STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

APPLICATION TO COURT FOR 96 HOUR DETENTION, EVALUATION AND TREATMENT/REHABILITATION

NO.

IN THE CIRCUIT COURT OF _____ COUNTY, MISSOURI
PROBATE DIVISION

IN THE MATTER OF _____, RESPONDENT.

DATE OF BIRTH: _____ GENDER: ☐ MALE ☐ FEMALE

The applicant herein states to the Court as follows:

1. That the respondent _____, age _____, birthdate _____, resides at

_____
(STREET) (CITY) (COUNTY) (STATE) (ZIP CODE)

and is now at _____.

2. That the applicant has reason to believe that the respondent is mentally disordered/abuses alcohol or drugs or both as defined by law and presents a likelihood of serious harm to h_____self or others, and thus is in need of detention, evaluation and treatment/rehabilitation.

3. The facts that support the applicant's belief that the respondent is mentally disordered/abuses alcohol or drugs or both are:

4. The facts that support the applicant's belief that the respondent presents a likelihood of serious harm are:

5. That attached and made a part of hereof are affidavits in support of this application and the names and addresses of persons known to the applicant to have personal knowledge of the facts.

WHEREFORE, the applicant requests the Court to hold a hearing on this application and to order that the respondent, be taken in to custody and transferred to _____ for detention, evaluation and treatment/rehabilitation for a period not to exceed 96 hours pursuant to Chapter 632, RSMo/Chapter 631, RSMo.

_____, applicant herein, verifies and affirms that the facts stated in the foregoing application are true to the best of h_____ knowledge and belief.

Attachments

DIVISION CLERK	DEPUTY DIVISION CLERK By	
APPLICANT		TELEPHONE
STREET	CITY	COUNTY / STATE / ZIP CODE

NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE	COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR	**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE / MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

AFFIDAVIT IN SUPPORT OF APPLICATION FOR DETENTION, EVALUATION AND TREATMENT/REHABILITATION - ADMISSION FOR 96 HOURS

IN THE MATTER OF _____ , RESPONDENT,

_____ , HEREBY AFFIRMS AN OATH AS FOLLOWS:

(Describe the behavior which respondent exhibits which supports the conclusion that respondent is mentally disordered or an alcohol or drug abuser and presents a likelihood of serious harm to himself or others.)

NAME (SIGNATURE)			
STREET ADDRESS			
CITY	STATE	ZIP CODE	TELEPHONE ( )

NOTARY PUBLIC EMBOSSER SEAL	STATE OF		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF 19		USE RUBBER STAMP IN CLEAR AREA BELOW.
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

AFFIDAVIT IN SUPPORT OF APPLICATION FOR DETENTION, EVALUATION AND TREATMENT/REHABILITATION - ADMISSION FOR 96 HOURS

IN THE MATTER OF _____ , RESPONDENT,

_____ , HEREBY AFFIRMS AN OATH AS FOLLOWS:

(Describe the behavior which respondent exhibits which supports the conclusion that respondent is mentally disordered or an alcohol or drug abuser and presents a likelihood of serious harm to himself or others.)

NAME (SIGNATURE)			
STREET ADDRESS			
CITY	STATE	ZIP CODE	TELEPHONE ( )

NOTARY PUBLIC EMBOSSER SEAL	STATE OF		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF 19		USE RUBBER STAMP IN CLEAR AREA BELOW.
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
LIST OF WITNESSES

NO.

IN THE CIRCUIT COURT OF _____ COUNTY, MISSOURI

PROBATE DIVISION

IN THE MATTER OF _____, RESPONDENT.

TO (ATTORNEY FOR RESPONDENT)

FOLLOWING ARE THE NAMES, ADDRESSES, AND TELEPHONE NUMBER OF PROSPECTIVE WITNESSES KNOWN TO THE APPLICANT/PETITIONER:

NAME	RELATIONSHIP	ADDRESS	PHONE

APPLICANT/PETITIONER	TITLE

FACILITY

ADDRESS

CITY	STATE	ZIP

TELEPHONE

TAKE PATIENT TO:_____

NAME OF PATIENT:_____

RESIDENCE ADDRESS OF PATIENT:_____

TELEPHONE NUMBER AT RESIDENCE
ADDRESS:_____

ADDRESS AT WHICH PATIENT MAY BE
LOCATED:_____

TELEPHONE NUMBER AT ADDRESS WHERE PATIENT MAY BE
LOCATED:_____

THE FOLLOWING WILL BE AT ABOVE ADDRESS OR MAY BE CONTACTED BY
OFFICERS:_____

_____

INFORMATION IN RE "PICK-UP" OF PATIENT: D/O/B _____

AGE:_____ RACE: _____ SEX:_____ HEIGHT:_____ WEIGHT: _____

DISTINGUISHING MARKS OR FEATURES: _____

_____

DESCRIPTION OF CAR OWNED BY
PATIENT:_____

GUNS, KNIVES, OR OTHER WEAPONS IN POSSESSION OF
PATIENT:_____

_____

REMARKS:
_____

_____

FORM MH-156