SAGINAW CHIPPEWA INDIAN TRIBE TRIBAL COURT MENTAL HEALTH DIVISION	ORDER AND REPORT ON ALTERNATIVE MENTAL HEALTH TREATMENT	Case No.

6954 East Broadway, Mount Pleasant MI 48858 (989) 775-4800

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

ORDER

IT IS ORDERED that _____ shall prepare a report assessing the current
Name (type or print)

availability and appropriateness of alternatives to hospitalization for the individual named above including alternatives available following an initial period of court-ordered hospitalization.

The report shall be made to the court before the hearing on _____ for
Date and time of hearing

_____.
Petition for 60-day order, discharge, etc.

_____ _____
Date Judge Bar no.

REPORT ON EVALUATION OF HOSPITAL TREATMENT AND/OR ALTERNATIVE PROGRAMS

1. I, _____, as _____, report as follows.
   Name Profession, organization, and position
2. I have reviewed, as to their availability in or near the individual's home community, treatment resources alternative to hospitalization and report as follows: (If practical, give name of agency, program, etc.)
   a. Independent mental health professional:

   _____
   _____
   _____

   b. Community mental health day treatment, aftercare service, work activity, or other program:

   _____
   _____
   _____

   c. Substance abuse, rehabilitation service, or similar program of public or private agency:

   _____
   _____
   _____

   d. Other:

   _____
   _____
   _____

3. I have reviewed, as to their availability in or near the individual's home community, residential accommodations, and I report as follows: (If practical, give name of residence, location, etc.)
   a. Independent: _____
      Individual's own house, apartment, etc.

   b. Residence of relative or friend: _____

   c. Foster care home: _____

   d. Nursing home:_____

   e. Other: _____

   _____

   _____

4. ☐ I recommend release.

5. ☐ I recommend a course of treatment of
   ☐ hospitalization.
   ☐ hospitalization for _____days, followed by assisted outpatient treatment as follows:
   ☐ assisted outpatient treatment as follows:

   _____

   _____

6. My recommendation is based upon the following described interviews, observations, and information:
   _____

   _____

   _____

   _____

7. The individual ☐ has ☐ does not have a durable power of attorney or advance directive that direct the following mental health treatment:
   _____

   _____

8. I believe the hospital to which admission is proposed ☐ can ☐ cannot provide its prescribed treatment program appropriately and adequately because
   _____

   _____

9. I recommend the following agency or independent mental health professional to supervise the outpatient

   treatment: _____
   Name Complete address
   The agency or professional ☐ has ☐ has not indicated capability and willingness to supervise the recommended program.

10. The individual currently has the following source(s) of funds to cover his or her care in the community:

    _____

11. ☐ The individual does not currently have sufficient sources of funds for community living.

☐ a. Application for supplemental funds has been made. They should be available _____.

☐ b. Application for supplemental funds has not been made because _____.

Application will be made on _____ and should be available about _____.

c. Pending receipt of supplemental funds, the following funds will be available:

☐ Direct relief.

☐ MDHHS/CMH emergency care funds.

☐ Other assistance: _____

☐ None. Reason: _____

_____ _____

Date Signature