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 a Parent or Guardian of a Minor)*

Name of Patient (Child/Ward): ____
please print

Address:__________________________City/Town:________________________State:_________

Social Security Number:____________________Date of Birth:________________Sex: M ☐ F ☐

Name of Guardian:_____________________________________Phone #:___________________

Address:__________________________City/Town:________________________State:_________

To the Facility Director of: ____
Name of Facility

1. I am the parent/legal guardian of the above-named patient (child/ward) with authority to consent to his/her admission to this facility. (If the applicant is not the parent of the minor, a copy of the guardianship decree must be provided.)
2. I wish to admit my child/ward as a conditional voluntary patient at the above facility.
3. I realize that when I want my child/ward to leave the facility, I must give written notice to the Facility Director, who may delay my child's/ward's departure for up to three days (excluding Saturday, Sunday and holidays).
4. Once I give notice that I want my child/ward to leave the facility, I realize that if the Facility Director thinks my child/ward 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 my child/ward committed to (ordered to stay at) the facility for up to six months. The Court will schedule a hearing. I understand that my child/ward 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, my child/ward must remain at the facility. At the hearing, the judge will decide whether or not my child/ward can leave the facility.
5. I agree to my child's/ward's receiving treatment at this facility for mental illness. I understand that this agreement does not limit my child/ward's right to refuse at any time specific treatment interventions such as antipsychotic medication, electroconvulsive therapy or psychosurgery.
6. I have been given a copy of the Notice of Rights (Form CV-301P/G).
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 applicable clinical and legal standards.

_______________________________________ ____________________________
Signature of Parent or Guardian Date

_______________________________________ ____________________________
Witness Date

*Facility Director means the superintendent, chief executive officer, program director, or other administrator designated by the facility to have administrative oversight of a facility, or his or her designee.…

ATTACH COPY OF GUARDIANSHIP DECREE

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.

1. This patient:

	Yes	No
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 <u>or</u> (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 applicant's status as parent or guardian has been confirmed.	☐	☐

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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 Parent/Guardian 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):

4. ☐ **Accept** this application for conditional voluntary hospitalization of a minor:

   ☐ A. The Parent/Guardian is applying for care and treatment of their child/ward 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.

5. ☐ **Reject** this application for conditional voluntary hospitalization. Reasons:

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______________________________	______________________
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