

At a \_\_\_\_\_ Part of the \_\_\_\_\_  
Court of the State of New York, located at \_\_\_\_\_  
New York, on the \_\_\_\_\_ day of \_\_\_\_\_,  
\_\_\_\_\_.

P R E S E N T :

Hon. \_\_\_\_\_, Judge/Justice

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In the Matter of the Application of \_\_\_\_\_  
\_\_\_\_\_, Director of Community Services  
for the (County) (City) of \_\_\_\_\_,

Petitioner,

For an Order Authorizing Assisted Outpatient  
Treatment

ORDER TO SHOW  
CAUSE PURSUANT  
TO MENTAL HYGIENE  
LAW § 9.60

Index No.

- for -

\_\_\_\_\_, Respondent.

----- x

Upon reading and filing the annexed petition of \_\_\_\_\_, Director of  
Community Services for the (County) (City) of \_\_\_\_\_, dated \_\_\_\_\_  
\_\_\_\_\_, and the affirmation of \_\_\_\_\_, M.D., dated \_\_\_\_\_  
\_\_\_\_\_, and upon all papers and proceedings had herein,

(And it appearing to the court that good cause exists to schedule a hearing in this matter  
more than three days after the filing of this petition, as otherwise required by Mental Hygiene  
Law §9.60(h), because \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_,)

Let the respondent show cause before this Court at \_\_\_\_\_  
on the \_\_\_\_\_ day of \_\_\_\_\_, at \_\_\_\_\_ (a.m.)(p.m.), or as soon thereafter as  
counsel can be heard

WHY an Order should not be made authorizing and requiring assisted outpatient treatment  
for the respondent in accordance with the attached treatment plan, dated \_\_\_\_\_  
\_\_\_\_\_, pursuant to Mental Hygiene Law §9.60;

SUFFICIENT CAUSE THEREFOR APPEARING, LET service of a copy of this Order  
to Show Cause, together with the papers upon which it was granted, be made on or before \_\_\_\_\_  
\_\_\_\_\_ upon (1) the respondent, \_\_\_\_\_, by personal  
service; (2) the Mental Hygiene Legal Services, by overnight delivery service or, with its consent,  
by facsimile transmission; (3) \_\_\_\_\_, as the appropriate  
Program Coordinator appointed pursuant to Mental Hygiene Law §7.17(f), by overnight delivery  
service or, with his/her consent, by facsimile transmission; (4) \_\_\_\_\_  
\_\_\_\_\_, the nearest relative of the  
respondent known to petitioner, and any other person designated in writing by respondent  
pursuant to Mental Hygiene Law §9.29, by overnight delivery service, and be deemed good and  
sufficient service.

\_\_\_\_\_  
Judge/Justice

\_\_\_\_\_ Court of the State of New York  
County of \_\_\_\_\_  
----- x

In the Matter of the Application of \_\_\_\_\_  
\_\_\_\_\_, Director of Community Services  
for the (County) (City) of \_\_\_\_\_,

Petitioner,

PETITION OF  
DIRECTOR OF  
COMMUNITY SERVICES  
PURSUANT TO MENTAL  
HYGIENE LAW § 9.60

For an Order Authorizing Assisted Outpatient  
Treatment

Index No.

- for -

\_\_\_\_\_, Respondent  
----- x

Petitioner \_\_\_\_\_, the Director of Community Services for the  
(County) (City) of \_\_\_\_\_, respectfully alleges that:

1. I am the Director of Community Services for the (County) (City) of \_\_\_\_\_  
\_\_\_\_\_, having been appointed to that position pursuant to Mental Hygiene Law  
(MHL) §§ 41.05 and 41.09.

2. I make this application to the Court for an assisted outpatient treatment order for  
\_\_\_\_\_, the respondent, pursuant to MHL §9.60.

3. Upon information and belief, respondent is present in \_\_\_\_\_ County,  
having a current residence at \_\_\_\_\_

4. The respondent (has) (has not) provided information as to his/her nearest relative.

If respondent has provided this information, set forth that relative's name, address, and

relationship to the respondent: \_\_\_\_\_  
\_\_\_\_\_.

5. The respondent (has) (has not) designated in writing other persons pursuant to MHL §9.29. If respondent has so designated other persons, set forth the names and addresses:

\_\_\_\_\_  
\_\_\_\_\_.

