SAGINAW CHIPPEWA INDIAN TRIBE TRIBAL COURT MENTAL HEALTH DIVISION	PROTECTING PERSONAL IDENTIFYING INFORMATION	Case No.

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

Plaintiff's/Petitioner's name	v	Defendant's/Respondent's name

In the matter of _____

This form is nonpublic because it contains personal identifying information (PII) that is protected from public inspection.

Instructions:

- When PII (such as date of birth) must be filed with the court on a public document, DO NOT include it on that public document. Instead, you must provide it on this form.
- **Provide only** the protected PII required for your particular case. For example, if you are filing a public document that requires you to provide a date of birth to the court, complete only that field on this form.

Name of form/document that this form is being filed with: _____

_____

Printed name of individual completing form and date

Instructions: Provide the name of the person that the PII applies to, followed by the specific PII that is required to be provided. For other, specify the type of PII in addition to the PII itself. Use the below reference number (Ref. No.) in the public document in place of the protected PII. For example, insert "Ref. No. 1" in place of the DOB in the public document.

Ref. No.	Name (required)
1	Date of birth
2	National ID no. / Last 4 digits of SSN XXX-XX-_____
3	Driver's License / State-issued ID no.
4	Passport no.
5	Other

Ref. No.	**Instructions:** List the name of the financial institution and the account number. List the paragraph that references the account, if needed for clarity. Use reference number (Ref. No.) when necessary to refer to account in public documents.		
6	Financial institution	Account no.	Paragraph no.
7	Financial institution	Account no.	Paragraph no.
8	Financial institution	Account no.	Paragraph no.
9	Financial institution	Account no.	Paragraph no.

SAGINAW CHIPPEWA INDIAN TRIBE TRIBAL COURT MENTAL HEALTH DIVISION	**PETITION FOR MENTAL HEALTH TREATMENT** ☐ **AMENDED**	**Case No.**

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

In the matter of _____ XXX-XX-_____
First, middle, and last name Last 4 digits of SSN

Court ORI	Date of birth	Driver's license no.	Place of birth	Race	Sex

1. I, _____, an adult _____ petition because
   Name (type or print) Specify whether a relative, neighbor, peace officer, etc.
   I believe the individual named above needs treatment.

2. The individual was born _____ has a permanent residence in _____, County
   Date
   at _____
   Street address City State Zip
   and can presently be found at _____ .
   Facility name or other address

   ☐ This petition is for a person who was found not guilty by reason of insanity in this county (NGRI).

3. I believe the individual has mental illness and
   ☐ a. as a result of that mental illness, the individual can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or others, and has engaged in an act or acts or made significant threats that are substantially supportive of this expectation.
   ☐ b. as a result of that mental illness, the individual is unable to attend to those basic physical needs that must be attended to in order to avoid serious harm in the near future, and has demonstrated that inability by failing to attend to those basic physical needs.
   ☐ c. the individual's judgment is so impaired by the mental illness that the individual is unable to understand the need for treatment and whose continued behavior as a result of the mental illness can reasonably be expected, on the basis of competent clinical opinion, to result in significant physical harm to the individual or others.

4. The conclusions stated above are based on
   a. my personal observation of the person doing the following acts and saying the following things:_____
   _____
   _____
   _____
   _____

   b. the following conduct and statements that others have seen or heard and have told me about:

   by: _____
   Witness name Complete address Telephone no.

5. The persons interested in these proceedings are:

NAME	RELATIONSHIP	ADDRESS	TELEPHONE
	Spouse		
	Guardian*		

*(Specify the county where the guardianship was established and the case number.) _____

6. The individual ☐ is ☐ is not a veteran.

7. ☐ Attached is a ☐ clinical certificate by a physician or licensed psychologist taken within the last 72 hours.
☐ clinical certificate by a psychiatrist taken within the last 72 hours.
☐ no clinical certificate is attached because only assisted outpatient treatment is requested.

8. ☐ (For hospitalization and combined treatment only.) An examination could not be secured because: _____
_____
_____
_____

I request:

☐ a. the individual be examined at _____ ,
the preadmission screening unit or hospital designated by the community mental health services program.
☐ b. a peace officer take the individual into protective custody and transport the individual to _____
_____

9. I request the court to determine the individual to be a person requiring treatment and to order:
☐ a. hospitalization only.
☐ b. a combination of hospitalization and assisted outpatient treatment.
☐ c. assisted outpatient treatment without hospitalization.

10. ☐ I request the individual be hospitalized pending a hearing.

I declare under the penalties of perjury that this petition has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

Signature of attorney	Date
Name (type or print) Bar no.	Signature of petitioner
Address	Address
City, state, zip Telephone no.	City, state, zip
	Home telephone no. Work telephone no.

