JIS CODE: RTD

STATE OF MICHIGAN PROBATE COURT WAYNE COUNTY	REQUEST TO DEFER HEARING ON COMMITMENT	FILE NO.

In the matter of ____
First, middle, and last name

PLEASE PRINT OR TYPE CLEARLY

1. I state that I have met with my legal counsel, a representative from the county community mental health program, and a member of the treatment team assigned to provide treatment. I agree to one of the following:

☐ a. Inpatient hospital treatment not to exceed 60 days.

☐ b. Outpatient treatment not to exceed 180 days.

☐ c. Combined hospitalization and outpatient treatment up to 180 days with hospitalization not to exceed 60 days.
The discharge plan for this inpatient hospitalization shall include transition instructions to assist the cmh outpatient treatment provider before my release from the hospital. The hospital shall file the discharge plan with the Detroit Wayne Integrated Health Network (DWIHN) and the Wayne County Probate Court's Behavioral Health Unit (BHU) five (5) days before discharge. For private insurance providers, please forward the discharge plan to the BHU directly five (5) days prior to discharge.

2. The treatment program will be as follows:

Hospitalization: ____

-Outpatient treatment under the supervision of (please insert CMH Provider information):____________________________

____

-Outpatient services to include:

☐ case management plan	☐ group therapy	☐ supervised living
☐ case management services	☐ individual and group therapy	☐ assertive community trtmt services
☐ all services rec.by trtmt provider	☐ day programs	☐ substance use disorder treatment
☐ medication, inc. Injectables and/or med drop	☐ partial day programs	☐ substance use disorder testing…
☐ blood or urinalysis tests…	☐ educational training	☐ any other services prescribed…
☐ individual therapy	☐ vocational training	

****Notice to Patient****

The court has appointed an attorney for you. You will be responsible to pay for the attorney's services unless you are found to be indigent by the Court.

3. I request that the court hearing be deferred for not longer than 60 days from today if I have chosen to remain hospitalized, or 180 days from today if I have chosen outpatient treatment or a combination of hospitalization and outpatient treatment.

4. I understand that I may refuse this treatment at any time during this deferral period and demand a court hearing.

______________ ______________________________
Date Patient's signature

____
Witness/Legal counsel Bar no.

Do not write below this line – For court use only