6. Upon information and belief, respondent suffers from \_\_\_\_\_  
\_\_\_\_\_, a mental illness as defined in MHL §1.03(20).

7. Attached hereto is the affirmation of \_\_\_\_\_,  
M.D., a physician who recently conducted, or attempted to conduct, a psychiatric examination of respondent. This petition is being submitted within ten (10) days of the examination described in the affirmation.

8. The respondent meets the following criteria set forth in Mental Hygiene Law §9.60(c):

- i. The respondent is 18 years of age or older;
- ii. The respondent is suffering from a mental illness;
- iii. The respondent is unlikely to survive safely in the community without supervision, based on a clinical determination;

iv. The respondent has a history of lack of compliance with treatment for mental illness that (check applicable paragraph(s)):

(a) at least twice within the last 36 months has been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any period

during which respondent was hospitalized or incarcerated immediately preceding the filing of this petition; or

(b) has resulted in one or more acts of serious violent behavior toward self or others, or threats of, or attempts at, serious physical harm to self or others within the last 48 months, not including any period in which respondent was hospitalized or incarcerated immediately preceding the filing of this petition;

v. The respondent is, as a result of his/her mental illness, unlikely to participate voluntarily in the treatment recommended in the proposed treatment plan as set forth in the attached physician's affirmation;

vi. In view of the respondent's treatment history and current behavior, he/she is in need of assisted outpatient treatment in order to prevent a relapse or deterioration of his/her present mental status which would be likely to result in serious harm to the respondent or others as defined in section 9.01 of the Mental Hygiene Law; and

vii. The respondent will likely benefit from assisted outpatient treatment.

9. The basis for the allegation that the petitioner meets the criteria set forth in section 9.60(c) of the Mental Hygiene Law is (check applicable paragraph(s)):

the statements made in the attached physician's affirmation, which, upon information and belief, are true and are incorporated herein by reference

the following facts and circumstances (State basis for conclusion)

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10. The relief requested herein is in the respondent's best interests, has been narrowly tailored to give substantive effect to his/her liberty interests, and is the least restrictive alternative form of treatment appropriate for the respondent.

11. It is requested that an order be issued requiring Assisted Outpatient Treatment, as set forth in the proposed treatment plan, for a period of (Insert time period of up to six months) \_\_\_\_\_  
\_\_\_\_\_.

12. The proposed treatment plan has been developed while taking into account any directions that may have been included in a health care proxy, as defined in Article 29-C of the Public Health Law, which has been executed by the respondent.

13. No previous application for this relief requested has been made to this or any other Court except (Insert details of any previous applications) \_\_\_\_\_  
\_\_\_\_\_.

WHEREFORE, petitioner respectfully requests that the Court order assisted outpatient treatment for respondent pursuant to the proposed treatment plan.

Date: \_\_\_\_\_

Respectfully submitted,

\_\_\_\_\_  
Attorney for Petitioner  
P.O. Address:

Tel. No.

**VERIFICATION**

STATE OF NEW YORK    )  
  )  
COUNTY OF                    )    ss.:

\_\_\_\_\_, being duly sworn, deposes and says that (s)he is the Director of Community Services for the (County) (City) of \_\_\_\_\_, and the petitioner in the within entitled proceeding. That (s)he has read the foregoing petition and knows the contents thereof. That the same is true of his/her knowledge, except as to the matters therein stated to be alleged upon information and belief, and as to those matters (s)he believes it to be true.

\_\_\_\_\_  
Petitioner

Sworn to before me this \_\_\_\_\_  
day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Notary Public

\_\_\_\_\_ Court of the State of New York  
County of \_\_\_\_\_

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In the Matter of the Application of \_\_\_\_\_  
\_\_\_\_\_, Director of Community  
Services for the (County) (City) of \_\_\_\_\_,

Petitioner,

For an Order Authorizing Assisted Outpatient  
Treatment

PHYSICIAN'S  
AFFIRMATION  
FOLLOWING  
EXAMINATION OF  
RESPONDENT  
PURSUANT TO MENTAL  
HYGIENE LAW §9.60

Index No.

- for -

\_\_\_\_\_, Respondent.