FOR HOSPITAL USE ONLY

This petition for mental health treatment was received by the hospital on _____ (Date) at _____ (Time)

Name of hospital representative (print legibly) Signature of hospital representative

MH201

SAGINAW CHIPPEWA INDIAN TRIBE TRIBAL COURT MENTAL HEALTH DIVISION	CLINICAL CERTIFICATE	Case No.

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

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

TO THE EXAMINER: You must read the following statement to the individual before proceeding with any questions.

I am authorized by law to examine you for the purpose of advising the court if you have a mental condition which needs treatment and whether such treatment should take place in a hospital or in some other place. I am also here to determine if you should be hospitalized or remain hospitalized before a court hearing is held. I may be required to tell the court what I observe and what you tell me.

1. I am a ☐ psychiatrist. ☐ licensed psychologist. ☐ physician.

2. I certify that on this date I read the above statement to the individual before asking any questions or conducting any examination.

3. I further certify that I, _____, personally examined _____
Name(type or print) Patient

at_____
Name and address where examination took place

on_____ starting at _____ and continuing for _____ minutes.
Date Time

INSTRUCTIONS: Describe in detail the specific actions, statements, demeanor, and appearance of the individual, together with other information which underlie your conclusion. Indicate the source of any information not personally known or observed. If this certificate is to accompany a petition for discharge, state why the individual continues to be or is no longer a person requiring treatment or in need of hospitalization.

4. My determination is that the person is
   ☐ mentally ill (has a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life).
   ☐ not mentally ill

☐ 5. (if applicable) The person has
   ☐ convulsive disorder. ☐ alcoholism. ☐ other drug dependence.
   ☐ mental processes weakened by reason of advanced years
   ☐ other (specify):_____

6. My diagnosis is:_____

7. Facts serving as the basis for my determination are:

_____

_____

_____

8. Explain in the space below the facts which lead you to believe that future conduct may result in (check applicable box)

☐ a. likelihood of injury to self. Facts:

Therefore, I believe that the examined person, as a result of mental illness, can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self.

☐ b. likelihood of injury to others. Facts:

Therefore, I believe that the examined person, as a result of mental illness, can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure others.

☐ c. inability to attend to basic physical needs. Facts:

Therefore, I believe that the examined person, as a result of mental illness, is unable to attend to those basic physical needs (such as food, clothing or shelter) that must be attended to in order to avoid serious harm in the near future and has demonstrated that inability by failing to attend to those basic physical needs.

☐ d. inability to understand need for treatment. Facts:

Therefore, I believe that the examined person, as a result of mental illness, is so impaired by that mental illness and whose lack of understanding of the need for treatment has caused him or her to continue behavior which can reasonably be expected, on the basis of competent clinical opinion, to present a substantial risk of significant physical or mental harm to himself/herself or others.

9. I conclude the individual ☐ is ☐ is not a person requiring treatment.

10. (optional) I recommend
☐ hospitalization only
☐ a combination of hospitalization and assisted outpatient treatment
☐ assisted outpatient treatment without hospitalization

I certify that I am a person authorized by law to certify as to the individual's mental condition. I am not related by blood or marriage either to the person about whom this certificate is concerned or to any person who has filed, or whom I know to be planning to file, a petition in this proceeding. I declare under the penalties of perjury that this certificate has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

Date	Time of signing	Signature

Print or type name and business telephone no.

SAGINAW CHIPPEWA INDIAN TRIBE TRIBAL COURT MENTAL HEALTH DIVISION	SUPPLEMENT TO CLINICAL CERTIFICATE ON APPEAL OF RETURN TO HOSPITAL/FACILITY	Case No.

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

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

Attached is my clinical certificate (form MH 208) setting forth why the above person requires treatment. I further certify and report as follows.

1. The reason(s) for this individual's return to the hospital or facility from authorized leave, and the need for treatment in a hospital or facility are

_____

_____

_____

2. The plans for further treatment of the individual are

_____

_____

_____

3. Should the court rule against the return of this individual, I recommend the court consider the following alternatives instead of a return to authorized leave status, if any of these options are available.

- ☐ Day treatment in a hospital or facility
- ☐ Residential placement
- ☐ Inpatient treatment at a private psychiatric unit, or a private residential facility
- ☐ Night treatment in a hospital or facility
- ☐ Custody of a friend or relative
- ☐ Assisted outpatient treatment
- ☐ Home care or homemaker service
- ☐ Day activity programs

☐ Other:_____

_____

☐ None of the above merits exploration. (state reasons)

_____

_____

_____

I declare under the penalties of perjury that this certificate has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

_____	_____	_____
Date	Signature	Title (physician, psychiatrist, licensed psychologist)

SAGINAW CHIPPEWA INDIAN TRIBE TRIBAL COURT MENTAL HEALTH DIVISION	NOTICE OF HOSPITALIZATION AND CERTIFICATE OF SERVICE	Case No.

