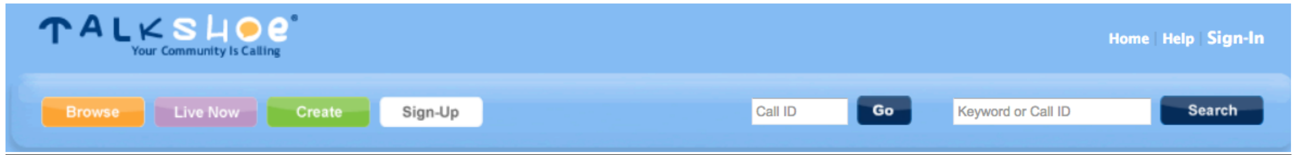
Targeted Individual for the State of Florida

Resource Guide

January 2018

TARGETED INDIVIDUAL HELP LINES



Talkshoe is the Community Help Line for Targeted Individuals (http://www.talkshoe.com). This is where you would go if you want to be online and have use of the chat room while the calls are in session. **This is for online access only. You can dial directly using the "Contact #" provided below, follow prompts when asked, and be immediately connected to "live" conversations for that specific day and time.**

To Contact the Talkshoe Conference Call: Dial the appropriate Contact Number, Enter the Conference ID and Pin (if required) when prompted. You are now in a live conversation.

For online Access, you can create an account as a member of Talkshoe or sign up as a Guest. Follow instructions on page. Once a member you can chat. You can also call in to be able to speak and chat.

Again, **you do not need to "Sign-Up" as a Talkshoe Member or a Guest to connect to these live calls, only if you want to participate online.**

IF YOU ARE IN "CRISIS", PLEASE ANNOUNCE THIS IMMEDIATELY TO THE HOST

Day	Time	Contact Number	Conference ID	PIN	Host
Sunday	3:00 pm EST	(724) 444-7444	114616#	Accepts Guest 1#	Renata
Sunday	9:00 pm EST	(724) 444-7444	134999#	Accepts Guest 1#	Neal - Florida
Sunday	Continued	(724) 444-7444	134999#	Accepts Guest 1#	Neal - Florida
Monday	6:00 pm EST	(641) 715-0632	116202#	Do Not Accept Guest	Mike
Monday	9:00 pm EST	(319) 527-2701	248671#	Do Not Accept Guest	Derrick
Monday	Following Derrick's Call	(724) 444-7444	142298#	Accepts Guest 1#	Ken
Tuesday	6:00 pm EST	(724) 444-7444	143944#	Accepts Guest 1#	Terry

Tuesday	8:00 pm EST	(724) 444-	140567#	Accepts Guest 1# Community Church	Millicent
Tuesday	9:00 pm EST	(724) 444-7444	141476#	Accepts Guest 1#	Ella
Tuesday	Following Ella’s Call	(724) 444-7444	142298#	Accepts Guest 1#	Kyle
Wednesday	8:00 pm EST	(724) 444-7444	140567#	Accepts Guest 1# Bible Study	Julie
Wednesday	9:00 pm EST	(646) 749-3112	450 414 301#	Do Not Accept Guest	Frank
Wednesday	Following Frank’s Call	(724) 444-7444	142298#	Accepts Guest 1#	Ken
Thursday	6:00 pm EST	(724) 444-7444	145495#	Accepts Guest 1#	Sue - Florida
Thursday	9:00 pm EST	(724) 444-7444	141476#	Accepts Guest 1#	Ella
Thursday	Following Ella’s Call	(724) 444-7444	142394#	Accepts Guest 1#	Kyle
Friday	6:00 pm EST	(646) 749-3112	450 414 301#	Do Not Accept Guest	Frank
Friday	9:00 pm EST	(724) 444-7444	140091#	Accepts Guest 1#	Linda
Friday	Following Linda’s Call	(724) 444-7444	142298#	Accepts Guest 1#	Ken
Saturday	6:00 pm EST	(724) 444-7444	140567	Accepts Guest 1# Community Church	Millicent
Saturday	8:00 pm EST	(724) 444-7444	144771#	Accepts Guest 1#	Loren
Saturday	9:00 pm EST	(319) 527-2701	248671#	Do Not Accept Guest	Derrick

WEBSITES FOR FURTHER GUIDANCE AND EDUCATION:

http://citizensaht.org

http://www.pactsntl.org

People Against Covert Torture

& Surveillance, International

https://www.stopgangstalkingcrimes.com

STOP GANGSTALKING CRIMES

BECOME AWARE

EMPOWER YOUR WORLD

LEARN THE TRUTH ABOUT AND BECOME AWARE OF

GANGSTALKING - TARGETED INDIVIDUALS (TI'S)

DIRECTED ENERGY WEAPONS (DEW'S)

https://www.freedomfortargetedindividuals.org

http://targetedmassachusetts.org

Targeted Massachusetts

STARS International

COUNTY INFORMATION AND REFERRAL SERVICES:
(Also Contact Salvation Army for Shelters in that County)

The information and referral service in your county will help you find local resources and services that can ***assist you with housing, food and clothing, healthcare, jobs and training, and other needs.***
County Information and Referral Services
Alachua 211 or (866) 288-4312
Baker 211 or (904) 632-0600
Bay (850) 769-2738 or (800) 696-8740 or (877) 211-7005
Bradford 211 or (866) 288-4312
Brevard 211 or (321) 632-6688
Broward 211 or (954) 537-0211
Calhoun (850) 769-2738 or (800) 696-8740 or (877) 211-7005
Charlotte 211 or (941) 205-2161
Citrus 211
Clay 211 or (904) 632-0600
Collier (239) 262-7227 or (800) 329-7227
Columbia 211 or (904) 632-0600
DeSoto 211 or (941) 308-4357
Dixie 211 or (866) 288-4312
Duval 211 or (904) 632-0600
Escambia (850) 595-5905
Flagler 211 or (386) 437-9730 or (877) 253-9010
Franklin 211 or (850) 617-6333 or (877) 211-7005
Gadsden 211 or (850) 617-6333 or (877) 211-7005
Gilchrist 211 or (866) 288-4312
Glades 211 or (863) 675-8383
Gulf (850) 769-2738 or (800) 696-8740 or (877) 211-7005
Hamilton 211 or (850) 769-2738 or (904) 632-0600 or (866) 318-0211
Hardee 211 or (863) 648-1515
Hendry 211 or (239) 433-3900
Hernando 211
Highlands 211 or (863) 648-1515
Hillsborough 211 or (813) 234-1234
Holmes (850) 769-2738 or (800) 696-8740 or (877) 211-7005
Indian River 211 or (561) 383-1111
Jackson (850) 769-2738 or (877) 211-7005 or (800) 696-8740
Jefferson 211 or (850) 617-6333 or (877) 211-7005
Lafayette 211 or (866) 288-4312
Lake (352) 728-8700
Lee 211 or (239) 433-3900
Leon 211 or (850) 617-6333 or (877) 211-7005
Levy 211 or (866) 288-4312
Liberty 211 or (850) 617-6333 or (877) 211-7005
Madison 211 or (850) 617-6333 or (877) 211-7005
Manatee 211 or (941) 366-5025
Marion 211 or (877) 215-4495
Martin 211 or (561) 383-1111
Miami-Dade 211 or (305) 358-4357
Monroe (305) 292-8445 or (800) 273-4558
Nassau 211 or (904) 632-0600 or (866) 318-0211
Okaloosa (850) 243-9111

