OFFICE OF THE
HARRIS COUNTY ATTORNEY
CHRISTIAN D. MENEFEE

COURT-ORDERED MENTAL HEALTH CARE
AND COURT ORDERED CHEMICAL DEPENDENCY CARE

Christian D. Menefee, the Harris County Attorney, and his assistants represent the State of Texas in civil commitment proceedings. We hope the following information will be helpful in explaining the procedure for obtaining court-ordered mental health care. Refer any questions you may have to the Harris County Attorney's Office (713) 741-6016. You may also contact the Probate Court/Mental Health Division at (713) 741-6020.

1. Please be specific when completing the application for court-ordered mental health care or court-ordered chemical dependency care, and the affidavit of the applicant. Include recent behavior and/or statements of the patient which prompted you to make this decision; i. e. what you have seen or heard which makes you feel the patient needs psychiatric care at this time.

2. Provide the caseworker who interviews you with all telephone numbers where you may be reached. We may need to make contact in the evening, so please include home, cell and work numbers. If the number belongs to a neighbor, friend or relative who will give you the message, please leave the name of that person. Please identify your relationship to the patient such as guardian, neighbor, etc.

3. If warranted, an Order of Protective Custody (OPC) will be issued. This order allows the patient to be held up to 14 days for evaluation. In most cases, a probable cause hearing will be held within 72 hours after the OPC is issued. These hearings are regularly scheduled on Monday, Wednesday, or Friday at 2800 South MacGregor Way. The patient will receive papers giving the date of this hearing. The applicant is not required to be present; however, you may call the number provided above if you have questions about whether or not to attend.

4. The final hearing must be held within the 14-day period but may be held at any time after the probable cause hearing, usually within one week. Final hearings are regularly scheduled every Monday and Friday, at 9 a.m. at 2800 South MacGregor Way. The patient's notice of hearing will provide the exact date and time. The dates may need to be changed for a variety of reasons, so please stay informed as a family member or person responsible for filing the application you may need to be present at the final hearing in order for the patient to receive court-ordered mental health or court-ordered chemical dependency care. The applicant must be prepared to give testimony concerning the patient's recent behavior within the past two months that tends to show the patient may be dangerous to himself/ herself or others as a result of his/her present mental illness or chemical dependency. In addition, a psychiatrist who has examined the patient will be present to answer questions concerning the diagnosis and recommendation for treatment.

5. The applicant will be notified by telephone one or two days prior to the hearing. We will attempt to call you by using the telephone numbers you provided on the application, so please be sure to give us good working numbers. If you have not been notified within four days after the probable cause hearing, check with the staff at the numbers provided above. Also, if you have been away from home or work or have had difficulty with your telephone, please contact us to confirm the date and time of the final hearing.

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If the applicant is not present at the final hearing, the patient may have to be released without further court-ordered treatment, so please keep yourself informed.

Helpful Phone Numbers	
Harris County Attorney's Office 2800 South MacGregor Way	(713) 741-6016
Probate Court/Mental Health Division	(713) 741-6020
Neuro Psychiatric Center	(713) 970-4640
The Harris Access Center	(713) 970-7000
Constable's Office 2800 South MacGregor Way After 1 p.m. Weekdays or on Weekends	(713) 741-6012 (713) 755-7628

Our job is to help you and we sincerely appreciate your efforts to cooperate with us.

Christian D. Menefee
Harris County Attorney

UTHealth | Harris County Psychiatric Center
The University of Texas Health Science Center at Houston

PATIENT FINANCIAL OBLIGATIONS

All patients admitted to HCPC are assigned a pay classification based on their ability to pay or the responsible party's ability to pay. Any insurance coverage that you have does not affect these assignments. This pay classification is determined from information received through MHMRA, HCPC Patient Registration, Financial Review Representative and/or telephone interviews conducted by HCPC Patient Account Services.

Information concerning total family income and total number of family members is used to compute the pay class on a sliding scale following the Federal Poverty Income Guidelines. The percentage indicated on this scale is the percentage of the final balance due that will be owed by the patient and/or guarantor.

In order of us to properly review your ability to pay and financial status the following items are required whether you were admitted voluntarily or involuntarily:

1. Driver's license
2. Proof of health care coverage (if insurance is available)
3. Copy of the following bills: (**Your name must appear on them**)
    a. Current house payment / rent receipt
    b. Current electric, water, gas, phone bill
4. Social Security Card
5. Proof of residency
6. Proof of day care expenses
7. Proof of dependents (Social Security Card, Birth Certificate)
8. Proof of income
    a. Current wage letter – call (888) 469-5627 for print out
    b. Current pay check stub
    c. A copy of your current federal income tax return

When you or your guarantor have gathered the above documents, please mail them to Patient Account Services, P.O. Box 203020, Houston, Texas 77216. You may bring these documents to the hospital to our Financial Review Representative. If you have any questions or need assistance please call (713) 741-6924 or (713) 741-3881. Once information has been received, a review will be made and a pay classification assigned. If you do not submit the required information you will be responsible for 100% of your bill.