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

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

NOTICE

TO THE MENTAL HEALTH COURT: Attached is a petition for hospitalization and two clinical certificates. You are notified that

1. The individual named above was hospitalized on _____ (Date) at _____ (Time) at _____ (Name of hospital).

2. The clinical certificate of the psychiatrist that is required for hospitalization was completed on _____ (Date) at _____ (Time).

CERTIFICATE OF SERVICE ON PATIENT

3. I certify that on the dates and times indicated a copy of each of the following documents was given to the individual named above.
   a. Petition — _____ Date _____ Time _____ Signature
   b. Statement explaining individuals rights — _____ Date _____ Time _____ Signature
   c. Clinical certificate of psychiatrist — _____ Date _____ Time _____ Signature
   d. Clinical certificate of licensed psychologist/physician/psychiatrist — _____ Date _____ Time _____ Signature
   e. Notice of hearing — _____ Date _____ Time _____ Signature

CERTIFICATE OF SERVICE ON THE OTHERS

4. I certify that copies of the petition, two clinical certificates, statement explaining rights, and notice of hearing were served
   ☐ by first-class mail ☐ personally on _____ (Date and time) on _____ (Individual's ☐ guardian ☐ nearest relative)
   and
   ☐ by first-class mail ☐ personally on _____ (Date and time) on _____ (Individual's attorney)

☐ 5. I further certify that the individual was asked whether to serve other persons with copies of the above documents.
   a. _____ (Name) was designated.
   ☐ Copies could not be served. ☐ Copies were served ☐ by first-class mail ☐ personally on _____ (Date).
   b. _____ (Name) was designated.
   ☐ Copies could not be served. ☐ Copies were served ☐ by first-class mail ☐ personally on _____ (Date).

_____ Date _____ Signature

MH211

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

SAGINAW CHIPPEWA INDIAN TRIBE TRIBAL COURT MENTAL HEALTH DIVISION	PETITION FOR SECOND MENTAL HEALTH TREATMENT ORDER	Case No.

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

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

1. I, _____, state that I am
   Name (type or print)
   ☐ the authorized representative of the agency or mental health professional supervising the individual's assisted outpatient treatment program.

   ☐ _____ of _____.
   Director or authorized representative Name of hospital

2. The individual is currently ☐ residing ☐ hospitalized at _____.
   Address and telephone no.

3. The initial order entered by this court for the individual expires on _____.
   Date
4. The individual continues to be a person requiring treatment and is in need of
   ☐ hospitalization for not more than 90 days.
   ☐ combined hospitalization and assisted outpatient treatment for not more than one year. The hospitalization portion of the order shall not exceed 90 days.
   ☐ assisted outpatient treatment for not more than one year.
5. The individual is likely to refuse treatment on a voluntary basis when the order expires.

INSTRUCTIONS: In answering items 6 and 7, include a description of the observed or reported behavior of the individual including, but not limited to, how behavior and conditions have changed since the last order and whether any stabilization or remission is contingent on continued medication or other treatment. Avoid medical terms and conclusions other than diagnosis.

6. The basis for this allegation is that I believe the individual has a mental illness and: (Check all that apply.)
   ☐ a. as a result of that mental illness, the individual can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or others, and has engaged in an act or acts or made significant threats that are substantially supportive of this expectation.
   ☐ b. as a result of that mental illness, the individual is unable to attend to those basic physical needs that must be attended to in order to avoid serious harm in the near future, and has demonstrated that inability by failing to attend to those basic physical needs.
   ☐ c. the individual's judgment is so impaired by that mental illness and whose lack of understanding of the need for treatment has caused him or her to continue behavior which can reasonably be expected, on the basis of competent clinical opinion, to present a substantial risk of significant physical or mental harm to the individual or others.

7. This conclusion is based upon
   a. my personal observation of the person doing the following acts and saying the following things:

   _____
   _____
   _____

b. the following conduct and statements that others have seen or heard and have told me about:

by: _____
Witness name Complete address Telephone no.

