APPLICATION FOR INVOLUNTARY EVALUATION (Pursuant to A.R.S. § 36-520)

ST	ATE OF ARIZONA)) ss.		
COUNTY OF MARICOPA)				
То	the			
	(Re _{	gional or Screening Authority)		
1.	The undersigned applicant requests that the above agency conduct a pre-petition			
	screening of the person nam	ned herein.		
2. The undersigned applicant alleges that there is now in the County a person whose				
	and address are:			
	(Name)	(Address)		
	and that he/she believes that	t the person has a mental disorder and as a result of said		
	mental disorder, is:			
	a danger to self;	a danger to others;		
	gravelydisabled	persistently or acutely disabled		
	; and is:			
	unwilling to undergo volun	ntary evaluation, as evidenced by the following facts:		
	unable to undergo voluntar	ry evaluation, as demonstrated by the following facts:		

and who	is believed	to be in need	of supervision,	care and	treatment	because of	f the
followin	g facts:						

- 3. The conclusion that the person has a mental disorder is based on the following facts:
- 4. The conclusion that the person is dangerous or disabled is based on the following facts:

PERSONAL DATA OF PROPOSED PATIENT:

Age Date of Birth Sex Race

Weight Height Hair Color Eye Color

Marital Status Number of Children

Social Security Number Religion

Distinguishing Marks

Occupation

Present Location

Dates and Places of Previous Hospitalization

How Long in Arizona State Last From

Veteran C-No. Education

NAMI	E ADDRESS AND TELEPHONE NUMBE	R OF:	
1)	Guardian		
2)	Spouse		
3)	Next of Kin		
4)	Significant Other Persons		
	DATE	Signature of Applicant	
Printed	d or Typed name of Applicant		
Relation	onship to Proposed Patient		
Applic	eant's Address		
Applic	eant's Telephone		
SUB	SCRIBED AND SWORN to before me this	day of	
		Notary Public	
My Co	ommission Expires:		

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APPLICATION FOR EMERGENCY ADMISSION FOR EVALUATION (Pursuant to A.R.S. § 36-524)

STATE OF ARIZONA	(MR/MS	
COUNTY OF MARICOPA) ss.)	WAS DETAINED AT URGENT PSYCHIATRIC CARE CENTRAL DATE: TIME:	
		PROVIDER:	
		TITLE:	
		SIGNATURE:	
The undersigned applicant, being	first dul	ly sworn/affirmed, hereby requests that:	
<u>(</u>		Evaluation Agency)	
admit the person named herein for	evaluat	ion.	
1. The undersigned applicant alleges that there is now in the County a person whose			
name and address are:			
(Name)		(Address)	
and that she/he believes that the pe	erson ha	as a mental disorder and as a result of said mental	
lisorder, is: a danger to self; a danger to others;			
and that during the time necessary	to com	plete pre-petition screening under A.R.S. §§ 36-520	
AND 36-521, the person is likely	without	immediate hospitalization to suffer serious	
physical harm or serious illness or	is likel	y to inflict serious physical harm upon another	
person.			
The conclusion that the perso	n has m	ental disorder is based on the following facts:	

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		r posed by this person is	•
A summary of t		upon which this statement	
Age I	Note of Digital		
	Date of Birth	Sex	Race
Weight	Height	Sex Hair Color	Race Eye Color
Weight Marital Status			
_	Height	Hair Color	
Marital Status	Height Number	Hair Color Number of Children	
Marital Status Social Security	Height Number	Hair Color Number of Children	
Marital Status Social Security Distinguishing M	Height Number Marks	Hair Color Number of Children	
Marital Status Social Security Distinguishing M Occupation Present Location	Height Number Marks	Hair Color Number of Children Religion	
Marital Status Social Security Distinguishing M Occupation Present Location	Height Number Marks 1 s of Previous Hos	Hair Color Number of Children Religion	

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NAM	E ADDRESS AND TELEPHONE NU	MBER OF:			
1)	Guardian				
2)	Spouse				
3)	Next of Kin				
4)	Significant Other Persons				
D	ATE	Applicant Signature			
Printe	d or Typed name of Applicant				
Relati	onship to Proposed Patient				
Applio	cant's Address				
Applio	cant's Telephone				
SUBS	SCRIBED AND SWORN to before me this	day of			
		·			
		Notary Public			
My Co	My Commission Expires:				

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WITNESS INFORMATION FORM

PROPOSED PATIENT: WITNESSES DATA: 1. NAME: **AGENCY: EMAIL ADDRESS** CITY ST ZIP CODE HOME NO.: WORK NO.: CELL No.: FAX NO. RELATIONSHIP TO PROPOSED PATIENT IF WORKING FOR AN AGENCY, SUPERVISOR'S NAME AND PHONE NO. ANTICIPATED TESTIMONY: RE: DTS DTO GD PAD 2. NAME: **AGENCY: EMAIL ADDRESS CITY** ST ZIP CODE HOME NO.: WORK NO.: CELL NO.: FAX NO. RELATIONSHIP TO PROPOSED PATIENT IF WORKING FOR AN AGENCY, SUPERVISOR'S NAME AND PHONE NO. ANTICIPATED TESTIMONY: DTS DTO PAD GD RE: 3. NAME: AGENCY: **EMAIL ADDRESS CITY** ST ZIP CODE HOME NO.: WORK NO.: CELL No.: FAX NO. RELATIONSHIP TO PROPOSED PATIENT IF WORKING FOR AN AGENCY, SUPERVISOR'S NAME AND PHONE NO. ANTICIPATED TESTIMONY: RE: DTS DTO **PAD** GD

This form to be completed and attached to Application for Emergency Admission in lieu of "Form C". For Maricopa Medical Center Psychiatric Annex, and Desert Vista in-house use only.