----- x

STATE OF NEW YORK     )  
  )     ss.:  
COUNTY OF                     )

\_\_\_\_\_, M.D., affirms the following to be true under penalty of  
perjury:

1. I am a physician licensed to practice medicine by the State of New York and I am  
practicing (Insert specialties and nature of practice) \_\_\_\_\_

\_\_\_\_\_ at (Indicate service provider affiliation, if any, and location of practice) \_\_\_\_\_

\_\_\_\_\_. I make this affirmation in support of the petition by \_\_\_\_\_

\_\_\_\_\_ for an order authorizing assisted outpatient treatment for the

respondent in accordance with §9.60 of the Mental Hygiene Law and the attached treatment plan.

2. I performed a psychiatric evaluation of \_\_\_\_\_, the respondent, on \_\_\_\_\_, \_\_\_\_\_, and have had occasion to observe him/her.

3. Currently, the respondent is (State whether the respondent is receiving inpatient or outpatient services and location where services are delivered) \_\_\_\_\_  
\_\_\_\_\_.

4. The respondent is at least 18 years of age. His/her diagnosis is \_\_\_\_\_, a mental illness as defined in section 1.03(20) of the Mental Hygiene Law that is described in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

5. Based upon my clinical observations, the respondent is unlikely to survive safely in the community without supervision because: (Insert basis for conclusion)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

6. (Complete applicable paragraph(s))

(a). As indicated below, the respondent has a history of lack of compliance with treatment that has necessitated hospitalization, or receipt of services in a forensic or mental health unit of a correctional facility or a local correctional facility, at least twice within the last 36 months, not including any period in which the respondent was hospitalized or incarcerated immediately preceding the filing of this petition: (Insert facts showing two hospitalizations or instances of service in a correctional setting) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

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(b). As indicated below, the respondent has a history of lack of compliance with treatment that has resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others, within the last 48 months, not including any period in which the respondent was hospitalized or incarcerated immediately preceding the filing of this petition: (State factual basis for conclusion)

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7. Because of the respondent's mental illness and failure to comply with treatment, it is my opinion that (s)he is unlikely to participate voluntarily in the recommended treatment pursuant to the proposed treatment plan. I spoke with the respondent about an outpatient treatment plan and provided him/her with the opportunity to actively participate in the development of the plan.

8. The attached outpatient treatment plan (Exhibit "A") was developed by me after consultation with the respondent and (If applicable, insert name of any significant individual designated by the respondent, such as a relative, close friend, or health care agent) \_\_\_\_\_.

The treatment plan, among other things, provides for care coordination in the form of (State form of coordination, e.g. Assertive Community Treatment team, intensive case management, or supportive case management)

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9. In view of the respondent's treatment history and current behavior, (s)he is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in serious harm to the respondent or others. (State clinical basis for conclusion)

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10. The proposed outpatient treatment plan has been narrowly tailored taking into consideration all relevant information available for the respondent. I do not believe the respondent can be safely maintained under any less restrictive provision of services.

11. It is my opinion that the respondent will likely benefit from assisted outpatient treatment and that the proposed plan is in the respondent's best interests. An order from the court incorporating the proposed treatment plan may enhance the respondent's ability to comply with recommended treatment and remain out of an inpatient setting. In my opinion, without care and treatment on an outpatient basis, the respondent will deteriorate and once again require inpatient psychiatric hospitalization.

12. The proposed treatment plan attached as Exhibit "A" provides for case management and other mental health services for the respondent.

13. An order should be issued requiring assisted outpatient treatment for this respondent for a period of (Insert time period of up to six months) \_\_\_\_\_ in accordance with the attached treatment plan.

14. I am willing and able to testify at the hearing in this matter

15. To my knowledge, no previous application for the relief requested has been made before this or any other Court, except: (Insert details of any previous applications) \_\_\_\_\_

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WHEREFORE, your affirmant respectfully requests that the Court issue an order requiring assisted outpatient treatment for the respondent in accordance with the annexed treatment plan.

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Date: \_\_\_\_\_

At a \_\_\_\_\_ Part of the \_\_\_\_\_  
Court of the State of New York, located at  
\_\_\_\_\_, New York  
on the \_\_\_\_\_ day of \_\_\_\_\_,  
\_\_\_\_\_.

