility policy) ____

____

____

____

____

____

8. Is client capable of taking his/her own medication? (check one) ☐ Yes ☐ No
Has medication education been provided? (check one) ☐ Yes ☐ No

9. History of medication compliance while in hospital. ☐ Never ☐ Sometimes ☐ Usually ☐ Always

CONTINUED

State Mental Health Facility Discharge Form (Page 5)

D. Nurse's Section: (continued)

10. Summary of pertinent nursing information including recent changes in the physical condition/mental status and current weight, blood pressure, pulse/respiration, patterns of elimination, nutrition including feeding and eating habits and any special dietary needs (address choking risk), personal hygiene, menstrual cycle (as indicated) and identifying any nursing/individual needs and recommendations for nursing care plans.

____
____
____
____
____
____
____
____
____
____
____
____

____ _______/_______/__________ Phone # (_______) __________________
Nurse's Signature Date (mm/dd/yyyy)

Pre-Release Contacts (Nurse will notify the community agencies, or jail, regarding any relevant medical/nursing issues):

Person Contacted ____

Phone # (_______) _________________ (_______) _________________

FAX # (_______) _________________ (_______) _________________

Response ____
____
____

Nurse Making Contact ________________________________ Date ____/____/_________ Time ________ am pm
(mm/dd/yyyy)

Phone # (_______) _________________________ Fax # (_______) _________________________

CONTINUED OVER

State Mental Health Facility Discharge Form (Page 6)

E. Rehabilitation Section Instructions: Check (3) the appropriate response.

Primary Language ______________________ ☐ Writes ☐ Speaks ☐ Signs

Secondary Language ______________________ ☐ Writes ☐ Speaks

Presently Attending Education: ☐ Yes ☐ No ☐ Reads ☐ Writes ☐ Counts ☐ Tells Time

Has completed: ☐ High School ☐ Vocational ☐ College

Interested in attending classes: ☐ High School ☐ Vocational ☐ College ☐ Graduate

Requires Therapeutic Devices: ☐ Glasses ☐ Hearing Aid

Behavioral Response Level

Language Skills ☐ Verbal ☐ Non-Verbal

Receptive Language (check one)
- ☐ Doesn't understand speech
- ☐ Understands simple conversation/instructions
- ☐ Understands complex conversation/instructions

Attention Span: ☐ 0-3 min. ☐ 4-9 min. ☐ 10+ min.

Expressive Language (check one)
- ☐ Makes no sounds
- ☐ Uses simple words
- ☐ Uses sentences
- ☐ Carries on conversation
- ☐ Other ______________________

Group Therapy Skills
- ☐ Likes Working in Group
- ☐ Expresses Feelings to Group
- ☐ Sets Goals for Self
- ☐ Speaks in Turn
- ☐ Responds to Feelings
- ☐ Identifies Interpersonal Barriers

Leisure Activities
- ☐ Initiates Leisure Activities
- ☐ Schedules Own Leisure Activities
- ☐ Selects Preferred Leisure Activities
- ☐ Participates in Offered Leisure Activities
- ☐ Invites Friends to Participate
- ☐ Evaluates Satisfaction

Social Skills (check all that apply)
- ☐ Expresses Feelings
- ☐ Expresses Affection Appropriately
- ☐ Initiates Conversations with Others
- ☐ Responds to Criticism (Pos/Neg)
- ☐ Converses About Family
- ☐ Compliments Others
- ☐ Offers Assistance
- ☐ Responds to Personal Statements
- ☐ Requests Assistance When Needed
- ☐ Expresses Opinions
- ☐ Asks Before Borrowing Items From Others
- ☐ Isolative
- ☐ Speaks in Normal Tone of Voice
- ☐ Boundary Issues (Personal Space)

Activity Preferences: (Mark boxes indicated by client)

☐ Arts/Crafts	☐ Parties/Programs	☐ Religious Services	☐ Music
☐ Horticulture	☐ Discussion Groups	☐ Exercising	☐ Outings
☐ Library	☐ Recreation	☐ Reading	☐ Movies
☐ Plays Sports	☐ Watches Sports		☐ Other ______________

