Select County

Print Form | Reset Form

IN THE CIRCUIT COURT OF _____ COUNTY, WEST VIRGINIA

IN RE: The Involuntary Hospitalization of:

Case No.: 2025 -MH -

Date: _____

_____
RESPONDENT (NAME OF PATIENT)

If this application is GRANTED, distribute copies of the application and Pickup / Custody Order (Form INV 4 / Form 903CCF or INV 5 / Form 903CCF24) to: Applicant, Respondent, Respondent's Attorney, Prosecuting Attorney and the Regional Mental Health Center.

APPLICATION FOR INVOLUNTARY CUSTODY FOR MENTAL HEALTH EXAMINATION OF MINOR

West Virginia Code: § 27-5-2 & § 27-4-1(d)

DO NOT USE THIS FORM IF THE PERSON TO BE EXAMINED IS:

* **INCARCERATED IN A JAIL, PRISON, OR OTHER CORRECTIONAL FACILITY** *[USE FORM INV 2 / 901C]*, **OR**

* **UNDER THE AGE OF 14** *[INVOLUNTARY COMMITMENT UNNECESSARY AS SUBJECT TO VOLUNTARY COMMITMENT BY PARENT(S) OR GUARDIAN, See, West Virginia Code § 27-4-1(B)]*, **OR**

* **UNDER THE AGE OF 18 AND DOES NOT OBJECT TO FURTHER VOLUNTARY TREATMENT** *[INVOLUNTARY COMMITMENT UNNECESSARY AS SUBJECT TO VOLUNTARY COMMITMENT BY PARENT(S) OR GUARDIAN OR SELF EMANCIPATED MINOR, See, West Virginia Code § 27-4-1(B)]*.

INSTRUCTIONS TO CHIEF MEDICAL OFFICER OF MENTAL HEALTH FACILITY:

A. Only the chief Medical Officer of the mental health facility in which a juvenile has been first voluntarily admitted for the 96 hour period as defined in *West Virginia Code* § 27-4-1 may file for involuntary hospitalization of a minor who is 14 years of age or older and objects to voluntary treatment.

B. All information must be printed or typed and be clearly readable.

C. All information requested must be provided, if known. If unknown, you must state it is unknown.

D. Any petition and application which does not provide the necessary information, or is unreadable, may be rejected or denied. Read and answer all questions carefully.

E. In this document, the RESPONDENT or MINOR is the person whose examination is requested.

Case No.: 2025 - MH -

1. FULL NAME OF MINOR TO BE EXAMINED ***[RESPONDENT]***: _____

Identification Information of Respondent:

DATE OF BIRTH: ____/____/____ ; WEIGHT _____ ;

HAIR COLOR _____ ; HAIR LENGTH _____ ;

GENDER _____ ; HEIGHT _____ ;

EYE COLOR _____; RACE _____.

2. MINOR'S LAST KNOWN ADDRESS: _____

_____

MINOR'S TELEPHONE NUMBER: _____

TELEPHONE NUMBER(S) OF MINOR'S CUSTODIAL PARENT(S) OR GUARDIAN: _____

_____

3. PLACE OF BIRTH **[state or country]** _____

4. WHERE IS MINOR NOW? PROVIDE NAME AND ADDRESS OF MENTAL HEALTH FACILITY WHERE MINOR IS BEING HELD PENDING THIS APPLICATION OR OTHER PRESENT LOCATION:

_____

_____

_____

TELEPHONE NUMBER OF MENTAL HEALTH FACILITY: _____

5. THE MINOR IS:

A. A RESIDENT OF _____ COUNTY, _____ STATE.

B. CURRENTLY PRESENT IN _____ COUNTY, _____ STATE.

6. APPLICANT CHIEF MEDICAL OFFICER'S FULL NAME _____

7. APPLICANT CHIEF MEDICAL OFFICER'S MAILING ADDRESS: _____

_____

WORK TELEPHONE NUMBER OF APPLICANT CHIEF MEDICAL OFFICER: _____

PLEASE PROVIDE A WAY TO CONTACT YOU PENDING THIS APPLICATION PROCESS (example: cell phone, pager number)**. THE COURT MUST BE ABLE TO REACH YOU AND NOTIFY YOU OF THE TIME AND PLACE OF ANY HEARING, WHICH WILL BE HELD IMMEDIATELY TO WITHIN 24 HOURS. FAILURE OF FACT WITNESSES WITH FIRSTHAND KNOWLEDGE OF THE MINOR'S CONDITION AND BEHAVIOR TO APPEAER AT THE HEARING MAY RESULT IN THE APPLICATION BEING DISMISSED AND THE MINOR BEING RELEASED.** If you do not want to minor to have this information, you may supply the information separately to the Court.