P R E S E N T:

HON. \_\_\_\_\_, Judge/Justice

-----X  
In the Matter of the Application of \_\_\_\_\_,  
Director of Community Services for the (County) (City) of  
\_\_\_\_\_.

Petitioner,

FINAL ORDER AND  
JUDGMENT  
PURSUANT TO  
MENTAL HYGIENE  
LAW §9.60

For an Order Authorizing Assisted Outpatient  
Treatment

Index No.

- for -

\_\_\_\_\_, Respondent.

-----X

Upon reading and filing the petition of \_\_\_\_\_, Director of  
Community Services for the (County) (City) of \_\_\_\_\_, verified the \_\_\_\_\_  
\_ day of \_\_\_\_\_, \_\_\_\_\_, and the affirmation of \_\_\_\_\_  
, M.D., signed the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, and this matter having come  
before the undersigned on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, and the  
respondent, having been represented by \_\_\_\_\_, Esq. of \_\_\_\_\_  
\_\_\_\_\_, and a hearing having been held before the

undersigned and testimony having been given therein by Dr. \_\_\_\_\_

(Add "and others" if more than one witness testified) \_\_\_\_\_,

And the Court having found by clear and convincing evidence that:

(a) the respondent meets all of the criteria for assisted outpatient treatment as set forth in Mental Hygiene Law section 9.60 (c), and

(b) the assisted outpatient treatment set forth below is the least restrictive treatment that is appropriate and feasible;

NOW, on motion of \_\_\_\_\_, Esq.,

It is hereby ORDERED AND ADJUDGED:

1. That respondent shall receive and accept assisted outpatient treatment for a period of (Insert duration of up to six months) \_\_\_\_\_ from the date of this order consisting of the treatment recommended in the attached treatment plan; and

2. That the petitioner as Director of Community Services shall provide and/or arrange for all the categories of service to respondent that are recommended in the attached treatment plan for the duration of this order and judgment.

ENTER

\_\_\_\_\_

Judge/Justice

## TREATMENT PLAN UNDER MENTAL HYGIENE LAW §9.60<sup>1</sup>

Respondent's/Patient's name \_\_\_\_\_

Physician who developed treatment plan \_\_\_\_\_

Physician's employer \_\_\_\_\_

Physician's business address \_\_\_\_\_

Date of examination \_\_\_\_\_

### COMPLETE PARTS A, B, C AND D.

A. In preparing a treatment plan, the respondent must be given an opportunity to actively participate in developing the plan. In addition, upon the request of the respondent, an individual significant to the respondent (e.g. a relative, close friend, or health care agent) may participate in developing the plan. List the name(s) of any individual(s) in addition to the respondent who participated in the development of this treatment plan, or indicate "none":

\_\_\_\_\_

B. Will medication be included as a category of service on this treatment plan? \_\_\_\_\_

If yes, the MEDICATION WORKSHEET must be completed and attached.

\_\_\_\_\_

<sup>1</sup> Section 9.60(a)(1) of the Mental Hygiene Law mandates case management/care coordination for any person ordered by the court to receive assisted outpatient treatment, and authorizes the court to order the following categories of service as recommended by a physician:

- Medication
- Periodic blood tests or urinalysis to determine compliance with prescribed medications
- Individual or group therapy
- Day or partial day programming activities
- Educational and vocational training or activities
- Alcohol or substance abuse treatment and counseling, and periodic tests for the presence of alcohol or illegal drugs
- Supervision of living arrangements
- Any other services prescribed 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 that may reasonably be predicted to result in suicide or the need for hospitalization.

C. Will alcohol or substance abuse counseling and treatment be included as a category of service? \_\_\_\_\_ If yes, the ALCOHOL/SUBSTANCE ABUSE WORKSHEET must be completed and attached. [Note: Blood tests or urinalysis for the presence of alcohol or illegal drugs shall be subject to review after six months by this physician (or another physician designated by the Director), and such physician shall be authorized to terminate such blood tests or urinalysis without further action by the court.]

D. For all categories of service other than medication and alcohol or substance abuse counseling and treatment, list the category of service, a brief description of the service recommended, and the name, address, telephone number and contact person of the program providing the service. (The description of the services should be detailed, e.g. "day or partial day programming activities" should indicate particular services which will be provided, such as anger management, medication education group, group therapy, etc. Add additional sheets of paper if necessary.)