Past Employment (check): ☐ Sheltered Workshops ☐ Supported Employment ☐ Private Sector

Presently Employed With ____

Comments (recap client participation in Rehab. activities)____

____

______________________ Rehab. Employee Signature

_____/_____/_____ Date (mm/dd/yyyy)

Phone # (_____) ______________

CONTINUED

State Mental Health Facility Discharge Form (Page 7)

F. Direct Care Section: Instructions: Place an **"I"** for **independent**, **"E"** for **needs encouragement** or **"A"** for **requires assistance**. In comment section, reflect on encouragement and assistance required.

Housekeeping:
___ Makes Beds
___ Operates Washer
___ Operates Dryer
___ Folds Clothes
___ Keeps room neat

Eating Habits:
___ Eats Breakfast, Lunch, and Dinner
___ Steals Food
___ Shares Food
___ Uses Good Table Manners
___ Follows Diet
___ Rate or Speed of Eating
___ Feeds Self Independently

Grooming:
___ Bathes
___ Dresses
___ Brushes Teeth
___ Washes Hair
___ Shaves
___ Grooms Hair
___ Wears Clean Clothes
___ Wears Appropriate Clothes
___ Uses Deodorant

Uses Telephone:
___ Local
___ Long Distance
___ Can Dial 911

Other:
___ Removes Items from Other's Rooms
___ Closes Bathroom Door
___ Flushes Toilet
___ Wash Hands after Using Rest Room
___ Washes Hands
___ Crosses Street Safely
___ Hoards Things
___ Dresses Appropriate to Season

Use of Tobacco Products:
___ Maintains a Schedule
___ Chain Smokes
___ Doesn't Smoke
___ Smokeless Tobacco Products

Budgets:
Spends $________________ Weekly
Spends ☐ Moderately ☐ Excessively on Snacks and Cigarettes
___ Can manage own money
___ Shops for Clothing
___ Saves Money
___ Saves for Leisure

Sexual Acting Out:
☐ Knowledge about
☐ Sexually Intruding on Others
☐ Exposing Self
☐ Public Masturbation
☐ Urinates in Public

Independent Living Clients Only
☐ Use of Transit Systems
☐ Develop a Budget
☐ Knows Food Safety Rules
☐ Knows Safety Rules for Kitchen
☐ Knows how to Evacuate in a Emergency
☐ Knows Items to Stock for Emergencies

Comments ____
____
____
____
____
____

____________________________________ Direct Care Staff Signature
_______/_______/__________ Date (mm/dd/yyyy)
Phone # (_________) __________________

CONTINUED OVER

State Mental Health Facility Discharge Form (Page 8)

G. Post Hospital Aftercare Recommendations by Service Team:

1. Check (3) indicates behavior as applicable to client:

Item	Previous History	Never	Sometimes	Often	Usually	Always
Violent to Self/Others/Property						
Suicidal						
Assaultive						
At Risk of Leaving						
Medication Compliance						
Therapeutic Activity Compliance						
Cooperative						
Demonstrates Understanding of Illness						
Has Supportive Family/Other						

2. List of circumstances under which relapse is apt to occur (early warning signs to look out for).

____

____

3. List crucial intervention needed to help promote successful placement (frequency of family contact, participation in AA, Day Treatment Group Therapy).

____

____

4. Description of the degree of supervision needed by the client. ☐ None ☐ Minimal ☐ Close

   Comments (describe circumstances): ____

____

5. Treatment Recommendations: ____

____

____

6. Client Preferences or Recommendations: ____

____

____

7. Appointment at Local Community Mental Health Agency Date ______/______/________ Time ______________ am pm
   (mm/dd/yyyy)

   Name of Therapist ________________________________ Appointment Confirmed By ____________________________

8. Appointment for Medical Problems Date ______/_______/_________ Time _____________ am pm
   (mm/dd/yyyy)

   Street Address ____

   Physician's Name ____Phone # (_____) ___________________________

   Name of Person Responsible for Medical Treatment (including financially) ________________________________

9. Additional Follow-up ____

____ Date Signed ___/___/________ Phone # (_____) _____________________

Service Team Leader or Designee (mm/dd/yyyy)

CONTINUED

State Mental Health Facility Discharge Form (Page 9)

H. Client's Copy of Discharge Summary: (To be completed with the client and assigned unit staff. A copy of this plan shall given to the client at the time of discharge).