Okeechobee 211 or (561) 383-1111
Orange 211 or (407) 849-2356 or (407) 839-4357
Osceola 211 or (407) 849-2356 or (407) 839-4357
Palm Beach 211 or (561) 383-1111
Pasco 211 or (877) 828-8929 or (727) 842-8605
Pinellas 211 or (727) 210-4211
Polk 211 or (863) 648-1515
Putnam 211 or (866) 318-0211
Santa Rosa (850) 983-7200
Sarasota 211 or (941) 366-5025
Seminole 211 or (407) 849-2356 or (407) 839-4357
St. Johns 211 or (904) 829-9721 or (904) 632-0600
St. Lucie 211 or (561) 383-1111
Suwannee 211 or (850) 769-2738 or (904) 632-0600 or (866) 318-0211
Sumter (352) 728-8700
Taylor 211 or (850) 617-6333 or (877) 211-7005
Union 211 or (866) 288-4312
Volusia 211 or (386) 253-0564 or (877) 253-9010
Wakulla 211 or (850) 617-6333 or (877) 211-7005
Walton (850) 243-9111
Washington (850) 769-2738 or (877) 211-7005

Don't have a telephone??? Go to your local library, or house of worship and ask to use their land-line telephone. They may even make the call on your behalf.

https://www.shelterlistings.org/state/florida.html
Please also visit this site as it may have more information for housing. "Shelter Listings is dedicated to serving the homeless and low-income. Choose the city in Florida where you want to find shelters, halfway houses, affordable housing, supportive housing, low cost housing, etc. The database consists of over 3,000 listings and includes emergency shelters, homeless shelters, day shelters, transitional housing, residential drug/alcohol, rehabilitation programs and permanent affordable housing."

JACKSONVILLE

FOOD & SHELTER: (Also Contact Salvation Army)

Find any local library to locate more shelters and food

If you know someone who is hungry please let him or her know about our food service program. Our non-resident meals are served at the times listed below. Meals are served on a first some first served basis but no one is ever turned away.

The Sulzbacher Center – Food, Shelter and emergency housing services.
611 East Adams Street
Jacksonville, FL 32202
Phone: 904-359-0457
Lunch – 12:30 pm
Dinner – 6:30 pm

Trinity Rescue Mission
Jacksonville, FL 32202
904-355-1205
Shelter, meals, showers, clean clothing, toiletries, counseling, hygiene items.

Family Promise of Jacksonville – Temporary Shelter
Jacksonville, FL 32203
904-354-1818
Homeless family temporary shelter.

SALVATION ARMY
Dinner for unsheltered homeless persons and the working poor occurs every night of the year at 6pm, and on Sunday mornings at 8:30am in the dining room of the Towers Center of Hope at 900 W. Adams Street, Downtown Jacksonville. The line forms at 5:30 pm at the gate on the Davis Street side of the building. **SHELTER**: Call our Social services office at 904-356-8641 for information on availability and rates. 900 West Adams St., Jacksonville Fl 32204

ORLANDO

FOOD AND SHELTER: (Also contact Salvation Army)

Find any local library to locate more shelters and food

From the Christian Service Center you are welcome to come enjoy a meal from Daily Bread anytime you are hungry. Everyone is invited to eat for free, no questions asked. Locations and dining times are as follows:

Daily Bread - Downtown Orlando
(Behind our administrative building located on Central Blvd.)
24 Glenn Lane
Orlando, FL 32804
407.425.523
Monday through Friday: 12:00 p.m.-1:00 p.m.
Sunday: 11:00 a.m.-12:00 p.m.

Daily Bread - West Orange
300 West Franklin Street
Ocoee, FL 34761
407.656.6678
Monday through Saturday: 11:30 a.m.-12:30 p.m.

ORLANDO RESOURCES:

Community Resources

If You Need Help, Dial 2-1-1
(Information & Referral)

Simply dial, 2-1-1, United Way's free, 24-hour information and referral helpline which links people in need with more than 2,000 local health and human service programs, including these community resources.

AIDS SERVICES
Orange County Health Dept 407-836-2680
Hope & Help Center 407-645-2577

CHILD CARE
Comm. Coord. Child Care (4C) 407-522-2252
Frontline Outreach 407-293-3000
Orlando Day Nursery 407-422-5291
Winter Park Day Nursery 407-647-0505

CLOTHING/PERSONAL ITEMS
Christian Service Center 407-425-2523
Frontline Outreach 407-293-3000
Lighthouse Mission 407-291-0124
Loaves and Fishes 407-886-6005
Orlando Union Rescue Mission 407-422-4855
Salvation Army 407-423-8581

CRISIS INTERVENTION
Lakeside Alt. (Mental Health) 407-875-3700
Harbor House (Domestic Abuse) 407-886-2856
Domestic Abuse Hotline 1-800-500-1119

DISABILITY ASSISTANCE
Deaf Services Ctr. 407-623-1070
Center for Independent Living 407-623-1070
Disability Determination 407-897-2970
Social Security 407-648-6673
Vocational Rehab 407-897-2700
TDD 407-897-2750

DRUG/ALOCHOL TREATMENT
Center for Drug Free Living 407-245-0014
Turning Point of Central FL 407-740-5655

EDUATIONAL SERVICES
Orange County Schools 407-317-3200
Head Start 407-836-6590

EMPLOYMENT ASSISTANCE
Agri. & Labor Program 1-800-330-3491
Christian Help 407-834-4022
Goodwill Industries 407-872-0770
Workforce Central FL 407-531-1227

FINANCIAL ASSISTANCE
Orange County Crisis 407-836-6500
American Red Cross 407-894-4141
Catholic Charities 407-658-1818
Christian Service Center 407-425-2415
Jewish Family Services 407-644-7593
Salvation Army 407-423-8581
Metropolitan Urban League 407-841-7654
LIHEAP 407-836-7429

FINANCIAL COUNSELING
Credibility 1-800-251-2227

FOOD PANTRY/MEALS
Christian Service Center 407-425-2523
Catholic Charities 407-658-1818
Frontline Outreach 407-293-3000
Jewish Family Services 407-644-7593
Loaves and Fishes 407-886-6005
Salvation Army 407-423-8581

HEATH SERVICES
AIDS Hotline 1-800-342-2437
Community Health Center 407-905-8827
Shepherd's Hope 407-876-6699

HOMELESS/SHELTER ASSIST
Coalition for the Homeless 407-426-1250
Lighthouse Mission 407-291-0124
Orlando Union Rescue 407-422-4855
Salvation Army 407-423-8581

HOUSING ASSISTANCE
Orlando Housing 407-895-3300
Winter Park Housing 407-645-2869
Orange County Housing Finance 407-894-0014

DEPT/CHILD & FAMILIES
Florida State 1-866-762-2237
Orange County 1-866-735-2469

LEGAL SERVICES
GOALS 407-841-7777
Lawyer Referral Service 407-422-4537
Legal Aid Society 407-841-8310
NCF 407-622-2911

MENTAL HEALTH SERVICES
Lakeside Alternatives 407-875-3700
FL Hospital Center Psych 407-303-8533
Dr. Phillips Hospital 407-351-8500

PREGNANCY SERVICES
BETA 407-277-1942
Orlando Women's Center 407-245-7999
Catholic Charities 407-658-1818
Community Health Center 407-905-8827
Orange County Health 407-836-2660
TLC Women's Center 407-294-4314

SENIOR SERVICES
Adult Abuse Hotline 1-800-962-2873
Seniors First 407-292-0177
Share the Care 407-423-5311

TRANSPORTATION
LYNX transit 407-841-5969
Access LYNX 407-423-8747
Greyhound 1-800-231-2222

