

For Clerk's Use Only

IN RE: INVOLUNTARY HOSPITALIZATION 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 OFFICER OF CORRECTIONAL FACILITY:

- 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 LENGTH: _____ ;
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 FACILITY AT WHICH RESPONDENT IS NOW BEING HELD:

6. ADDRESS OF CORRECTIONAL FACILITY:

CORRECTIONAL FACILITY TELEPHONE NUMBER: _____

7. CHIEF ADMINISTRATIVE OFFICER'S FULL NAME: _____

WORK PHONE NUMBER OF CHIEF ADMINISTRATIVE OFFICER: _____

EMAIL ADDRESS OF CHIEF ADMINISTRATIVE 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. FAILURE OF FACT WITNESSES WITH FIRSTHAND KNOWLEDGE OF RESPONDENT'S CONDITION AND BEHAVIOR TO APPEAR AT THE HEARING MAY RESULT IN THE APPLICANT 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 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 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. PLEASE EXPLAIN WHY THE CORRECTIONAL FACILITY CANNOT REASONABLY PROVIDE TREATMENT AND OTHER SERVICES TO PREVENT THE RESPONDENT FROM SERIOUSLY HARMING HIS/HERSELF AND/OR OTHERS DUE TO MENTAL ILLNESS AND/OR SUBSTANCE USE DISORDER.

14. DO YOU BELIEVE THE RESPONDENT, BECAUSE OF SUBSTANCE USE DISORDER, HAS LOST THE POWER OF SELF CONTROL WITH RESPECT TO SUBSTANCE USE, IS IN NEED OF SUBSTANCE ABUSE SERVICES AND, BY REASON OF SUBSTANCE ABUSE IMPAIRMENT, HIS OR HER JUDGMENT HAS BEEN SO IMPAIRED THAT THE INDIVIDUAL IS INCAPABLE OF APPRECIATING HIS OR HER OWN NEED FOR SUCH SERVICES AND IS FURTHER INCAPABLE OF MAKING A RATIONAL DECISION IN REGARD YES NO
PLEASE EXPLAIN:

15. 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 AND PROVIDE THEIR EMAIL ADDRESSES TO THE COURT/CRISIS WORKER.

16. IS THE RESPONDENT CURRENTLY HOSPITALIZED? YES NO
IF YES, STATE WHERE HOSPITALIZED AND EXPECTED LENGTH OF STAY IN HOSPITAL:

17. HAS THE RESPONDENT BEEN UNDER THE RECENT CARE OF A PHYSICIAN? YES NO
IF YES, STATE PHYSICIAN'S NAME, ADDRESS, AND PHONE NUMBER:

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

YES NO

IF YES, DESCRIBE THE CONDITION/DISEASE:

19. IS THE RESPONDENT TAKING ANY MEDICATIONS? YES NO

IF YES, LIST THE MEDICATIONS AND DOSAGE:

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

A. IMMEDIATELY? YES NO

B. WITHIN THE NEXT 24 HOURS? YES NO

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

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

22. TO THE BEST OF YOUR KNOWLEDGE, HAS THE RESPONDENT EVER BEEN DIAGNOSED WITH:

INTELLECTUAL OR DEVELOPEMENT DISABLITY YES NO

DEMENTIA YES NO

EPILEPSY YES NO

TRAUMATIC BRAIN INJURY (TBI) YES NO

23. HAS THE RESPONDENT 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 RESPONDENT WAS HOSPITALIZED, AND THE DATE(S) OF HOSPITALIZATION:

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

Respondent's Spouse:

Name

Street Address

Telephone

City, State, Zip

B. Respondent's
Parents/Guardians:

Name

Street Address

Telephone

City, State, Zip

C. Respondent's
Next-of-Kin:

Name

Street Address

Telephone

City, State, Zip

25. _____ *[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.**

26. _____ *[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]

[print NAME OF CORRECTIONAL FACILITY here] Correctional facility, hereby certify that I truly believe

that the Respondent _____ is suffering from substance use disorder and/or
[print RESPONDENT'S name here]

mental illness and because of mental illness or substance abuse disorder is likely to cause serious harm to him/her self and/or others if allowed to remain at liberty even while incarcerated OR Respondent has a substance use disorder and he/she has lost the power of self-control with respect to substance use, he/she is in need of substance abuse services and, by reason of substance about impairment, his or her judgment has been so impaired that the individual is incapable of appreciating his or her need for such services and is further incapable of making a rational decision in regard such services, and should therefore, be taken into custody for examination. I therefore petition that the 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 *W. Va. Code § 27-5-2*.

I understand that MALICIOUS MAKING OF AN APPLICATION (with intent to harm), to any circuit court or mental hygiene commissioner for the purpose of having another person declared mentally ill or an inebriate (suffers from substance abuse disorder) IS A CRIME and can result in fine or imprisonment up to one year, or both as provided in *W. Va. 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.

Date

Time

CHIEF ADMINISTRATIVE OFFICER'S SIGNATURE