Date: ___________________Name:____
(mm/dd/yyyy)
Hospital #:_____________________________________ SSN: ____

Legal Status: ☐ Voluntary ☐ Involuntary
☐ Competent ☐ Incompetent ☐ Incompetent to Proceed ☐ Not Guilty by Reason of Insanity
☐ Advance Directive ☐ Health Care Surrogate
Guardian: ☐ Person ☐ Property

This individualized discharge plan has been developed by:

____ ____ _______________________________
Staff Person Client Case Manager

Guardian's Name: ____ (______)_________________________
Address Phone

Address ____

Provision for Placement: {For persons returning to jail, the following information is submitted for consideration in regards to potential placement and follow-up services.}
I will reside at: ____
Address

(________)________________________ ____
Phone # Contact Person

I understand the client rules are: ____

____

I ☐ agree ☐ do not agree to abide by the rules. (Check one)

Family: My family ☐ has ☐ has not been notified of my discharge or ☐ has not been by my request.
They will assist me through ____

____

Family was provided education on ____

Community Services Recommended	Available in Community	Recommended by Team	Agreed to by Client	Comments
Intensive Case Management				
Case Management				
Medical				
Substance Abuse				
Therapy				
Sheltered Employment				
Supported Employment				
Home Help				
Independent Living Skills Training				
Day Treatment				
Religious Services				
Financial				
Legal				
Educational				
Other (Specify):				

CONTINUED OVER

State Mental Health Facility Discharge Form (Page 10)

H. Client's Copy of Discharge Summary:

Psychiatric Services: Psychiatric Services will be provided by Dr.: ____________________

Address: ____________________

Phone: (_______)____________________ Contact Person: ____________________

My first appointment will be: Date: ____________________ Time: ______________ am pm
(mm/dd/yyyy)

Medical Services: Provision of medical care will be provided by Dr.: ____________________

Address: ____________________

Phone: (_______)____________________ Contact Person: ____________________

My special medical needs are: ____________________

Medication: My medications are for ____________________ dosage ____________________

I understand the importance of medication and agree to take it as prescribed. If I have problems, I will contact my case manager who is: ____________________ at (_______) ____________________

Financial: I will receive income of

Amount	Source
$ ____________________	____________________
$ ____________________	____________________

My cost of care will be $____________________ I will receive for spending $____________________

Transportation: Upon discharge, transportation will be provided by: ____________________

My daily transportation need to Dr. appointments, day treatment and recreational activities will be provided by ____________________.

Case Management Services: ____________________ will serve as my case manager. ____________________ will be my link to community services. I should let him/her know what my needs or concerns are. I will meet with him/her on (mm/dd/yyyy) ______________ at _________ am pm for our first community visit at ____________________. He/She works for: ____________________.

Address: ____________________ Phone #: (_____)____________________

Provision for State Hospital Follow Up & Continuity of Care: I will be on a ______________ day leave of absence to ensure my adjustment and smooth transition into community living.

