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IN THE CIRCUIT COURT OF_____COUNTY, WEST VIRGINIA

For Clerk's Use Only

IN RE: INVOLUNTARY HOSPITALIZTION OF _____, RESPONDENT

DATE: _____ CASE NUMBER: _____ -MH- _____

If this application is GRANTED, distribute copies of the application and Form INV 4 or 5 ORDER to: Applicant, Respondent, Respondent's Attorney, Prosecuting Attorney and the Regional Mental Health Facility.

APPLICATION FOR INVOLUNTARY CUSTODY FOR MENTAL HEALTH EXAMINATION OF INDIVIDUAL INCARCERATED IN A JAIL, PRISON, OR OTHER CORRECTIONAL FACILITY

W. Va. Code § 27-5-2(a)(2)

INSTRUCTIONS TO CHIEF ADMINISTRATIVE OFFICEER OF CORRECTIONAL FACILITLY:

A. All information must be printed or typed and be clearly readable.
B. All information requested must be provided, if known. If unknown, you must state is it unknown.
C. Any petition and application that does not provide the necessary information, or is unreadable, may be rejected or denied.
D. In this document, the **RESPONDENT** is the incarcerated individual whose examination is being requested.

1. FULL NAME OF INCARCERATED PERSON TO BE EXAMINED ***[RESPONDENT]***:

_____

Identification Information: DATE OF BIRTH __/__/__ WEIGHT _____

HAIR COLOR _____ HAIR LENTGH _____

SEX _____ HEIGHT _____ EYE COLOR _____

RACE _____

2. RESPONDENT'S LAST KNOWN ADDRESS PRIOR TO INCARCERATION:

_____

_____

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

4. THE RESPONDENT IS:

   A. A RESIDENT OF _____ COUNTY _____ STATE.

   B. CURRENTLY PRESENT IN _____ COUNTY, _____ STATE.

5. NAME OF CORRECTIONAL FACILILTY AT WHICH RESPONDENT IS NOW BEING HELD:

_____

6. ADDRESS OF CORRECTIONAL FACILITY:

_____

_____

CORRECTIONAL FACILITY TELEPHONE NUMBER: _____

7. CHIEF ADMINISTRATEIVE OFFICER'S FULL NAME: _____

   WORK PHONE NUMBER OF CHIEF ADMINISTRATIVE OFFICER: _____

PLEASE PROVIDE A WAY TO CONTACT YOU PENDING THIS APPLICTION 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. FAILURE OF FACT WITNESSES WITH FIRSTHAND KNOWLEDGE OF RESPONDENT'S CONDITION AND BEHAVIOR TO APPEAR AT THE HEARING MAY RESULT IN THE APPLICATING BEING DISMISSED AND THE RESPONDENT BEING RETURNED TO YOUR CORRECTIONAL FACILITY.** If you do not want the Respondent to have this information, you may supply the information separately to the Court.

PHONE NUMBER TO REACH CHIEF ADMINISTRATIVE 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 RESPONDENT, ***BECAUSE OF MENTALL 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 RESPONDENT IS LIKELY TO CAUSE SERIOUS HARM TO HIM/HER SELF AND/OR OTHERS. **INCLUDE APPROXIMATE DATE(S) WHEN EACH ACT OCCURRED:**

_____

_____

_____

(Attach additional sheets if necessary)

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

   IF YES, PLEASE EXPLAIN: _____

_____

B. IS RESPONDENT VIOLENT? ☐ YES ☐ NO ☐ UNKNOWN

   IF YES, PLEASE EXPLAIN: _____

_____

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

_____

_____

_____

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

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

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

_____

_____

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

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

_____

_____

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

☐ YES ☐ NO

IF **YES**, DESCRIBE THE CONDITION/DISEASE:

_____

_____

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

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

_____

_____

18. DOES THE RESPONDENT NEED MEDICAL CARE, TREATMENT, OR HOSPITALIZATION THAT WOULD PREVENT EXAMINTION BY A MENTAL HEALTH PROFESSIONAL OR A COURT APPEARANCE?

A. IMMEDIATELY? ☐ YES ☐ NO

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

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

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

_____

_____

20. HAS THE RESPONDENT EVER BEEN DIAGNOSED WITH AN INTELLECTUAL DISABLITY?

☐ YES ☐ NO

21. HAS THE RESPONDENT EVER BEEN CONFINED IN A HOSPITAL FOR MENATL ILLNESS OR ADDICTION? ☐ YES ☐ NO

IF **YES**, STATE THE REASON FOR HOSPITALIZATION, THE FACILITY IN WHICH THE RESPONDENT WAS HOSPITALIZED, AND THE DATE(S) OF HOSPITALIZATION:

_____

_____

22. NOTICE INFORMATION – **YOU <u>MUST</u> COMPLETE THIS SECTION:**

A. Respondent's Spouse: _____ _____
Name *Address*

_____ _____
City, State, Zip *Telephone*

B. Respondent's Parents/Guardians: _____ _____
Name *Address*

_____ _____
City, State, Zip *Telephone*

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

_____
City, State, Zip *Telephone*

23. _____ *[initial]* **THE HEREIN NAMED CORRECTIONAL FACILITY AT WHICH THE RESPONDENT IS INCARCERATED CANNOT REASONABLY PROVIDE TREATMENT AND OTHER SERVICES FOR THE RESPONDENT'S MENTAL ILLNESS OR ADDICTION.**

24. _____ *[initial]* **THE NAMED RESPONDENT HAS BEEN OFFERED VOLUNTARY TREATMENT, BUT HAS EITHER REFUSED APPROPRIATE VOLUNTARY HOSPITALIZATION AND/OR TREATMENT, OR IS IN A MENTAL OR MEDICAL CONDITION PRECLUDING HIS OR HER ABILITY TO CONSENT TO VOLUNTARY HOSPITALIZATION AND/OR TREATMENT.**

NOTICE:

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

(1) Prohibited from possessing and receiving firearms and ammunition, 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 firearm purchases and permits/licenses to carry concealed weapons, and
(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 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.

I, _____ the Applicant and Chief Administrative Officer of the
[print your name here]

_____ Correctional facility, hereby certify
[print NAME OF CORRECTIONAL FACILITY here]

that I truly believe that the Respondent, _____
*[print **RESPONDENT'S** name here]*

[check applicable category(s)] ☐ addicted and/or ☐ mentally ill and because of **mental illness 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 Respondent be brought before 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 of 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. *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 shole basis and reasons for the making of this application. I understand that if 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 CHIEF ADMINISTRATIVE OFFICER'S SIGNATURE

The foregoing Petition and Application was subscribed and sworn to or affirmed before the undersigned authority this _____day of _____ , 20 _____ .

[*if notary – affix Notarial Seal*] _____
NOTARY PUBLIC/CIRCUIT CLERK

My Commission Expires: _____