



**VERIFIED PETITION
FOR 60/360 DAY INVOLUNTARY TREATMENT
(SUBSTANCE USE DISORDER)**

Case No. _____
Court _____ District _____
County _____
Division _____

IN THE INTEREST OF: _____
Respondent's Name (please print)

RESPONDENT'S RESIDENCE ADDRESS: (please print)

Phone Number: _____

CURRENT LOCATION: (if different)

Phone Number: _____

1. PETITIONER, _____
Petitioner's Name (please print)

PETITIONER'S ADDRESS: (please print)

Phone Number: _____

states that he/she is: Spouse; Relative; Friend; or Guardian, of the above-named Respondent.

2. PETITIONER further states that the name, address, and residence of persons related to the Respondent are:
(if unknown, so state)

Parents or guardian: _____

Spouse: _____

Person having custody of Respondent: _____

Near relative: _____

Other: _____

3. PETITIONER believes that the Respondent is a person suffering from a substance use disorder because:
(state facts to support belief)

4. PETITIONER also believes that the Respondent presents a danger or threat of danger to self, family or others because: (state facts to support belief)

5. PETITIONER requests that the Respondent be detained for examination, evaluation and hospitalization/admittance to a treatment facility if he/she meets the criteria for:

- involuntary treatment for not more than sixty (60) consecutive days; or
- involuntary treatment for not more than three hundred and sixty (360) consecutive days.

_____, 2_____
Date

Signature of Petitioner

Name of Petitioner (*please print*)

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 2_____

My Commission Expires: _____

Notary/Clerk

By: _____, D.C.

GUARANTEE OF PAYMENT

Pursuant to KRS 222.432(4)(f), either the Petitioner or other authorized person (spouse, relative, friend, or guardian) shall guarantee any and all costs for treatment of the Respondent for a substance use disorder, as may be hereinafter ordered by the Court. The GUARANTEE below shall be completed by either the Petitioner or other authorized person.

By my signature below, I do hereby assume responsibility for and GUARANTEE PAYMENT FOR ALL COSTS incurred on behalf of the Respondent for all substance use disorder treatment, including, but not limited to, initial examination and transportation costs, as hereinafter ordered by the Court.

_____, 2_____
Date

Name (please print)

Relationship to Respondent
(Petitioner, or Spouse, Relative, Friend, Guardian)

Signature

Billing Address: _____

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 2_____

My Commission Expires: _____

Notary/Clerk

By: _____, D.C.

Attach copy of Verified Petition to each copy of Warrant, Summons, and Hearing, Examination and Appointment of Counsel Notice and Order.

Distribution: Respondent; Petitioner; Respondent's Legal Guardian, Spouse, Parent(s), Near Relative or Friend (if applicable).