VICTIM SERVICES
Child Protection Team 407-317-7430
Harbor House (Domestic Abuse) 407-886-2856
Sexual Assault Hotline 407-497-6701
Sexual Assault Treatment 407-228-1430
Victim Advocate Program 407-254-7248
Domestic Abuse Hotline 1-800-500-1119

YOUTH
Youth Crisis Line 1-800-442-HOPE
Runaway Hotline 1-800-RUNAWAY
Girls/Boys Town 1-800-448-3000
Youth 9-Line 1-800-999-9999

Christian Service Center
for Central Florida
ChristianServiceCenter.org

Downtown Orlando
808 W. Central Blvd , Orlando, FL 32805
407-425-2523

Winter Park
At Redeemer Lutheran Church
3377 Aloma Ave., Winter Park, FL 32792
407-628-1692

West Orange
300 W. Franklin St., Ocoee, FL 34761
407-656-6678

Updated 8/2017

TAMPA

FOOD & SHELTER: (Also contact Salvation Army)

Find any local library to locate more shelters and food

Meals are served at two Tampa Bay locations (shown below) weekdays at
11:30 a.m. – 12:30 p.m. and weekends for breakfast at our Nebraska location, 9 a.m. – 10 a.m.
Trinity Cafe Address:
2801 N. Nebraska Avenue
Tampa, FL 33602

Trinity Cafe 2 Address:
2202 E. Busch Boulevard
Tampa, FL 33612
Phone: (813) 865-4822

Visit: http://www.suntopia.org/tampa/fl/homeless_shelters.php for Shelters, Rental Assistance, Food Pantries, Clothing, and Emergency Loans.

Helpless Helping Helpless –
Assist homeless men and women back into permanent housing.
(813) 415-3586
Information: Facility has 25 beds. Breakfast and Dinner provided when available.
Population: Men and Women
Eligibility: $10 per night

Red Shield Lodge/Emergency Shelter – Salvation Army
1514 N. Florida Ave
Tampa, Fl 33602
(813) 221-4440
Information: Facility has 104 male beds and 23 female beds. Check-in is at 4 pm daily. People can stay for up to 5 nights for free; after 5 nights, there is a charge of $10 per night. Homeless individuals can stay at the Lodge for a total of 45 days in a calendar year. The Red Shield Lodge provides each person with a bed, linens, a locker, a locker and three meals each day. Support and referral services are available to those who wish to use them.
Population: Men and Women
Eligibility: $10 per night

MIAMI

FOOD & SHELTER: (Also contact Salvation Army)

Find any local library to locate more shelters and food

MIAMI RESCUE MISSION
3553 NW 50TH Street
Miami, Fl 33142
(305) 571-2273
Helping men, women and children with meals, safe shelter, life changing residential programs, employment and housing.

CHAPMAN PARTNERSHIP HOMELESS HELPLINE: 1-877-994-4357
They will help you find food, shelter, healthcare, etc.

MIAMI HOMELESS SHELTER OR SUPPORT CENTER CONTACT NUMBER for Soup Kitchens, Food Pantry Food Banks:

Allapattah Community Action, Inc in Miami, Florida

Allapattah Community Action, Inc is a food pantry located at 2257 NW North River Drive, Miami, FL 33125. Mondays through Fridays 8am - 5pm. Call (305) 633-0466 for more food bank, food pantry, soup kitchen resources and information.
2257 NW North River Drive
Miami, FL 33125

Ministerio International in Miami, Florida

Ministerio International is a food pantry located at 16300 Southwest 137th Ave., Miami, FL 33177. Call (305) 255-4407 for more food bank, food pantry, soup kitchen resources and information.
16300 Southwest 137th Ave
Miami, FL 333177

FLORIDA BAKER ACT

IMPORTANT: It is strongly suggested you do not speak to hospital personnel or law enforcement that you are a targeted individual, hear voices, the use of direct energy weapons, having implants or being gangstalked as this could lead to you being hospitalized and medications then could be administered.

Free Help and Consultation
Call 800-782-2878

CCHR Florida provides only facts and does not provide medical or legal advice.

Our office recommends that an individual seek a competent medical examination by a non-psychiatric medical professional.

BAKER ACT - FLORIDA

Mental Health Involuntary Commitment

In Florida, the Involuntary Commitment law is referred to as the Baker Act. If someone you know has been involuntarily committed, you have the right to be fully informed about the step-by-step procedure of involuntary commitment as well as your rights and the rights of the person who was, or is being, committed. **Call the CCHR Florida hotline to get fully informed – 800-782-2878**.

Question: How long may a person be held for involuntary examination, a Baker Act?

Answer: An adult may be held up to 72 hours for an involuntary examination. However the examination period for a minor, anyone 17 or younger, is 12 hours. Specifically the examination "shall be initiated within 12 hours after the patient's arrival at the facility."

If the examination period for an adult or a minor ends on a weekend or a holiday than no later than the next working day one of the following actions must be taken:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released for voluntary outpatient treatment;

3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient and, if such consent is given, the patient shall be admitted as a voluntary patient; or
4. A petition for involuntary services shall be filed in the circuit court if inpatient treatment is deemed necessary. This is the start of a possible involuntary psychiatric commitment.

Question: When does a patient need to be examined by a health practitioner?

Answer: Florida Statute 394.459 Rights of patients, Section (2) RIGHT TO TREATMENT, Subsection (c) states:

"(c) Each person who remains at a receiving or treatment facility for more than 12 hours shall be given a physical examination by a health practitioner authorized by law to give such examinations, within 24 hours after arrival at such facility."

It is important to understand that according to the Florida Administrative Code 65E-5.160 Right to Treatment that this examination must included a determination that abnormalities of thought, mood or behavior due to
non-psychiatric causes have been ruled out.

"(3) The physical examination required to be provided to each person who remains at a receiving or treatment facility for more than 12 hours must include:

(a) A determination of whether the person is medically stable; and

(b) A determination that abnormalities of thought, mood, or behavior due to non-psychiatric causes have been ruled out."

Question: Does a patient have a right to say what treatment they do or do not want to receive?

Answer: Florida Statute 394.459, Rights of patients, Section (2) RIGHT TO TREATMENT, Subsection (e) states:

"(e) Not more than 5 days after admission to a facility, each patient shall have and receive an individualized treatment plan in writing which the patient has had an opportunity to assist in preparing and to review prior to its implementation. The plan shall include a space for the patient's comments."

However, if you truly want to ensure that your wishes are respected, you should complete a Mental Health Advance Directive. This form can be downloaded from the Department of Children and Families at this link – Mental Health Advance Directive. You may also be interested in attending one of our workshops on Mental Health Advance Directives. *These workshops are delivered by an attorney and are free of charge*. For more information please call 727-442-8820.

Question: What is Express and Informed Consent?

Answer: Florida Statute 394.459, Rights of patients, Section (3), RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT, Subsection (a) 2. states:

"2. Before giving express and informed consent, the following information shall be provided and explained in plain language to the patient, or to the patient's guardian if the patient is 18 years of age or older and has been adjudicated incapacitated, or to the patient's guardian advocate if the patient has been found to be incompetent to consent to treatment, or to both the patient and the guardian if the patient is a minor: the reason for admission or treatment; the proposed treatment; the purpose of the treatment to be provided; the common risks, benefits, and side effects thereof; the specific dosage range

for the medication, when applicable; alternative treatment modalities; the approximate length of care; the potential effects of stopping treatment; how treatment will be monitored; and that any consent given for treatment may be revoked orally or in writing before or during the treatment period by the patient or by a person who is legally authorized to make health care decisions on behalf of the patient."