PHONE, CELL, PAGER OR OTHER PHONE NUMBER TO REACH CHIEF MEDICAL OFFICER: _____

8. DO YOU BELIEVE THE RESPONDENT IS:
   A. ADDICTED TO DRUGS, ALCOHOL AND/OR OTHER SUBSTANCES? ☐ YES ☐ NO
   B. MENTALLY ILL? ☐ YES ☐ NO

9. HOW LONG HAS THE RESPONDENT SHOWN SUCH BEHAVIOR? _____

10. IN YOUR OWN WORDS, PROVIDE ANY INFORMATION WHICH SUPPORTS YOUR BELIEF THAT THE RESPONDENT IS ADDICTED AND/OR MENTALLY ILL:

_____

_____

_____

_____

_____

_____

_____

_____

[Attach additional pages if necessary]

11. DO YOU BELIEVE THE MINOR, ***BECAUSE OF MENTAL ILLNESS OR ADDICTION***, IS LIKELY TO CAUSE SERIOUS HARM TO:
   A. HIM/HER SELF? ☐ YES ☐ NO
   B. OTHER PEOPLE? ☐ YES ☐ NO

12. LIST ANY AND ALL RECENT ACTS WHICH SUPPORT YOUR BELIEF THAT THE MINOR IS LIKELY TO CAUSE SERIOUS HARM TO HIM/HER SELF AND/OR OTHERS. **INCLUDE APPROXIMATE DATE(S) WHEN EACH ACT OCCURRED:**

_____

_____

_____

_____

_____

_____

_____

[Attach additional pages if necessary]

A. IS MINOR A SUICIDE RISK? ☐ YES ☐ NO ☐ UNKNOWN

IF **YES**, EXPLAIN: _____

_____

B. IS MINORVIOLENT? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, EXPLAIN: _____

_____

C. IS MINOR IN POSESSION OF WEAPONS? YES ☐ ☐ NO ☐ UNKNOWN

IF **YES**, IDENTIFY WEAPON(S), INCLUDING ALL FIREARMS: _____

_____

13. LIST THE NAMES AND ADDRESSES OF OTHER PERSONS WHO HAVE SEEN THE BEHAVIOR OR CONDITION OF THE MINOR:

_____

_____

IF YOU WANT THESE PEOPLE TO APPEAR AT HEARING ON THIS APPLICATION, **YOU** MUST CONTACT THEM DIRECTLY.

14. IS THE MINOR CURRENTLY HOSPITALIZED? ☐ YES ☐ NO

IF **YES**, STATE WHERE HOSPITALIZED AND EXPECTED LENGTH OF STAY IN HOSPITAL:

_____

_____

15. HAS THE MINOR BEEN UNDER THE RECENT CARE OF A PHYSICIAN? ☐ YES ☐ NO

IF **YES**, STATE PHYSICAN'S NAME, ADDRESS, AND PHONE NUMBER:

16. IS THE MINOR IN NEED OF MEDICAL CARE FOR ANY PHYSICAL CONDITION OR DISEASE?

☐ YES ☐ NO IF **YES**, DESCRIBE THE CONDITION/DISEASE:

17. IS THE MINOR TAKING ANY MEDICATIONS? ☐ YES ☐ NO

IF **YES**, LIST THE MEDICATIONS AND DOSAGE:

18. DOES THE MINOR NEED MEDICAL CARE, TREATMENT, OR HOSPITALIZATION THAT WOULD PREVENT EXAMINATION BY A MENTAL HEALTH PROFESSIONAL OR COURT APPEARANCE:

A. IMMEDIATELY? ☐ YES ☐ NO

B. WITHIN THE NEXT 24 HOURS? ☐ YES ☐ NO

19. HAS THE MIINOR BEEN EXAMINED BY A PSYCHIATRIST OR PSYCHOLOGIST? ☐ YES ☐ NO

IF **YES**, STATE PSYCHIATRIST'S OR PSYCHOLOGIST'S NAME, ADDRESS, AND DATE OF LAST EXAMINATION:

20. HAS THE MINOR EVER BEEN DIAGNOSED WITH INTELLECTUAL DISABILTY? ☐ YES ☐ NO

21. HAS THE MIINOR EVER BEEN CONFINED IN A HOSPITAL FOR MENTAL ILLNESS OR ADDICTION?

☐ YES ☐ NO IF **YES**, STATE THE REASON FOR HOSPITALIZATION, THE FACILITY IN WHICH THE MINOR WAS HOSPITALIZED, AND THE DATE(S) OF HOSPITALIZATION:

Case No.: 2025 - MH -

22. NOTICE INFORMATION - **YOU MUST COMPLETE THIS SECTION**:

A. Minor's Spouse, if any: *Name:* _____

Address: _____ *Telephone:* _____

_____

B. Minor's Parents/Guardians: *Name:* _____

Address: _____ *Telephone:* _____

_____

C. Minor's Next-of-Kin: *Name:* _____

Address: _____ *Telephone:* _____

_____

23. _____ *[initial]* **THE NAMED MINOR, WHO IS 14 YEARS OF AGE OR OLDER, HAS BEEN OFFERED VOLUNTARY TREATMENT, BUT HAS OBJECTED TO HIS OR HER FURTHER TREATMENT, OR THE PARENT OR GUARDIAN HAS REVOKED HIS OR HER CONSENT.**

WARNING:

If involuntarily committed, the minor against whom you are filing this application, will be:

(1) prohibited from possessing and receiving firearms, ammunition, and explosives, in some cases for his or her entire life,

(2) required to immediately surrender ANY firearms owned or in his or her possession,

(3) if committed for treatment of mental illness, reported to both federal and state database registries used for firearms purchases and permits/licenses to carry concealed weapons, as well as used by federal agencies for explosives prohibition, background checks, and other uses permitted by federal law or regulation.

(4) subject to future criminal charges for possession or receipt of firearms or ammunition. Conviction in West Virginia can result in a fine up to $1,000.00 or jail time of up to one year. Federal conviction is a FELONY and can result in fines and jail time up to TEN years. ***(See, W.Va. Code §61-7-7 and 18 U.S.C.A. § 924(a)(2))***

Persons seeking voluntary admission for treatment, who have NOT been involuntarily committed, are NOT subject to these prohibitions and requirements.

Case No.: 2025 - MH - _____

I, _____ ***[print YOUR name here]***, the Applicant Chief Medical Officer do hereby certify that I truly believe that the minor Respondent, _____ ***[print Respondent's name here]*** is ***[check applicable category(s)]*** ☐ addicted and/or ☐ mentally ill and because of ***mental illlness or addiction*** is likely to cause serious harm to him/her self and/or others if allowed to remain at liberty, and should, therefore, be taken into custody for examination and treatment. I therefore petition that the minor Respondent be brought before the Court in order that the Court may determine what further actions, if any, are warranted according to the provisions of the ***West Virginia Code*** § 27-5-2.

I understand that **MALICIOUS MAKING OF AN APPLICATION** to any circuit court or mental hygiene commissioner for the purpose of having another person declared mentally ill or an inebriate **IS A CRIME** and can result in fine or imprisonment up to one year, or both as provided in ***West Virginia Code***: § 27-12-1.

I further certify, **UNDER PENALTIES OF FALSE SWEARING** as provided by law, that the information, statements and allegations contained in this Petition and Application are true and accurate to the best of my knowledge, information and belief and constitute the sole basis and reasons for the making of this application. I understand that if I knowingly provide ***FALSE*** information in the application, I could be subject to a criminal charge of false swearing.

[NOTE: APPLICATION MUST BE MADE UNDER OATH/NOTARIZED OR WILL BE DENIED]

Click here to auto-fill date/time below

_____ _____ _____

Date Time Applicant's Signature

The foregoing Petition and Application was subscribed and sworn to or affirmed before the undersigned authority this _____ day of _____ ***[month]***, 20_____ ***[year]***.

[if notary - affix Notarial Seal]

_____

Signature of Notary Public / Circuit Clerk

My Commission Expires: _____