____________________ will follow up with ______________ phone calls and/or face to face visits.
Social Worker's Name Number/frequency

I may feel free to contact treatment team members during this transition. My treatment contacts are:

Names	Phone #'s
____________________	(_____)____________________
____________________	(_____)____________________

CONTINUED

State Mental Health Facility Discharge Form (Page 11)

Other Significant Information:

This treatment plan has been approved and agreed upon this ___________ day of ____________________, ____________
by affixed signatures:

____ ____
Client Hospital Personnel

____ ____
Case Manager Legal Guardian

Client did not agree to sign. Reason: ____

____

____

____

CONTINUED OVER

State Mental Health Facility Discharge Form (Page 12)

Client Name ______________________ Client ID#: ______________________ SS# ______________________

State Mental Health Facility Staff Person ______________________ Phone # ______________________

Signature ______________________ Date Discharge Packet Sent (mm/dd/yyyy)

This side to be completed by the State Mental Health Facility Staff Person and sent with discharge packet prior to discharge	This side to be completed by the Community Case Manager after receiving the discharge packet			
	Rating			Notes (Please Note Incomplete and/or Missing information Items) (Use Back if Necessary)
Check ☒ if included in packet or circle "NA"	Complete Info	Incomplete Info	No Info	
1. Form 7001 A. Social Worker's Section ☐ NA	3	2	1	
B. Psychiatrist's Section ☐ NA	3	2	1	
C. Medical Physician's Section ☐ NA	3	2	1	
D. Nurse's Section ☐ NA	3	2	1	
E. Rehabilitation Section ☐ NA	3	2	1	
F. Direct Care Section ☐ NA	3	2	1	
G. Post Hospital Aftercare ☐ NA	3	2	1	
H. Discharge Plan ☐ NA	3	2	1	
I. Attachments 1. Service Plan ☐ NA	3	2	1	
2. Court Orders ☐ NA	3	2	1	
3. Clinical Summaries ☐ NA	3	2	1	
4. Physical Exam ☐ NA	3	2	1	
5. Psychosocial History ☐ NA	3	2	1	
6. Other ______ ☐ NA	3	2	1	
7. Other ______ ☐ NA	3	2	1	
8. Other ______ ☐ NA	3	2	1	

2. Joint Review (of admission packet information) (Community Case Manger Completes)

A. Who Reviewed? State Mental Health Facility ______________________ Community Case Manager ______________________

B. When Reviewed? Dates(s) (mm/dd/yyyy) ______________________ ______________________

C. What incomplete/missing information items need to be resolved? (Use back if needed)

Above Item #	Action to Resolve	Who to Resolve	Date Due (mm/dd/yyyy)

3. Satisfaction of the Community Case Manager Please Circle Appropriate Rating	Rating					Comments (Please Explain Low Ratings: 3 or Less) (Use Back if Necessary)
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	
A. Overall, I am very satisfied with the admission packet inoformation and process.	5	4	3	2	1	

B. Community Case Manager Signature ______________________ Phone # (________) ______________________

See s. 394.4573 and s. 394.468 Florida Statutes
CF-MH 7001, Jan 98 (Recommended Form)

BAKER ACT

Physician to Physician Transfer Form

Must be completed at time of transfer to and from the State Hospital

Person's Name:	DOB:
Referring Facility:	Phone # ( )
Referring Physician:	Phone # ( )
Date of Admission to Referring Facility:	
Discharge Diagnosis AXIS I:	
AXIS II:	AXIS III:

Significant/Critical Events During Hospitalization (current status, suicide attempts/gestures, self injurious behavior, restraints, special precautions, etc.:

____

____

____

____

Significant Medical History, Treatment & Diagnosis (Allergies, recent significant laboratory findings, med/surg procedures, etc.)

____

____

____

Current Medications (List using additional sheet if necessary or attach current MAR)

Name of Medications	Dosage	Frequency	Lab Values	Taken Day of Transfer		
				Yes	Time Taken	No

Failed Medication Regimens:____

____

____

Current Precautions (suicide precautions, elopement precautions, etc.):____

____

____

Management Suggestions:____

____

____

____

Signature of Physician *: ______________________________ Date______________________

Printed Name of Physician ______________________________ Physician's approved designee may sign in the absence of the physician

Use reverse or attach additional sheets if needed

By authority of s. 394.455(29) and s. 394.461(2), Florida Statutes
CF-MH 7002, Feb 05 (obsoletes previous editions) (Recommended Form)

BAKER ACT