8. The diagnoses of mental conditions are:_____
_____

9. The treatment program(s) provided to the individual thus far, and the results, are:_____
_____
_____

10. The present treatment The individual ☐ is ☐ is not adequate and appropriate to the individual's condition. The individual ☐ is ☐ is not motivated to participate in this treatment program. The estimate of further time necessary to provide the required treatment is_____.
The following modifications are currently planned for the next period of treatment: (Write "none" if no modifications are expected.) _____
_____
_____

11. The interested parties, their addresses, and their representatives are identical to those appearing on the initial petition except as follows:_____
_____
_____

12. Attached is a clinical certificate executed by a psychiatrist.

13. **I REQUEST** the court to order the individual to receive
☐ hospitalization for not more than 90 days.
☐ combined hospitalization and assisted outpatient treatment for not more than one year. The hospitalization portion of the order shall not exceed 90 days.
☐ assisted outpatient treatment for not more than one year.

I declare under the penalties of perjury that this petition has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

_____ _____
Date Signature of petitioner

_____
Address

_____
City, state, zip Telephone no.

SAGINAW CHIPPEWA INDIAN TRIBE TRIBAL COURT MENTAL HEALTH DIVISION	PETITION FOR CONTINUING MENTAL HEALTH TREATMENT ORDER	Case No.

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

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

1. I, _____, state that I am
   Name (type or print)

   ☐ the authorized representative of the agency or mental health professional supervising the individual's assisted outpatient treatment program.

   ☐ _____ of _____.
   Director or authorized representative Name of hospital

2. The individual is currently ☐ residing ☐ hospitalized at _____.
   Address and telephone no.
3. The ☐ second ☐ continuing order entered by this court for the individual expires on _____.
   Date
4. The individual continues to be a person requiring treatment and is in need of
   ☐ hospitalization for not more than one year.
   ☐ continuing hospitalization for a period of one year.
   ☐ combined hospitalization and assisted outpatient treatment for not more than one year.
   ☐ assisted outpatient treatment for not more than one year.

5. The individual is likely to refuse treatment on a voluntary basis when the order expires.

INSTRUCTIONS: In answering items 6 and 7, include a description of the observed or reported behavior of the individual including, but not limited to, how behavior and conditions have changed since the last order and whether any stabilization or remission is contingent on continued medication or other treatment. Avoid medical terms and conclusions other than diagnosis.

6. The basis for this allegation is that I believe the individual has a mental illness and: (Check all that apply.)
   ☐ a. as a result of that mental illness, the individual can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or others, and has engaged in an act or acts or made significant threats that are substantially supportive of this expectation.
   ☐ b. as a result of that mental illness, the individual is unable to attend to those basic physical needs that must be attended to in order to avoid serious harm in the near future, and has demonstrated that inability by failing to attend to those basic physical needs.
   ☐ c. the individual's judgment is so impaired by that mental illness and whose lack of understanding of the need for treatment has caused him or her to continue behavior which can reasonably be expected, on the basis of competent clinical opinion, to present a substantial risk of significant physical or mental harm to the individual or others.

7. This conclusion is based upon
   a. my personal observation of the person doing the following acts and saying the following things:
   _____
   _____
   _____

b. the following conduct and statements that others have seen or heard and have told me about:

_____

_____

_____

by: _____
Witness name Complete address Telephone no.

8. The diagnoses of mental conditions are:_____

_____

9. The treatment program(s) provided to the individual thus far, and the results, are:

_____

_____

10. The present treatment the individual ☐ is ☐ is not adequate and appropriate to the individual's condition. The individual ☐ is ☐ is not motivated to participate in this treatment program. The estimate of further time necessary to provide the required treatment is_____.
The following modifications are currently planned for the next period of treatment: (Write "none" if no modifications are expected.)

_____

_____

_____

11. The interested parties, their addresses, and their representatives are identical to those appearing on the initial petition except as follows:

_____

_____

12. Attached is a clinical certificate executed by a psychiatrist.

13. **I REQUEST** the court to order the individual to receive
☐ hospitalization for not more than one year.
☐ continuing hospitalization for not more than one year.
☐ combined hospitalization and assisted outpatient treatment for not more than one year.
☐ assisted outpatient treatment for not more than one year.

I declare under the penalties of perjury that this petition has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

_____
Date

_____
Signature of petitioner

_____
Address

_____
City, state, zip Telephone no.

SAGINAW CHIPPEWA INDIAN TRIBE TRIBAL COURT MENTAL HEALTH DIVISION	PETITION FOR DISCHARGE FROM CONTINUING MENTAL HEALTH TREATMENT	Case No.

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

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

1. I, _____,state that the individual is subject to a one-year order
   Name (type or print)

   of involuntary mental health treatment and I am

   ☐ the Director, or designee of Tribal Behavioral Health, or the executive director of the community mental health services program for the county of residence of the individual.