This simply means that a person, or the person's guardian, is to be told, among other things:

- the reason for admission or treatment;
- the proposed treatment;
- the purpose of the treatment to be provided;
- **the common risks,**
- the benefits
- **the side effects**
- **alternative treatment;**
- the approximate length of care;
- the potential effects of stopping treatment;
- how treatment will be monitored;
- and that any **consent given for treatment may be revoked orally or in writing** before or during the treatment period by the patient or by a person who is legally authorized to make health care decisions on behalf of the patient

Question: Does a parent/guardian have the right to express and informed consent to treatment if a patient is a minor?

Answer: Yes.

Florida Statute 394.459, Rights of patients, Section (3), RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT, Subsection (a)1. states:

"(a)1. Each patient entering treatment shall be asked to give express and informed consent for admission or treatment. If the patient has been adjudicated incapacitated or found to be incompetent to consent to treatment, express and informed consent to treatment shall be sought instead from the patient's guardian or guardian advocate. If the patient is a minor, express and informed consent for admission or treatment shall also be requested from the patient's guardian. Express and informed consent for admission or treatment of a patient under 18 years of age shall be required from the patient's guardian, unless the minor is seeking outpatient crisis intervention services under s. 394.4784. Express and informed consent for admission or treatment given by a patient who is under 18 years of age shall not be a condition of admission when the patient's guardian gives express and informed consent for the patient's admission pursuant to s. 394.463 or s. 394.467."

Question: Does a patient have the right to communicate to their attorney, family and/or report alleged abuse?

Answer: Yes, but there are restrictions.

The law covering this is Florida Statute 394.459, Rights of patients, Section (5) COMMUNICATION, ABUSE REPORTING, AND VISITS, Subsections (c), (d) and (e) and it can be found by clicking here.

In our viewpoint, the important points to know are that :

- A person does have the right to communicate freely and privately with persons outside the facility unless it is determined that such communication is likely to be harmful to the person or others
- **A telephone that allows for free local calls and access to a long-distance service is to be made available as soon as reasonably possible**
- The telephone shall be readily accessible to the patient and shall be placed so that the patient may use it to communicate privately and confidentially.
- Facility rules on the use of the telephone may not interfere with a patient's access to a telephone to report abuse
- Each patient shall be allowed to receive, send, and mail sealed, unopened correspondence
- No patient's incoming or outgoing correspondence shall be opened, delayed, held, or censored by the facility unless there is reason to believe that it contains items or substances which may be harmful to the patient or others
- Each facility must permit immediate access to any patient, subject to the patient's right to deny or withdraw consent at any time, by the patient's family members, guardian, guardian advocate, representative, Florida statewide or local advocacy council, or attorney, unless such access would be detrimental to the patient

"If a patient's right to communicate or to receive visitors is restricted by the facility, written notice of such restriction and the reasons for the restriction shall be served on the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative; and such restriction shall be recorded on the patient's clinical record with the reasons therefor. The restriction of a patient's right to communicate or to receive visitors shall be reviewed at least every 7 days. The right to communicate or receive visitors shall not be restricted as a means of punishment."

- Each facility shall establish reasonable rules governing visitors, visiting hours, and the use of telephones by patients in the least restrictive possible manner.
- Patients shall have the right to contact and to receive communication from their attorneys at any reasonable time.
- **Each patient receiving mental health treatment in any facility shall have ready access to a telephone in order to report an alleged abuse.**
- The facility staff shall orally and in writing inform each patient of the procedure for reporting abuse and shall make every reasonable effort to present the information in a language the patient understands.
- A written copy of that procedure, including the telephone number of the central abuse hotline and reporting forms, shall be posted in plain view.

Question: Does the family or Representative of a patient, who was sent for involuntary examination have to be notified?

Answer: Yes, according to Florida Statute 394.4599 Notice, a facility is required to give prompt notice of the whereabouts of an adult who is being involuntarily held for examination to the individual's guardian, guardian advocate, health care surrogate or proxy, attorney or representative, by telephone or in person within 24 hours after the individual's arrival at the facility. These contact attempts are to be documented in the individual's clinical record and begun as soon as reasonably possible after the individual's arrival.

In the case of a child, a facility is required to give notice of the whereabouts of a minor who is being involuntarily held for examination to the minor's parent, guardian, caregiver, or guardian advocate, in

person or by telephone or other form of electronic communication, immediately after the minor's arrival at the facility.

However, the facility may delay notification for no more than 24 hours after the minor's arrival if the facility has submitted a report to the central abuse hotline based upon knowledge or suspicion of abuse, abandonment, or neglect and if the facility deems a delay in notification to be in the minor's best interest.

Question: What are the criteria used for involuntary examination, a Baker Act?

Answer: Florida Statute 394.463, Involuntary examination, states:

(1) CRITERIA.—A person may be taken to a receiving facility for involuntary examination **if** there is reason to believe that the person has a mental illness **and** because of his or her mental illness:

(a)1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **or**

2. The person is unable to determine for himself or herself whether examination is necessary; **and**

(b)1. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **or**

2. There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

Emphasis has been added to show the key parts of these criteria.

CCHR FLORIDA

The Citizens Commission on Human Rights of Florida is a non-profit watchdog organization that investigates and exposes psychiatric abuse and educates the public about their rights in the field of mental health.

CCHR Florida provides only facts and does not provide medical or legal advice.

Our office recommends that an individual seek a competent medical examination by a non-psychiatric medical professional.

CONTACT CCHR FLORIDA

109 N. Fort Harrison Ave.
Clearwater, Florida 33755
Tel: 1-800-782-2878
Tel: (727) 442-8820

For further information on this, you may be able to obtain a release letter. Have the name of the hospital and doctor and contact: Citizens Against Harmful Technology at (386) 402-7158.

Psychiatric Living Will

(Advance Protective Directive)

I, ______________________________, born on ______________________, __________, in ________________________, ________________________, address: ____,
being of sound mind, willfully and voluntarily make known the following:

1. Under no circumstances should I be subjected to psychiatric hospitalization or psychiatric treatments or procedures including but not limited to the following:
   - Psychotropic drugs (substances which exert a mind-altering effect, including but not limited to antidepressants, antipsychotics, benzodiazepines, mood stabilizers and tranquilizers);
   - Psychosurgical or neurological operation such as lobotomy or leucotomy;
   - Convulsive treatments such as electroconvulsive therapy (also known as electroshock, shock treatment or ECT) and insulin shock;
   - Deep sleep treatment (narcosis, narcosynthesis, sleep therapy, prolonged narcosis, modified narcosis or neuroleptization);

2. I maintain my right not to have any psychiatric evaluation or diagnosis based upon the Diagnostic and Statistical Manual of Mental Disorders (DSM) as such diagnoses are unreliable. According to Allen Frances, who was chairman of the fourth edition of DSM, "There are no objective tests in psychiatry—no X-ray, laboratory, or exam finding that says definitely that someone does or does not have a mental disorder." ("Psychiatric Fads and Overdiagnosis," Psychology Today, 2 June 2010.) Additionally, the DSM system is not scientific. It's own editors state that "there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder." (DSM-IV, pg. xxii)
   Such codes and descriptions should not be entered into my medical records as this unreliable and unscientific information will remain in my records and may wrongly influence any future medical treatment I might receive.

3. Involuntary hospitalization or commitment is a violation of my civil rights under U.S. Code, Title 42, Chapter 21 § 1983, Civil action for deprivation of rights. Lawsuits for involuntary commitment have resulted in verdicts of $1 million or more against hospitals, doctors and other agencies and personnel:
   - Lund vs. Northwest Medical Center, (Case No. Civ. 1805-95, Court of Common Pleas, Venango County, PA, June 16, 2003), jury awarded $1,100,000 million in damages.
   - Marion vs. LaFargue Case No. 00 Civ. 0840, 2004 WL 330239, U.S. District Court for the Southern District of New York, February 23, 2004), jury verdict of $1,000,001 in damages.
   - Dick vs. Watonwan County (Case No. Civ. 4-82-1.16, U.S. District Court, District of Minnesota, April 11, 1983), more than $1 million in damages awarded to plaintiff.

