INFORMATION FOR FILING MENTAL HEALTH BOARD PETITION:

The patient must be dangerous as well as mentally ill.

There must be an overt act of dangerousness to the patient or to someone else occurring within the last three months.

There must be information establishing mental illness.

Subject must be found in Douglas County at time Petition is filed.

The Petition will be presented to the Deputy County Attorney to determine if there is sufficient evidence of dangerous acts and mental illness for approval of the filing of the Petition.

Petitioner and other witnesses must appear at the commitment hearing to give sworn testimony to the evidence of dangerousness to self or others as well as mental illness. The subject and his/her attorney will be present. Failure to appear might result in the dismissal of the Petition.

A Public Defender will be appointed to represent the subject if he/she is indigent.

The only testimony permitted to be introduced at the hearing is first-hand information. No hearsay evidence can be introduced.

The commitment hearing will be held within 7 days after patient is admitted to hospital.

Commitment by the Board of Mental Health is for persons who refuse voluntary treatment.

The Board of Mental Health does not commit persons who are mentally retarded only.

The Board of Mental Health does not pay for the care of patients or pay for the Physician while subject is in the hospital.

A Petition has to be signed by a Notary if it is faxed or mailed to the Board of Mental Health.

After 4:30 p.m. and weekend: Call 911 for emergency assistance.

Board of Mental Health,
801 Civic Center
1819 Farnam Street
Omaha, Ne. 68183
PHONE Number: 402-444-7191
FAX Number: 402-444-6455

Deputy County Attorney
909 Civic Center
1819 Farnam Street
Omaha, Ne. 68183
PHONE Number: 444-7542

Nebraska Revised Statute 71-962 - VIOLATIONS; PENALTY.

Any person who willfully
(1) files, or causes to be filed, a certificate of petition under this act, knowing any of the allegations thereof to be false,

(2) deprives a subject of any of the rights granted the subject by this act or section 71-956 or

(3) breaches the confidentiality of records required by section 71-961 shall be guilty of a **Class II Misdemeanor** in addition to any civil liability which he may incur for such acts.

MENTAL HEALTH BOARD INTAKE INFORMATION

DATE_____

REPORTING PARTY:

NAME _____ RELATIONSHIP TO SUBJECT _____

ADDRESS _____

PHONE Number: HOME _____ WORK _____ CELL _____

SUBJECT AND RISK DATA:

NAME _____ SOCIAL SECURITY NUMBER _____

IMMEDIATE LOCATION OF SUBJECT _____

_____

**IF IN HOSPITAL, LIST ROOM, BED NUMBER AND CONTACT PERSON: _____

_____

CURRENT ADDRESS: _____ COUNTY _____

CITY / STATE / ZIP: _____

PHONE Number: HOME _____ WORK _____ CELL _____

DATE OF BIRTH _____ AGE _____ SEX Male _____ or Female _____

RACE _____ HEIGHT _____ WEIGHT _____

HAIR COLOR _____ HAIR LENGTH _____ EYE COLOR _____

WEARS GLASSES: Yes ____ No ____ FACIAL HAIR: Beard _____ Mustache _____

TATTOOS (DESCRIPTION & LOCATION):_____

_____

SCARS (LOCATION) _____

IS THE SUBJECT CURRENTLY IN JAIL? Yes ____ No ____ IF YES, LIST CURRENT CRIMINAL CHARGES PENDING:

_____

DOES THE SUBJECT HAVE A HISTORY OF VIOLENCE? Yes ____ No ____ IF YES, PLEASE DESCRIBE:

_____

DOES THE SUBJECT POSSESS ANY WEAPONS? Yes ____ No ____ IF YES, PLEASE DESCRIBE:

_____

NAME AND CONTACT INFORMATION OF LEGAL GUARDIAN, (IF APPLICABLE):

_____

MARITAL STATUS _____

NAME AND ADDRESS OF SPOUSE: _____

NAME AND CONTACT INFORMATION OF ADULT CHILDREN, IF AVAILABLE:

_____

DOES THE SUBJECT HAVE MINOR CHILDREN? Yes _____ No ____

WHO WILL CARE FOR CHILDREN DURING HOSPITALIZATION?

_____

MENTAL HEALTH AND SUBSTANCE ABUSE HISTORY:

DOES THE SUBJECT HAVE A HISTORY OF MENTAL ILLNESS? YES ___ NO ____

IF YES, DESCRIBE:

_____

DOES THE SUBJECT HAVE A HISTORY OF ALCOHOL OR DRUG ABUSE? YES ____ NO ____

IF YES, DESCRIBE:

_____

DO YOU BELIEVE THE SUBJECT WILL BE INTOXICATED WHEN TAKEN INTO CUSTODY? YES ___ NO ___

NAMES OF CURRENT PSYCHIATRIST/PHYSICAN:_____

IS THE SUBJECT CURRENTLY TAKING ANY MEDICATIONS? YES ____ NO ____

IF YES, LIST:

_____

_ **PREVIOUS PSYCHIATRIC HOSPITALIZATIONS?** YES ____ NO ____

IF YES, LIST:

_____	_____	_____
MONTH / YEAR	HOSPITAL / FACILITY	PSYCHIATRIST
_____	_____	_____
MONTH / YEAR	HOSPITAL / FACILITY	PSYCHIATRIST
_____	_____	_____
MONTH / YEAR	HOSPITAL / FACILITY	PSYCHIATRIST

DOES SUBJECT HAVE MENTAL HEALTH INSURANCE? YES ___ NO ___

IF YES, NAME OF COMPANY: _____

WITNESSES OF SUBJECTS'S MENTAL ILLNESS AND / OR DANGEROUSNESS:

_____	_____	_____
NAME	ADDRESS & ZIP CODE	PHONE NUMBER
_____	_____	_____
NAME	ADDRESS & ZIP CODE	PHONE NUMBER
_____	_____	_____
NAME	ADDRESS & ZIP CODE	PHONE NUMBER
_____	_____	_____
NAME	ADDRESS & ZIP CODE	PHONE NUMBER

State reasons you believe subject is mentally ill and/or dangerous to self and/or others.
Include personal observations of subject and statements made by subject to which you can testify.
Describe in detail acts of dangerousness occurring to self or others within the past three (3) months.
***Please* attach additional pages if necessary.**

_____

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☐ **PLEASE check if extra pages are attached with additional information**

I Agree with the above information and statements: _____
Reporting Party

Subscribed and sworn to before me this _____ day of _____, 20_____

_____
NOTARY PUBLIC