PROBATE COURT
JEFFERSON COUNTY COURTHOUSE
BIRMINGHAM, ALABAMA

By signing this Petition, you are asking the Court to have this person evaluated for possible commitment to the Alabama State Department of Mental Health for treatment.

As a result of the Petition, this person could be committed to the custody of Bryce Hospital, the VA Hospital in Tuscaloosa, Alabama, or any other facility operated by the Alabama State Department of Mental Health.

I understand that a probable cause hearing concerning this petition will be scheduled within one week after the petition is activated; that I MUST be present at such hearing, and that I will be subject to sanctions by the Court upon my failure to appear.

Furthermore, I understand that by signing the Pauper's Oath, I am requesting of the Court to be relieved of the payment of Court costs and attorney fees. However, I understand that the Court is not responsible for any hospital costs accrued during the process.

_____	_____
Petitioner	Petitioner
_____	_____
Address	Address
_____	_____
City State Zip Code	City State Zip Code
_____	_____
Home Phone Number	Home Phone Number
_____	_____
Work Phone Number	Work Phone Number
_____	_____
Cell Phone Number	Cell Phone Number

IN THE MATTER OF THE INVOLUNTARY COMMITMENT OF _____ RESPONDENT	IN THE PROBATE COURT OF JEFFERSON COUNTY, ALABAMA CASE NO: _____

PETITION

TO THE HONORABLE JAMES P. NAFTEL & SHERRI C. FRIDAY, JUDGES OF PROBATE

COME(S) NOW_____ and petition(s) this Honorable Court, under the provisions of the laws of the State of Alabama in accordance with 22-52-1 et seq., Code of Alabama 1975, to order the Sheriff of Jefferson County to take into custody _____(who is hereinafter referred to as respondent) and whose approximate physical characteristics are as follows:

Height: ____ft___in; Weight: _____lbs.: Age: ____Yrs.; Sex____; Race: _____who is presently located at _____and, after proper investigation and hearings, to find that the said respondent ***is*** mentally ill and to commit the said respondent to the custody of the Alabama Department of Mental Health.

Petitioner(s) relationship with the said respondent is_____.

As grounds for said Petitioner(s) say(s):

1. That the Petitioner(s) has reason to believe that said respondent is mentally ill; that as a result of the mental illness, the respondent poses a real and present threat of substantial harm to him(her) self and/or to others; that as a result of the mental illness, the respondent will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently, and the respondent is unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable, that commitment is the least restrictive alternative that is necessary and available for the respondent's illness.

2. That a threat of substantial harm to the respondent or to others has been evidence by the following recent behavior, acts, attempts or threats: (please set out what happened, and when and where it happened:

_____
_____
_____
_____
_____
_____
_____
_____
_____

3. That the names and addresses, if known, of the respondent's spouse, legal counsel or next of kin are:

_____
_____
_____
_____

4. That the persons shown below have knowledge of the act(s) set out in the preceding paragraph:

FULL NAME	ADDRESS	PHONE NUMBERS

Respectfully submitted on this the____day of _____, 20___.

_____ _____
Petitioner Petitioner's Attorney or Co-Petitioner

The State of Alabama
Jefferson County

The Petitioner(s) whose name(s) is (are) signed above, has/have duly sworn, deposes and says on oath that the facts alleged in the Petition above are true and correct.

_____

_____
Petitioner(s)

Sworn to and subscribed before me, the undersigned authority,
on this the ____day of _____, 20___.

_____
(Judge of Probate) (Notary Public) (Chief Clerk)

The State of Alabama
Jefferson County

PROBATE COURT
Case No:_____

IN THE MATTER OF THE COMMITMENT OF

_____

Alleged To Be Mentally Ill

Before me, the undersigned, a Notary Public in the said County and State personally appeared before me_____, Petitioner(s) in the aforementioned cause, who after being duly sworn by oath, depose(s) and say(s) that ____he is an indigent person(s) wholly without funds to pay any fees or other costs incurred in the litigation and, therefore, pray(s) that ___he be allowed to proceed under **the Pauper's Act** of the State of Alabama.