4. The above directions apply in all cases, including any instance where:
   - It is claimed that my capacity or ability to give instructions may be impaired;
   - I am in a state of unconsciousness;

- It is impossible in an actual and legal sense for me to communicate or;
- Any physician, psychiatrist, psychologist, mental health practitioner or law enforcement official or person asserts that the matter is a “life-saving” situation requiring emergency intervention and/or treatment under any involuntary commitment law or similar legal authority.

5. In the absence of my ability to give further directions regarding the above, it is my intention that this declaration be honored by my family and physician(s) as an expression of my legal right to refuse medical, psychiatric or surgical treatment although this statement concerns only psychiatric treatment.

6. The individuals listed below are appointed and authorized to enforce this declaration of intention. Should this declaration be violated, they have my permission to initiate whatever criminal and/or civil procedures are necessary to rectify such a violation:

____________________________ ____________________________

____________________________ ____________________________

By this declaration, I release all medical doctors and their organizations as well as therapists from their professional discretion or confidentiality towards provision of information to the above named attorney(s) and other person(s).

This declaration is also binding for my lawful agents, guardians, family, executors or any person with the legal or other right to take care of me or my affairs.

____________________________	____________________________
Signed	Date
____________________________	____________________________
Street Address	City, State, Zip

Your Rights While Receiving Mental Health Services

The following rights are guaranteed to you under Florida law. These rights will be fully explained to you upon admission to this facility.

Individual Dignity

- ✓ You have the right to be treated respectfully and to not be abused.
- ✓ You have the right to move freely within this facility unless your safety is at risk or your movemen has been restricted by a judge.
- ✓ You have the right to reasonable accommodations under the Americans with Disabilities Act (ADA).

Designation of a Representative

- ✓ You will be asked to identify a person that we can contact in case of emergency.
- ✓ You may identify a person to receive notice that you are here in this facility.
- ✓ If you do not, or cannot, choose a representative, one will be selected for you.

Communication

- ✓ You have the right to talk privately by phone and during visiting hours, and can receive and send private mail. This facility is required to develop reasonable rules about visiting hours, mail and the use of telephones.
- ✓ If your access to the phone, mail, or visitation is restricted, you will be given a written notice that includes the reasons for the restriction. The restriction must be reviewed by the physician at least every 7 days.
- ✓ You have the right to contact your attorney at any time.
- ✓ You have the right to use a phone at any time for the purpose of reporting abuse to the Florida Abuse Hotline, or to Disability Rights Florida.

Confidentiality of Information and Records

- ✓ Information about your stay in this facility is private and may not be released without your consent (or the consent of your guardian, guardian advocate, or health care surrogate/proxy, if you have one) except under certain instances.
- ✓ You have the right to see your clinical record, unless this is determined to be harmful to you by your physician.

Treatment

- ✓ You have the right to receive the least restrictive, most appropriate and available treatment in this facility.
- ✓ You will get a physical exam within 24 hours of arrival.
- ✓ You will be asked to help develop a treatment plan that meets your needs.

Complaints

- ✓ You have the right to file an internal complaint and to receive a response within 24 hours of the conclusion of the investigation (may take up to 7 days).

Advance Directives

- ✓ You have the right to prepare a document, when competent to do so, that lists the mental health care that you want or don't want, and to name a person that can make decisions for you if you are unable to make those decisions for yourself.

Informed Consent

- ✓ Before treatment begins, you will be given information about the purpose of the treatment, the common side effects of medication you receive, alternative treatments, and the approximate length of stay at this facility.
- ✓ You (or your guardjan, guardian advocate, or health care surrogate/proxy) may withdraw your consent to treatment at any time.

Clothing and Personal Effects

- ✓ You have the right to keep your clothing and personal~belongings unless they are removed for safety or medical reasons.
- ✓ If your belongings are taken from you, an inventory of the items will be prepared and given to you to sign. Your items will be returned to you or your representative upon your discharge or transfer from this facility.

Right to Contact the Court

- ✓ You, or your representative, have the right to ask the Court to review the following:
  - The reason and legality of your detention in this facility.
  - A denied legal right or privilege.
  - A procedure that is not being followed.

Voting

- ✓ You have tbe right to register to vote and to cast your vote in any election unless the court has removed this right from you.

Discharge

- ✓ If you request discharge (and you are voluntarily admitted), your doctor will be notified and you will be discharged within 24 hours from a community facility, or within 3 working days from a state hospital, unless you change your mind or you meet the criteria for involuntary placement.
- ✓ You must be released within 72 hours of arrival at the facility unless you are on voluntary status. If you meet the criteria for involuntary placement, a petition must be filed with the court within 72 hours of arrival, or 2 working days of your transfer from voluntary to involuntary status.
- ✓ You have the right to seek treatment from the professional or agency of your choice after your discharge from this facility.

MYFLFAMILIES.COM

If you believe your rights have been violated, you can contact:

Florida Abuse Hotline
1-800-96-ABUSE
1-800-962-2873 (Voice)
1-800-453-5154 (TTY /TTD)

Americans with Disabilities Act (ADA)
1-800-514-0301 (Voice)
1-800-514-0383 (TTY)

Disability Rights
Florida
1-800-342-0823 (Voice)
1-800-346-4127 (TTY/TTD)

This poster can be downloaded from the DCF website at http://www.myflfamilies.com/service-programs/substance-abuse/publications. This poster must be placed next to the telephone used by people receiving services.

RECEIVED

MAY 29 2008

OFFICE OF THE SECRETARY

STATE OF FLORIDA

BILL McCOLLUM
ATTORNEY GENERAL

May 28, 2008

08-31

Mr. Robert A. Butterworth
Secretary
Department of Children and Families
1317 Winewood Boulevard
Tallahassee, Florida 32399-0700

Dear Secretary Butterworth:

You ask substantially the following question:

May physician assistants refer a patient for involuntary evaluation pursuant to section 394.463, Florida Statutes?

As of 2008 Physician Assistants are now able to refer a Patient for Involuntary Evaluation. Please go to the designated website for all information. **http://www.myflfamilies.com/service-programs/mental-health/baker-act**

The following forms and information was taken directly from this website:
http://www.myflfamilies.com/service-programs/mental-health/baker-act-forms

(Please note that some of these forms cannot be reduced further so some information may be slightly missing)

Report of Law Enforcement Officer Initiating Involuntary Examination

State of Florida, County of _______________, Florida

I, ____, am a law enforcement officer certified by the State of Florida. Florida.

In my opinion, ____ appears to meet the following criteria for involuntary examination:

1. I have reason to believe said person has a mental illness as defined by section 394.455, Florida Statutes:

   "Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

   AND because of the mental illness (check all that apply):

   ☐ a. Person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **AND/OR**

   ☐ b. Person is unable to determine for himself/herself whether examination is necessary; **AND**

2. Either (check all that apply):

   ☐ a. Without care or treatment said person is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his/her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **AND/OR,**

   ☐ b. There is substantial likelihood that without care or treatment the person will cause serious bodily harm to (check one or both) ☐ **self** ☐ **others** in the near future, as evidenced by recent behavior.