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_
5. \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

### MEDICATION WORKSHEET

Respondent's/Patient's name \_\_\_\_\_ Date of birth \_\_\_\_\_

Physician who developed treatment plan \_\_\_\_\_

Date of treatment plan \_\_\_\_\_

1. List the types or classes of medications recommended (e.g., antipsychotics, antidepressants, mood stabilizers, anxiolytics, antiparkinsonians) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. List each medication recommended, the dosage, frequency, and route you anticipate prescribing, and whether self-administration or administration by authorized personnel is recommended for each medication. Whenever possible, indicate contingencies/medication alternatives (e.g., if X medication is prescribed, but is determined to be ineffective after a specified trial period, Y medication will be initiated in its place).

(a) Medication: \_\_\_\_\_

Class: \_\_\_\_\_

Dosage Range/Frequency: \_\_\_\_\_

Route: \_\_\_\_\_

Administration: \_\_\_\_\_

Contingencies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(b) Medication: \_\_\_\_\_

Class: \_\_\_\_\_

Dosage Range/Frequency: \_\_\_\_\_

Route: \_\_\_\_\_

Administration: \_\_\_\_\_

Contingencies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(c) Medication: \_\_\_\_\_

Class: \_\_\_\_\_

Dosage Range/Frequency: \_\_\_\_\_

Route: \_\_\_\_\_

Administration: \_\_\_\_\_

Contingencies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(d) Medication: \_\_\_\_\_

Class: \_\_\_\_\_

Dosage Range/Frequency: \_\_\_\_\_

Route: \_\_\_\_\_

Administration: \_\_\_\_\_

Contingencies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(e) Medication: \_\_\_\_\_

Class: \_\_\_\_\_

Dosage Range/Frequency: \_\_\_\_\_

Route: \_\_\_\_\_

Administration: \_\_\_\_\_

Contingencies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. Briefly describe the beneficial and detrimental physical and mental effects of each medication.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Have the beneficial and detrimental physical and mental effects of each medication been discussed with the respondent/patient (and the respondent's relative, close friend, or health care agent, if applicable)? \_\_\_\_\_ If not, please explain: \_\_\_\_\_

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5. Will the medication(s) listed above be likely to provide maximum benefit to this respondent/patient? \_\_\_\_\_ If not, are there other medications which would likely provide maximum benefit to this respondent/patient? \_\_\_\_\_ If so, explain why they are not recommended here:

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Physician's Signature

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Date

**ALCOHOL/SUBSTANCE ABUSE WORKSHEET**

Respondent's/Patient's name \_\_\_\_\_ Date of birth \_\_\_\_\_

Physician who developed treatment plan \_\_\_\_\_

Date of treatment plan \_\_\_\_\_

1. List the respondent's/patient's alcohol abuse and or substance abuse diagnosis(es): \_\_\_\_\_

2. What treatments and/or counseling to address alcohol and/or substance abuse are recommended for this respondent/patient?

	TYPE OF SERVICE	FREQUENCY/DURATION	SERVICE PROVIDER
a)	_____	_____	_____
b)	_____	_____	_____
c)	_____	_____	_____
d)	_____	_____	_____
e)	_____	_____	_____

3. If alcohol testing (blood level and/or breathalyser) is recommended:

a) Does this respondent/patient have a history of alcohol abuse that is clinically related to his/her mental illness? \_\_\_\_\_ If yes, state facts which support this conclusion:

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b) Is such testing necessary to prevent a relapse or deterioration that would be likely to result in serious harm to self or others? \_\_\_\_\_ If yes, state facts which support this conclusion:

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4. If testing for illegal substances (blood or urinalysis) is recommended:

a) Does this respondent/patient have a history of substance abuse that is clinically related to his/her mental illness? \_\_\_\_\_ If yes, state facts which support this conclusion:

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b) Is such testing necessary to prevent a relapse or deterioration that would be likely to result in serious harm to self or others? \_\_\_\_\_ If yes, state facts which support this conclusion:

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[Note: Blood tests or urinalysis for the presence of alcohol or illegal drugs shall be subject to review after six months by this physician (or another physician designated by the Director) and such physician shall be authorized to terminate such blood tests or urinalysis without further action by the court.]

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Physician's Signature

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Date