_____

_____

Sworn to and subscribed before me on this the ___day of _____, 20__.

_____

Notary Public

Patient Personal History

Name: _____ Date of Birth: _____ Sex: _____
Patient's Address:
_____ Telephone: _____
_____ Social Security Number: _____
_____ , _____ _____ Race: _____
Country of origin (*if applicable*): _____
Primary Language: _____

Marital Status:

☐single ☐widowed
☐legally married ☐separated/absent
☐divorced ☐common law

Education:

☐high school graduate
☐GED
☐college graduate college level completed: _____
If dropped out, highest grade level completed: _____

Hearing Status:

☐hearing ☐deaf
☐hard of hearing

Sight Status:

☐no loss/vision corrected ☐partially sighted
☐legally blind ☐totally blind

Living Arrangement:

☐living independently ☐with family
☐homeless/shelter ☐group home
☐boarding home

Number of individuals in household: _____
Spouse's Name: _____
Spouse's Address: _____
Spouse's Phone: _____

In case of emergency, notify (name): _____ Phone: _____
Name of minor children: _____ Address: _____
Father's Name: _____ Mother's Name: _____
If the patient has a legal-appointed guardian, please provide guardian's name: _____

If patient ever been to another mental hospital or had psychiatric treatment *by* a psychiatrist at a mental health center, clinic, etc., please provide:
Name:
_____
Address:
_____
When:
_____

List any past medications the patient has been on:
_____
_____
When did you first notice patient's illness:
_____
What behavior changes have occurred?
_____
Describe patient prior to present problem:
_____

Does patient have epilepsy?
☐yes ☐no
☐treated by a physician?

If patient has epilepsy and is treated by a physician, provide physician's name:
_____
What medication? _____ Time of last seizure? _____

If patient has ever had any other convulsions, "fits", or unconscious spells, please describe:
_____

If patient has had a severe head injury or any other kind of injury:

When: _____ Describe: _____

Where were they treated: _____

Has patient had a serious illness/accident, i.e. stroke, heart trouble, abnormal blood pressure, diabetes, syphilis, or other venereal disease? ☐yes ☐no

If patient takes medication for this, what do they take:
_____

What medications is the patient allergic to, if any: _____
Please list any physical handicaps or accessibility needs: _____
Please list any operations the patient has had: _____
If the patient abuses drugs (including alcohol), please list: _____
Does the patient use tobacco? ☐yes ☐no

Legal Information

Has the patient ever been arrested? ☐yes ☐no Please describe: _____

Action Taken: _____

Does the patient currently have any pending criminal charges? ☐yes ☐no

If so, please identify with whom and classification of charge (such as a misdemeanor or felony):

_____

Number of arrests in the last 30 days: _____ Number of arrests in the last 12 months: _____

Registered sex offender: ☐yes ☐no

Financial Information

Patient's Usual Occupation: _____

Name of Last Employer: _____ Address: _____

Date Last Worked: _____ Household/Family income amount: _____

Source of Income:

☐Social Security Amount: _____ Payee Name: _____

☐SSI Amount: _____

☐VA Amount: _____

☐Retirement Amount: _____

☐Civil Service Amount: _____

☐Wages Amount: _____

☐Other Specify: _____ Amount: _____

Hospital Insurance? ☐yes ☐no Type: _____ Policy #: _____ Group #: _____

If yes, name of insured: _____ DOB: _____ SSN: _____

Relationship to patient: _____

Name of company insurance is issued through: _____

Company Address: _____

If patient has Medicare, please provide Medicare Claim Number: _____

If patient has Medicaid, please provide Medicaid Number: _____

If patient is a veteran, complete the following:

Service Branch: _____ Dates of Service: _____ Type of Discharge: _____

Claim #: _____

If patient is a dependent of a veteran, please complete the following:

Name of Veteran: _____ Veteran's Claim #: _____

Patient's relationship to veteran: _____

Any Additional Information:

_____

_____

_____

This form has been completed by: _____

Relationship to patient: _____ Date: _____