Circumstances supporting this opinion, including specific information about the person's behavior, threats and actions, and information offered by others:

Has the law enforcement officer initiating this examination
completed a 40-hour Crisis Intervention Team (CIT) training program? .... ☐ Yes ☐ No

Was the examination initiated in the officer's capacity as a school resource officer? .... ☐ Yes ☐ No

Signature of Law Enforcement Officer

Date (mm/dd/yyyy)

Time ☐ am ☐ pm

Printed Name of Law Enforcement Officer

Full Name of Law Enforcement Agency (printed)

Badge or ID Number

Law Enforcement Case Number

Certificate of Professional Initiating Involuntary Examination

ALL SECTIONS OF THIS FORM MUST BE COMPLETED AND LEGIBLE (PLEASE PRINT)

I have **personally examined** (printed name of person) ________________________________ at (time)______ ☐ am ☐

(time must be within the preceding 48 hours) on (date) ___________ in___________________ County and said person appears to m
criteria for involuntary examination.

☐ CHECK HERE if you are a physician certifying non-compliance with an involuntary outpatient placement order and you are initiating involuntary examination. (If so, personal examination within preceding 48 hours is not required. However, please provide documentation of efforts to solicit compliance in Section IV on page 2 of this form.)

This is to certify that my professional **license number** is: _________________________________ and I am a licensed *(check one b*

☐ Psychiatrist ☐ Physician (but not a Psychiatrist) ☐ Clinical Psychologist ☐ Psychiatric Nurse

☐ Clinical Social Worker ☐ Mental Health Counselor ☐ Marriage and Family Therapist ☐ Physician's Assistant

Section I: CRITERIA

1. There is reason to believe said person has a mental illness as defined in section 394.455, Florida Statutes:

"Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

Diagnosis of Mental Illness is: List all mental health diagnoses applicable to this person.		DSM Code(s) (if know

AND because of the mental illness (check all that apply):

☐ a. Person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **AND/OR**

☐ b. Person is unable to determine for himself/herself whether examination is necessary; **AND**

2. Either (check all that apply):

☐ a. Without care or treatment said person is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his/her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **AND/OR,**

☐ b. There is substantial likelihood that without care or treatment the person will cause serious bodily harm to (check one or both) ☐ **self** ☐ **others** in the near future, as evidenced by recent behavior.

Section II: SUPPORTING EVIDENCE

Observations supporting these criteria are (including evidence of recent behaviors related to criteria). Please include the person's behaviors and statements, including those specific to suicidal ideation, previous suicide attempts, homicidal ideation or self-injury.

Section III: OTHER INFORMATION

Other information, including source relied upon to reach this conclusion is as follows. If information is obtained from other persons, describe these sources (e.g., reports of family, friends, other mental health professionals or law enforcement officers, as well as medical or mental health records, etc.).

Section IV: NON-COMPLIANCE WITH INVOLUNTARY OUTPATIENT PLACEMENT ORDER

Complete this section if you are a physician who is documenting non-compliance with an involuntary outpatient placement order: This is to certify that I am a physician, as defined in Florida Statutes 394.455, F.S. and in my clinical judgment, the person has failed or has refused to comply with the treatment ordered by the court, and the following efforts have been made to solicit compliance with the treatment plan:

Section V: INFORMATION FOR LAW ENFORCEMENT

Provide identifying information (if known) if requested by law enforcement to find the person so he/she may be taken into custody for examination:

Age: ______ ☐ Male ☐ Female Race/ethnicity: ____________________________________

Other details (such as height, weight, hair color, what wearing when last seen, where last seen):

If relevant, information such as access to weapon, recent violence or pending criminal charges:

This form must be transported with the person to the receiving facility to be retained in the clinical record. Copies may be retained by the initiating professional and by the law enforcement agency transporting the person to the receiving facility.

Section VI: SIGNATURE

_______________________________________ _______________ __________ ☐ am ☐ pm

Signature of Professional | Date Signed | Time

_______________________________________ _______________________________

Printed Name of Professional | Phone Number (including area code))

Baker Act Service Eligibility

Public Receiving Facility Name: ____

1. **IDENTIFYING INFORMATION:**
   Person's Name: ____________________________
   Date of Birth: ______________________________ Gender: ☐ Male ☐ Female Race: ____________

2. **FINANCIAL INFORMATION:** Prospective monthly income (6-month average) $________________
   Number of Family Members: _______________ Title XX Eligible: ☐ Yes ☐ No

3. **LEGAL STATUS:** ☐ Voluntary Admission ☐ Involuntary Examination

4. **CRITERIA:** (check the appropriate criteria)
   ☐ There is reason to believe the above-named person has a mental illness, as defined in 394.455(18), **AND**
   ☐ Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself, such neglect or refusal poses a real and present threat of substantial harm to his or her well-being, and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services,
   OR
   ☐ There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

5. **MOST RECENT DSM OR ICD ADMISSION DIAGNOSIS AND CODE NUMBER**: _________________________

6. **SUMMARY**: Behavioral manifestations justifying diagnosis. (A completed CF-MH 3052a or 3052b or Ex Parte Order may be attached for persons on involuntary status)

7. **RECOMMENDED DISPOSITION / PLACEMENT**:

8. **WHY IS A LESS RESTRICTIVE PLACEMENT NOT BEING UTILIZED?**

9. **APPROVAL OF DISPOSITION/PLACEMENT** ☐ does ☐ does not include authorization for payment of contracted 24-hour care.

____ _______________ __________ am pm
Signature of Administrator or Designee Date Time

____
Printed Name of Administrator or Designee

By authority of s. 394.74, 394.875, 394.879, Florida Statutes
CF-MH 3084, Feb 05 (obsoletes previous editions) (Mandatory Form for Public Receiving Facilities) **BAKER ACT**

Transportation to Receiving Facility

Part I: General Information

The circumstances, under which (Name of Person) ______________________________ was taken into custody are as follows: Time: am pm Date:
Place or Facility Name:
Pick Up Address:

Family members or others present when person was taken into custody			
Name	Address	Relationship	Phone Number
Next of Kin (if known)			

Indicate personal knowledge by family members and others about the person's condition.   Delivered to (Nearest Receiving Facility):
Basis for Custody: (Check one) ☐ Ex Parte Order ☐ Certificate of Mental Health Professional ☐ Report of Law Enforcement Officer

Signature of Law Enforcement Officer ______________________ Date ______________ Time ____________ am pm

Printed Name of Law Enforcement Officer ______________________ Full Name of Law Enforcement Agency ______________________

Badge or ID Number ______________________ Law Enforcement Case Number ______________________

CONTINUED OVER

There are more pages to view. Please visit website.

Application for Designation as a Receiving Facility

Name of Applicant Facility: ____

Street Address: ____

City: _________________________________ , FL Zip Code: ____________ - _________________

Telephone Number: (_____)______________________________

Administrator: ____

Provide complete responses to the following questions and issues, attaching additional sheets where necessary.

1. Designation requested for:
   - ☐ All populations
   - ☐ Adults Only – Approved Transportation Exception Plan attached
   - ☐ Minors Only – Approved Transportation Exception Plan attached

2. The following are the street addresses for each location at which persons will be received or treated for involuntary examination. Each will operate 24 hours / 7 day a week emergency services and psychiatric licensed beds.

Name of Facility	Street Address	City	Zip Code

3. Psychiatric services, including any distinct programs to be provided to each of the following consumer groups, and the projected numbers of persons to be served in each group are as follows:

	Psychiatric Services	Distinct Programs	Projected Number
Minors below 10 years of age			
Minors between the ages of 10 to 17 years			
Adults			
Persons 60 or more years of age			
Other specialty groups			

CONTINUED OVER

Specific Authorization for Psychotropic Medications

Discussion of psychotropic medication should occur within the context of the person's medical history and current overall medication regimen.

