Vince Ryan
Harris County Attorney

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

Vince Ryan, County Attorney of Harris County, Texas and his assistants, represent the State of Texas in civil commitment proceedings. We hope that 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 County Attorney's Office at (713) 741-6016. You may also contact the Probate Court/Mental Health Division at (713) 741-6020 or the MHMRA.

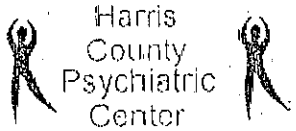
(1) Please be specific when filling out the application for court-ordered mental health care or court-ordered chemical dependency care, and the affidavit of witness. Include recent behavior and/or statements of the patient which prompted you to make this decision; i.e. what you have seen or heard which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

(2) Provide the caseworker who interviews you with all of the telephone numbers where you may ordinarily be reached. We may need to contact you in the evening, so please include home as well as work numbers. If the number belongs to a neighbor or friend or other family member who will give you the message, please leave the name of that person. Please identify you relation to patient, (for instance, guardian, neighbor, etc.).

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

(4) The final hearing must be held within the fourteen day period but may be held at any time after the probable cause hearing, usually within one week. These final hearings are regularly scheduled every Monday, at 9:00 a.m. and Friday, at 10:00 a.m. at 2800 South MacGregor Way. Once again, the patient's notice of hearing should give the exact date and time. The dates may need to be changed for a variety of reasons, so please keep yourself informed as a family member or person responsible for filing the application 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 that 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 listed 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.



UNIVERSITY OF TEXAS-HOUSTON HEALTH SCIENCE CENTER
HARRIS COUNTY PSYCHIATRIC CENTER

PATIENT FINANCIAL OBLIGATIONS

All patients admitted to HCPC are assigned a Pay Classification based on their or the responsible party's ability to pay. Any insurance coverage that you have does not effect 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 in then 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)
   Current House payment/Rent receipt
   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 TX 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 then a review will be made and a pay Classification assigned. If you do not submit the required information you will be responsible for your bill at 100%.

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, 75 Leg., ch. 260 Sec.3, eff. Jan. 1, 1998).

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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.

These phone numbers might be helpful to you. For further information, feel free to contact:

County Attorney's Office at 2800 South MacGregor Way	(713) 741-6016
Probate Court/Mental Health Division	(713) 741-6020
MHMRA Neuro Psychiatric Center	(713) 970-4640
MHMRA Access Center	(713) 970-7000
Constable's Office at 2800 South MacGregor Way	(713) 741-6012
To reach the Constable's after 10:00 p.m. Weekdays or on Weekends	(713) 755-7628

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

Vince Ryan
Harris County Attorney

Client & Informant Information (Number_____) Date:_____

Have you/client traveled out of the country within the past 21 days? Yes No (circle one)/Where_____

Have you/client traveled to any Ebola affected countries? (Sierra Leone, Guinea, Liberia, and Nigeria) Yes No (circle one)

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

Client Information:

Name: _____Social Security #:_____DOB:_____

Address: _____

City/State/Zip:_____County:_____

Phone Number: _____ Employer:_____

Insurance Provider Information

Insurance Name: _____

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

Gold Card: Yes No *(Circle One), If YES, note* Gold Card Patient Identification Number: _____

Subscribers Name: _____

Subscribers Address: _____ City/State/Zip: _____

Subscribers Phone: _____Relationship: _____DOB:_____

Admission Authorized: Yes No (Circle One) 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) Receptionist

Clerk: _____

Start Time: _____

Completed: _____

Packet #: _____

(2) Financial Screening

Screener: _____

Start Time: _____

End Time: _____

Packet #: _____

(3) Nurse Review (Y / N)

Screener: _____

Start Time: _____

End Time: _____

Packet #: _____

(4) HCPI Screening

Screener: _____

Start Time: _____

End Time: _____

Packet #: _____

(5) Courts

Screener: _____

Start Time: _____

End Time: _____

Packet #: _____

(6) Bed Availability

Resource	Contract
Bed	w/o Bed

FOR OFFICE USE ONLY

PROBATE 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:_____

SEX:_____RACE:_____

HEIGHT:_____WEIGHT:_____

DATE OF BIRTH:_____AGE:_____

PATIENT LOCATION:_____

CITY:_____

COUNTY:_____

ZIP:_____

VETERAN: YES_____ NO_____

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

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.

Chris Hollins, County Clerk

By: _____
Deputy County Clerk

HARRIS CENTER
Mental Health and IDD

HARRIS COUNTY PSYCHIATRIC INTERVENTION
INFORMATION SHEET

DATE: _____ Social Security No. _____
APPLICANT NAME: _____ Relationship to consumer: _____
CONSUMER NAME: _____ Case #_____
D.O.B._____ RACE:_____ SEX:_____
Is consumer in Jail? _____Hospital? _____
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

SUBSTANCE ABUSE:

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

If YES, please answer questions on page 2.

HARRIS CENTER for Mental Health and IDD

HARRIS COUNTY PSYCHIATRIC INTERVENTION
INFORMATION SHEET

SUBSTANCE ABUSE QUESTIONNAIRE

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.