HCPC is required by the Health and Safety Code to provide you with this information (Health and Safety Code Subtitle F, "Powers and Duties of Hospitals", Sec, 311.046, (d), Added by Acts 1993, 73rd Leg., Ch. 360, Sec 4, eff. Sept. 1, 1993. Amended by Acts 1997, 76th Leg., Ch. 260, Sec. 3, eff. Jan. 1, 1998).

PROBATE MENTAL HEALTH COURT #3

PRINT ONLY

PRIVATE HOSPITAL _____

HARRIS COUNTY PSYCHIATRIC HOSPITAL

NEUROPSYCHIATRIC CENTER

MEDICARE _____ MEDICAID _____

MENTAL HEALTH _____ CHEMICAL DEPENDENCY _____

TIME _____ DATE_____ INITIALS_____

PATIENT INFORMATION

FULL LEGAL NAME: _____

PERMANENT ADDRESS: _____

CITY: _____ STATE: _____

COUNTY: _____

ZIP: _____ AGE: _____

SEX: _____ RACE: _____

HEIGHT: _____ WEIGHT: _____

DATE OF BIRTH: _____ VETERAN: YES ◯ NO ◯

PATIENT LOCATION: _____

CITY: _____

COUNTY: _____

ZIP: _____

TDL _____ S.S.# _____

DOES THE PATIENT HAVE A COURT APPOINTED LEGAL GUARDIAN?
(THIS DOES NOT REFER TO A SOCIAL SECURITY PAYEE)

YES ◯ NO ◯

IF YES, NAME _____ PH# _____

INFORMANT INFORMATION

FULL NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____

COUNTY: _____

ZIP: _____

HOME PHONE: _____

WORK PHONE: _____

RELATIONSHIP TO PATIENT: _____

LAST DATE PATIENT WAS SEEN BY YOU: _____

_____
SIGNATURE

FINANCIALLY RESPONSIBLE PARTY: PATIENT _____ PARENT _____

GUARDIAN _____ OTHER _____

ADDRESS: _____

_____

PHONE: _____

_____
SIGNATURE

B30 Affidavit - Application for Temporary or Extended Mental Health Services

NO. _____

THE STATE OF TEXAS
FOR THE BEST INTEREST
AND PROTECTION OF

_____

AFFIDAVIT OF APPLICANT

Before me, the undersigned authority personally appeared _____, known to me to be the person whose signature appears below, who, after being duly sworn by me, upon his/her oath stated as follows:

My name is _____. That my address is _____. That on or about the _____ day of _____, 20_____, I saw the proposed patient do the following:

_____
_____
_____
_____
_____
_____
_____

That on or about the _____ day of _____, 20_____, I heard the proposed patient say as follows:

_____
_____
_____
_____
_____
_____
_____

That I have had the opportunity to watch the proposed patient recently, and I have seen him/her act as follows:

_____
_____
_____
_____
_____
_____
_____

I understand that should sufficient probable cause not exist to restrain the Proposed Patient until the time of trial, he/she will be released pending final hearing.

SIGNED this the _____ day of _____, 20_____.

_____
Applicant

STATE OF TEXAS
COUNTY OF HARRIS

Before me, the undersigned authority, on this day personally appeared applicant, who being by me duly sworn, on oath said that he/she is the applicant and has read the above and foregoing statements, and that every statement contained therein is within his/her personal knowledge and is true and correct.

Subscribed and sworn to before me on the _____ day of _____, 20_____, to certify which witness my hand and official seal.

Teneshia Hudspeth, County Clerk

By: _____
Deputy County Clerk

Client & Information (Number _____) Date: _____

Have you/ client traveled out of the country within the past 21 day? (Circle one) Yes ◯ No ◉

If yes, where? _____

Have you/ client traveled to any Ebola affected countries? (Sierra Leone, Guinea, Liberia, and Nigeria)

(Circle one) Yes ◯ No ◉

Have you/ client had exposure to a person who has Ebola disease? (Circle one) Yes ◯ No ◉

Client Information:

Name: _____

Social Security # _____ DOB: _____

Address: _____

City/ State/ Zip: _____

Phone Number: _____ Employer: _____

Insurance Provider Information

Insurance Name: _____

Insurance Number (s): *Policy* _____ *Group:* _____

Gold Card: (Circle one) Yes ◯ No ◉ If Yes, not Gold Card Patient Identification Number: _____

Subscribers Name: _____

Subscribers Address: _____

Subscribers City/State/ Zip: _____

Subscribers Phone: _____ Relationship: _____

DOB: _____

Admission Authorized: (Circle one) Yes ◯ No ◉ by: _____

Informant Information:

Name: _____ Phone Number: _____

Address: _____ City/State/Zip/County: _____

VERIFIED BY ADMISSION STAFF: _____

PLEASE BE ADVISED THIS PROCESS MAY TAKE MORE THAN 4 HOURS TO COMPLETE. *THANK YOU!*

DATE: _____

(1) RECEPIONIST

CLERK: _____

START TIME: _____

COMPLETED: _____

PACKET # _____

(2) FINANCIAL SCREENING

SCREENER: _____

START TIME: _____

COMPLETED: _____

PACKET # _____

(3) NURSE REVIEW (Y / N)

SCREENER: _____

START TIME: _____

COMPLETED: _____

PACKET # _____

(4) HCPI SCREENING

SCREENER: _____

START TIME: _____

COMPLETED: _____

PACKET # _____

(5) COURTS

SCREENER: _____

START TIME: _____

COMPLETED: _____

PACKET # _____

(6) BED AVAILABILITY

RESOURCE	CONTRACT

BED	W/O BED

FOR OFFICE USE ONLY

The HARRIS CENTER for Mental Health and IDD

HARRIS COUNTY PSYCHIATRIC INTERVENTION

INFORMATION SHEET

DATE: _____ Social Security No. _____

APPLICANT NAME: _____ Relationship to consumer: _____

CONSUMER NAME: _____ Case# _____

DOB _____ Race: _____ Sex: _____

Is consumer in Jail? Y ◯ N ◉ Hospital? Y ◯ N ◉

If YES, which jail or hospital: _____

Does consumer have Medicaid? _____ Medicare? _____ Private Insurance? _____

Is consumer willing to volunteer for treatment? YES ◯ _____ NO ◉ _____

TREATMENT HISTORY:

Is consumer seeking treatment for: Mental Illness? _____ Drugs / Alcohol? _____

Is consumer referred here by a: Harris Center clinic? _____ Which Clinic? _____

Private Hospital? _____ Which? _____

Other? _____ Which? _____

Has the consumer been treated for mental illness? _____ Where? _____

Has the consumer been hospitalized for mental Illness? _____ Where? _____

Has the consumer been hospitalized for substance abuse? _____ Where? _____

Is the consumer taking or supposed to take medication? _____ If YES, what type of Medication (s)

_____

PRESENTING PROBLEMS:

Has consumer experienced any trauma or stressful events in the last 6 months? _____ If YES, what?

_____

Has the consumer tried to hurt him/herself? Yes _____ No _____

Has the consumer talked about hurting him/herself? Yes _____ No _____

Has the consumer tried to hurt someone else? Yes _____ No _____

Recently, has the consumer been: Fearful _____ Depressed _____ Agitated _____

Is the consumer seeing or hearing things others do not see or hear? _____

Has the consumer's habits changed regarding: Sleep? _____ Appetite? _____

Does the consumer's conversation flow and make sense? Yes _____ No _____

MEDICAL PROBLEMS:

Does the consumer have any medical problems: If YES, what? _____

Is the consumer confined to a wheelchair? _____ Physically handicapped? _____

Is the consumer experiencing: Yes or No _____ Dizziness/Falls _____ Recent wounds/injuries

_____Recent surgeries _____ Coughing up blood _____ Hearing impairment _____ Blindness

Has consumer been diagnosed with: _____ Pregnancy _____ Cancer _____ Diabetes

_____ Seizure disorder _____ High blood Pressure _____breathing disorder

The HARRIS CENTER for Mental Health and IDD

HARRIS COUNTY PSYCHIATRIC INTERVENTION
INFORMATION SHEET

SUBSTANCE ABUSE:

Do you suspect the consumer is using Drugs? _____ Alcohol? _____

Why do you suspect use or abuse of alcohol/drugs? Check all that apply:

_____ Consumer admits to use

_____ Paraphernalia found i.e. pipe, drugs, and valves)

_____ Observed consumer using drugs

_____ Friend or family member told you

_____ Significant weight loss recently

_____ Consumer steals and pawns property from others

What type of drugs being used?

Type of drug	How often?	How long?
_____ Alcohol	_____	_____
_____ Cocaine	_____	_____
_____ Crack	_____	_____
_____ Barbiturates	_____	_____
_____ Prescriptions	_____	_____

How is consumer ingesting drugs? Check all that apply:

_____ Smoking

_____ Orally (by mouth)

_____ Injecting

_____ Snorting

Why are you seeking hospitalization for consumer today?

_____

_____

_____

_____

Thank you for completing this questionnaire. Your cooperation will assist our intervention staff in assessing your needs and providing treatment recommendations/ alternatives if indicated. Please turn this page 2 form to the front desk.