I, the undersigned, a ☐ competent adult, ☐ guardian, ☐ guardian advocate, or ☐ health care surrogate/proxy hereby authorize the professional staff of this facility to administer treatment, limited to mental health medications, as follows:

____
____
____

I have been given detailed information about:

1. The proposed medications and dosage range and frequency;
2. The purpose of my treatment;
3. Common short- and long-term side effects of my proposed medication, including contraindications and clinically significant interactions with other medications;
4. Alternative medications;
5. Approximate length of care

I further understand that a change of medication dosage range from that listed above or on the attached will require my express and informed consent.

I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.

The information I have relied upon to make the decision to consent to treatment, including full disclosure of each of the above subjects, is attached to this authorization and signed by me. I have read and had this information fully explained to me and I have had the opportunity to ask questions and receive answers about the treatment.

____ ____________________
____________ am pm
Signature of Person Date Time

____ ______________
____________ am pm
Signature of Witness for Person Date Time

____ ______________
____________ am pm
Signature of: (check one when applicable) Date Time
☐ Guardian ☐ Guardian Advocate
☐ Health Care Surrogate ☐ Health Care Proxy

If I am the guardian advocate, health care surrogate, or health care proxy for the person, I certify that I have met and talked with the person and the person's physician in person, if at all possible, and by telephone, if not about the proposed treatment prior to signing this form.

Talked to person on:_________(date) ☐ In person ☐ By telephone. If not in person, explain why not.________________________

____

Talked to person's physician on: _____(date) ☐ In person ☐ By telephone. If not in person, explain why not.___________________

____

____ ________________ _____________ am pm Signature of: (check one when applicable) Date Time

☐ Guardian ☐ Guardian Advocate
☐ Health Care Surrogate ☐ Health Care Proxy

____ ________________ _____________ am pm

Signature of Witness for Substitute Decision-Maker Date Time

* The person shall always be asked to sign this authorization form. However, if the person is a minor, is incapacitated, or is incompetent to consent to treatment, the consent of his or her guardian, guardian advocate, or health care surrogate/proxy is required. Court orders, letters of guardianship, or advance directives must be retained in the clinical record if a person other than the person signs the consent to treatment. The guardian, guardian advocate, or health care surrogate/proxy must agree to keep the facility informed of their whereabouts during the term of the hospitalization. Facilities may devise unique disclosure forms or use commercially prepared forms, but in either case, the material must include all statutorily required elements.

See s. 394.459(3), Florida Statutes

CF-MH 3042b, Feb 05 (obsoletes previous editions) (Recommended Form) **General Authorization for**

Treatment Except Psychotropic Medications

I, the undersigned, a ☐ competent adult, ☐ guardian, ☐ guardian advocate, or ☐ health care surrogate/proxy
hereby authorize the professional staff of this facility to administer assessment and treatment specified below.

- ☐ Routine medical care ____________ (Initials of Person or Authorized Decision Maker)
- ☐ Psychiatric Assessment ___________ (Initials of Person or Authorized Decision Maker)
- ☐ Other (Specify & Initial) ____

____

____

I understand that more information will be provided to me before my informed consent will be requested for the administration of any psychotropic medications.

I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.

I have read and had this information fully explained to me and I have had the opportunity to ask questions and receive answers about the treatment.

____ ____________________
______________ am pm
Signature of Competent Adult Date Time

____ ____________________
______________ am pm
Signature of Witness for Person Date Time

____ ____________________
______________ am pm
Signature of: (check one when applicable) Date Time
☐ Guardian ☐ Guardian Advocate
☐ Health Care Surrogate ☐ Health Care Proxy

If I am the guardian advocate, health care surrogate, or health care proxy for the person, I certify that I have met and talked with the person and the person's physician in person, if at all possible, and by telephone, if not about the proposed treatment prior to signing this form.

Talked to person on:_________(date) ☐ In person ☐ By telephone. If not in person, explain why not.________________________
____
____

Talked to person's physician on: _____(date) ☐ In person ☐ By telephone. If not in person, explain why not.____________________

____
______________ am pm
Signature of: (check one when applicable) Date Time
☐ Guardian ☐ Guardian Advocate
☐ Health Care Surrogate ☐ Health Care Proxy

____ ____________________

______________ am pm

Signature of Witness for Substitute Decision-Maker Date Time

The person shall always be asked to sign this authorization form. However, if the person is a minor, is incapacitated, or is incompetent to consent to treatment, the consent of his or her guardian, guardian advocate, or health care surrogate/proxy is required. Court orders, letters of guardianship, or advance directives must be retained in the clinical record if an individual other than the person signs the consent to treatment. The guardian, guardian advocate, or health care surrogate/proxy must agree to keep the facility informed of their whereabouts during the term of the hospitalization.

See s. 394.459(3), Florida Statutes
CF-MH 3042a, Feb 05 (obsoletes previous editions) (Recommended Form)

Authorization for Electroconvulsive Treatment

As the physician for this person, I have recommended a series of ____________ electroconvulsive treatments and have provided sufficient information to ensure express and informed consent to the treatment.

________________________________ ____________________________ ______________ ________ am pm

Signature of Physician | Printed Name of Physician | Date | Time

I have agreed with the need for this series of __________ electroconvulsive treatments after
☐ examination of the person or ☐ review of the person's treatment records. I am not directly involved with the person.

________________________________ ____________________________ _______________ _________ am pm

Signature of Second Physician | Printed Name of Second Physician | Date | Time

---

I, the undersigned, ☐ competent adult, ☐ guardian, ☐ guardian advocate, ☐ health care surrogate

authorize ____________________________ **Electroconvulsive Treatments** for ____.

Number of treatments authorized | Name of Person to Receive Treatment

a person in ____

Name of Facility

The information provided to the person to make the decision to consent to electroconvulsive treatment (which must include the purpose of the procedure, the common side effects, alternative treatments, and the approximate number of procedures considered necessary and that my consent may be revoked prior to or between treatments) is:
____
____
____
____

I have read and understood the information provided to me above and have been given an opportunity to ask questions and receive answers about the procedures. Knowing the above, I hereby consent to the treatment described.

____ __________________ __________
am pm

Signature of Competent Adult | Date | Time

____ __________________ __________
am pm

Signature, * as appropriate, of: | Date | Time

☐ Guardian, ☐ Guardian Advocate,
☐ Parent of a Minor, ☐ Health Care Surrogate

____ __________________ __________
am pm

Signature of Witness	Date	Time

Facility should attach information about or copies of educational materials provided to the person and/or substitute decision maker.

*** A guardian shall produce letters of guardianship prior to authorizing ECT to demonstrate authority to provide consent. A guardian advocate requires express Court approval to provide consent to this procedure. A health care surrogate requires an advance directive expressly delegating such authority to the surrogate. In the absence of such an advance directive, a health care surrogate or proxy require express court approval to consent to ECT. The authorizing documentation must be validated by staff and filed in the person's clinical record.**

See s. 394.459(3)(b), 458.325, Florida Statutes
CF-MH 3057, Feb 05 (obsoletes previous editions) (Recommended Form)

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT
IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ____ CASE NO.: _____________________

__________________________________,
Petitioner,

vs.

__________________________________,
Administrator,

__________________________________,
Facility Respondent.

Petition for Writ of Habeas Corpus or for Redress of Grievances

1. This Court has jurisdiction pursuant to Section 394.459 (8), Florida Statutes.
2. Petitioner is being held by ____ , (Administrator) in _______________________________________, (Facility), in _______________________ (City), Florida.

