COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Application For Care And Treatment On A Conditional Voluntary Basis

M.G.L. Chapter 123, Sections 10 & 11

(*made by Health Care Agent*)

Name of Patient: _____
please print

Address: _____ City/Town: _____ State: _____

Social Security Number: _____ Date of Birth: _____ Sex: M ☐ F ☐

Name of Health Care Agent: _____ Phone #: _____

Address: _____ City/Town: _____ State: _____

To the Facility Director of: _____
Name of Facility

1. I am the health care agent of the above-named patient with authority to consent to his/her voluntary admission to this facility. A copy of the health care proxy establishing this authority is attached.
2. I wish to admit the above-named patient to the facility.
3. I realize that when I want the patient to leave the facility, I must give written notice to the Facility Director of the facility, who may delay the patient's departure for up to three days (excluding Saturday, Sunday and holidays).
4. Once I give notice that I want the patient to leave the facility, I realize that if the Facility Director thinks the patient might be a danger to himself or herself or other people because of mental illness, he or she may petition the District Court within the three-day period seeking to have the patient committed to (ordered to stay at) the facility for up to six months. The Court will schedule a hearing. I understand the patient has the right to be represented by an attorney at the hearing. If he or she cannot afford an attorney, the Court will appoint one. After the filing of the petition, the Court has five (5) business days to begin a hearing on the petition for commitment. During this time, the patient must remain at the facility. At the hearing, the judge will decide whether or not the patient can leave the facility.
5. I agree to the patient's receiving treatment at this facility for mental illness subject to any limitations identified in the health care proxy. I understand that this agreement does not limit the patient's right to submit a three-day notice, revoke his or her health care proxy or to otherwise refuse at any time specific treatment interventions such as antipsychotic medication or electroconvulsive therapy. I may also refuse any specific treatment interventions subject to any limitations identified in the health care proxy.
6. I have been given a copy of the Notice of Rights (Form CV-301HCA).
7. I have been offered the opportunity to consult with a lawyer or person under the supervision of an attorney concerning the effect of a conditional voluntary admission.
8. I understand that the facility will accept or reject this application in accordance with the applicable clinical and legal standards.

_____ _____
Signature of Health Care Agent Date

_____ _____
Witness Date

ATTACH COPY OF HEALTH CARE PROXY

ACCEPTANCE/REJECTION BY THE FACILITY

In accordance with the criteria set forth below the application shall be accepted or rejected, by a designated physician***** of the facility.

	Yes	No
1. This patient:		
A. has been diagnosed with mental illness, as defined in 104 CMR 27.05 (2).	☐	☐
B. is in need of care and treatment for this mental illness,	☐	☐
C. is in need of hospitalization (i) for such care and treatment or (ii) to prevent serious harm due to the absence of a more appropriate placement alternative.	☐	☐
2. This facility is suitable for such care and treatment.	☐	☐
3. The patient has a valid health care proxy which has not expired or been revoked.	☐	☐
4. The health care proxy has been properly invoked based upon the patient's incapacity to make informed health care decisions.	☐	☐

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If every box is checked "Yes", then the application shall be accepted unless the patient has not yet been admitted, in which case the application may be accepted only if the facility's criteria for admission have been met. If any box is checked "No", the application shall be rejected, unless only boxes "1.A", "1.B", or "2" are checked "No" in which case the facility may accept if the patient's conditional voluntary hospitalization is necessary to prevent serious harm due to the absence of a more appropriate placement alternative.

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The Patient or Health Care Agent may not sign a three-day notice unless this form has been accepted.

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I, a designated physician***** of this facility, hereby (check all applicable boxes):

5. ☐ **Accept** this application for conditional voluntary hospitalization:
   - ☐ A. The health care agent is applying for care and treatment of the patient on a conditional voluntary basis.
   - ☐ B. I have determined that all criteria for conditional voluntary admission status are met.
   - ☐ C. Only boxes "1.A", "1.B" or "2" are checked "No" and continued hospitalization is necessary to prevent serious harm due to the absence of a more appropriate placement alternative.
6. ☐ **Reject** this application for conditional voluntary hospitalization. Reasons:

_____

_____

_____

Designated Physician**'s** Signature _____ Date _____

Printed Name _____ Title _____

This patient's Conditional Voluntary status must be reassessed at the time of each periodic review.

FILE IN PATIENT'S RECORD IMMEDIATELY

***** A physician who meets the criteria in 104 CMR 33.02