   ☐ hospitalized in _____.
   Name of hospital

   ☐ under a one-year assisted outpatient or a one-year combined treatment order under the supervision of

   _____

2. ☐ I object to the conclusion(s) in the periodic review report of _____
   Name of patient/resident
   dated and filed with this court. The individual named in that report is not a person requiring continuing involuntary mental health treatment and should be discharged from the program. My objection is based on the following reasons:

   _____

   _____

   _____

   _____

3. The interested parties, their addresses, and their representatives are identical to those appearing on the initial petition, except as follows:

   _____

   _____

4. I **REQUEST** that the court set a hearing and order a discharge.

I declare under the penalties of perjury that this petition has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

_____ _____
Date Signature of petitioner

SAGINAW CHIPPEWA INDIAN TRIBE TRIBAL COURT MENTAL HEALTH DIVISION	NOTIFICATION OF NONCOMPLIANCE ☐ REQUEST FOR MODIFIED ORDER	Case No.

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

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

1. I, _____, make this notification as the
   Name (type or print)
   - ☐ agency.
   - ☐ mental health professional who is supervising the individual's assisted outpatient treatment program.
   - ☐ individual.
2. The individual who is the subject of this notification was ordered to undergo a program of assisted outpatient treatment or combined hospitalization and assisted outpatient treatment.
   - ☐ a. The assisted outpatient treatment has not been or will not be sufficient to prevent the individual from inflicting harm or injuries to self or others.
   - ☐ b. The individual is not complying with the order for assisted outpatient treatment or combined hospitalization and assisted outpatient treatment.
   - ☐ c. I believe that my assisted outpatient treatment program is not appropriate.
3. ☐ The individual was in the hospital _____ days for mental health treatment. The individual needs immediate hospitalization.
4. This conclusion is based upon
   - ☐ a. my personal observation of the individual doing the following acts and saying the following things:

     _____
     _____
     _____
     _____

   - ☐ b. conduct and statements seen or heard by others and related to me:
     State the conduct and statements and the name, address, and telephone number of each witness.

     _____
     _____
     _____
     _____
     _____

5. ☐ A psychiatrist has ordered the individual to return to the hospital.
6. ☐ **I request** the court to modify its last order of ☐ assisted outpatient treatment
   - ☐ combined hospitalization and assisted outpatient treatment to direct the individual to:
     - ☐ a. undergo another assisted outpatient treatment program.
     - ☐ b. undergo hospitalization or combined hospitalization and assisted outpatient treatment, with hospitalization not to exceed _____ days.
     - ☐ c. be transported to the hospital by a peace officer if the individual refuses to comply with the psychiatrist's order to return to the hospital.

Date	Signature
Title	Business Address
Agency	City, state, zip Telephone no.

SAGINAW CHIPPEWA INDIAN TRIBE TRIBAL COURT MENTAL HEALTH DIVISION	NOTICE OF INABILITY TO SECURE EVALUATION/EXAMINATION	Case No.

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

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

1. A petition for mental health treatment was filed on _____.
Date

2. The individual has failed to make himself or herself available for an evaluation/examination.

3. I am interested in this matter as
   - ☐ petitioner.
   - ☐ caseworker.
   - ☐ psychiatrist/psychologist/physician.
   - ☐ interested person.
   - ☐ other _____.

4. The following reasonable attempts were made to obtain the individual's cooperation:

_____

_____

_____

_____
Date

_____
Signature

_____
Name (type or print)

_____
Agency

_____
Address

_____
City, state, zip

_____
Telephone no.

Do not write below this line – For court use only

SAGINAW CHIPPEWA INDIAN TRIBE TRIBAL COURT MENTAL HEALTH DIVISION	**PROOF OF SERVICE**	**Case No.**

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

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

1. Titles of the papers served or mailed: _____

2. ☐ I served by ☐ ordinary mail ☐ registered mail (copy of return receipt attached) ☐ certified mail (copy of return receipt attached) the papers described above or posted in the following locations:

Name	Complete address of service	Date

3. ☐ I served by **personal service** the papers described above on:

Name	Complete address of service	Date

4. ☐ After diligent search and inquiry, I have been unable to find and serve the following interested persons:

_____

_____

I have made the following efforts in attempting to serve process

_____

I declare under the penalties of perjury that this proof of service has been examined by me and that its contents are true to the best of my information, knowledge and belief.

Service fee	Miles traveled	Mileage fee	Total fee
$		$	$

Date

Signature

☐ TRIBAL COURT ☐ TRIBAL OPERATIONS ☐ NIMKEE CLINIC ☐ 7TH GENERATION ☐ SAGANING RESERVATION

MH564