3. ☐ Petitioner believes that he/she is being deprived of her/his freedom for invalid and illegal reasons. Petitioner believes that her/his confinement is illegal because:

____
____
____
____
____
____
____

and/or

4. ☐ Petitioner believes that he/she is being unjustly denied a right or privilege or that a procedure authorized by law is being abused. Petitioner believes that he/she is being unjustly denied a right or privilege or that a procedure authorized by law is being abused because:

____
____
____

____

____

____

____

5. Petitioner is unable to afford counsel and would like the Office of the Public Defender or other counsel to be appointed to represent her/him in the above captioned matter.

CONTINUED OVER

Petition for Writ of Habeas Corpus or for Redress of Grievances (Page 2)

WHEREFORE, Petitioner respectfully requests that this Court:

☐ Appoint the Office of Public Defender or other counsel to represent your Petitioner in these proceedings; and

☐ Enter an Order setting a return hearing on this Petition for Writ of Habeas Corpus for respondent to show by what legal authority he/she holds petitioner, and/or

☐ Set a hearing for the purpose of a judicial inquiry into the allegations of this Petition for Redress of Grievances and for ordering a correction of abuse of rights or privileges granted under Chapter 394, Part I, F.S.

I HEREBY CERTIFY that the above stated matters In the Petition for Writ of Habeas Corpus and Redress of Grievances are true and correct to the best of my information, knowledge, and belief.

____ ________________ ________
am pm
Signature of Petitioner Date Time

____
Printed Name of Petitioner

There ☐ is or ☐ is not a petition for involuntary placement pending.

The person ☐ is or ☐ is not currently represented by counsel.

Facilities must provide this form to any person making a verbal request for access to the Court. The completed form must be filed with the Clerk of the Court no later than the next working day and a copy retained in the person's clinical record. A copy of the completed Petition for Writ must be provided immediately to the person and copies of the Petition provided to those listed below, as applicable.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Person		am pm	

☐ Guardian		am pm	
☐ Guardian Advocate		am pm	
☐ Representative		am pm	
☐ Attorney		am pm	
☐ Health Care Surrogate/Proxy		am pm	

See s. 394.459(8), Florida Statutes
CF-MH 3090, Feb 05 (obsoletes previous editions) (Recommended Form)

Refusal or Revocation of Consent to Treatment

PART I

______________________________________, a person in this facility, ☐ refuses consent ☐ revokes previous consent;

OR ___________________________________, the ☐ guardian, ☐ guardian advocate, or ☐ health care surrogate/proxy for ___________________________________, a person who is incapacitated or incompetent to consent to treatment in this facility,

☐ refuses consent ☐ revokes previous consent for: ☐ All treatment, **or** ☐ The following treatment:

____

____

The reason given for this refusal/revocation, if any, is:

____

____

____ ___________ am pm

Signature of Competent Adult (or staff if oral refusal) Date Time

____ ___________ am pm

If incompetent, signature of ☐ Guardian, ☐ Guardian Advocate, Date Time
☐ Health Care Surrogate, ☐ Health Care Proxy

PART II Facility Response

A person on voluntary status who has been admitted to a facility and who refuses to consent to or revokes consent to treatment shall be discharged within 24 hours after such refusal or revocation, unless transferred to involuntary status or unless the refusal or revocation is freely and voluntarily rescinded by the person. The guardian, guardian advocate, or health care surrogate/proxy has the right to refuse or revoke consent to treatment. The decision of the guardian, guardian advocate, or health care surrogate/proxy may be reviewed by the court, upon petition of the person's attorney, the person's family, or the facility administrator.

The facility's response to the refusal/revocation of consent was:

____

____

____

____

____ ___________________________

Staff Signature Profession

____ ___________ am pm

Typed or Printed Name of Staff Date Time

PART III Withdrawal of Refusal or Revocation of Consent to Treatment

I, ____, freely and voluntarily rescind my previous refusal or revocation of consent to treatment for the following reason(s):

____

____

____ ____________________ ____________ am pm

Signature of Authorized Decision-Maker | Date | Time

☐ Person, ☐ Guardian, ☐ Guardian Advocate,
☐ Health Care Surrogate, ☐ Health Care Proxy

____ ________________ ________________ ________ am pm

Signature of Witness | Credentials | Date | Time

See s. 394.4625(2)(b), Florida Statutes
DCF-MH 3105, Feb 05 (obsoletes previous editions) (Recommended Form)

Transfer Evaluation
(To a State Mental Health Treatment Facility)

I, ____ ☐ concur ☐ do not concur
Full Name of Mental Health Center/Clinic Director or Chief Clinical Officer

that ____ , residing at ____
Full Name of Person / Name and Address of Receiving Facility

meets statutory criteria for ☐ voluntary or ☐ involuntary admission to a state mental health treatment facility.
I find that less restrictive community based treatment alternatives have been considered for this person and were determined to be (Check one): ☐ inappropriate ☐ unavailable ☐ appropriate and available.

If placement at a State Mental Health Treatment Facility is recommended, specify the reason for the recommendation:

____

____

____

If it is determined that the person does not meet criteria for admission to a state mental health treatment facility, and consequently a diversion to a less restrictive voluntary community-based service is appropriate, specify the recommended facility and type of service:

____

____

____

______________________________ ______________________________ ______________ ___________ am pm
Signature of Evaluator / Printed Name and Title of Evaluator / Date / Time of Evaluation

____ _________________________ ____________ am pm
Original Signature of / Date / Time
☐ Executive Director or ☐ Chief Clinical Officer

____ (______)_____________________
Name and Address of Community Mental Health Center or Clinic / Telephone Number

This form is to be completed by a designated staff member employed by a Community Mental Health Center or Clinic whenever a person is being considered for admission to a state mental health treatment facility either on a voluntary or involuntary basis. In the case of potential involuntary admission, the original copy of this form shall be provided for the Court's consideration prior to the hearing on the petition for involuntary placement. The evaluator or another knowledgeable person from the center or clinic shall be present at the court hearing to provide testimony as desired by the court.

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
☐ Circuit Court		am pm	
☐ District DCF Mental Health Office		am pm	

By Authority of s. 394.455(29), 394.461, Florida Statutes
CF-MH 3089, Feb 05 (obsoletes previous editions) (Mandatory Form) **BAKER ACT**

IN THE CIRCUIT COURT OF THE __________ JUDICIAL CIRCUIT
IN AND FOR ___________________________ COUNTY, FLORIDA

IN RE: ______________________________________ CASE NO.: _________________

Notice to Court
Request for Continuance of Involuntary Placement Hearing

_______________________________________, a person awaiting a hearing on:

☐ Involuntary Inpatient Placement, pursuant to 394.467, FS, or

☐ Involuntary Outpatient Placement, pursuant to 394.4655, FS

at ___________________________________ Receiving or Treatment Facility has requested a continuance of his/her hearing for a period of _________________ (not to exceed a period of four weeks).

Any independent expert examination, if requested, will be completed and results provided to the undersigned attorney of record during the period of this continuance.

____ ____________ ________
am pm
Signature of Counsel Date Time

____
Typed or Printed Name of Counsel

cc: ☐ Person ☐ Facility Administrator ☐ State Attorney ☐ Guardian ☐ Representative

See s. 394.467(5), Florida Statutes
CF-MH 3113, Feb 05 (obsoletes previous editions) (Recommended Form)

Refusal or Revocation of Consent to Treatment

PART I

_______________________________________, a person in this facility, ☐ refuses consent ☐ revokes previous consent;

OR ____________________________________, the ☐ guardian, ☐ guardian advocate, or ☐ health care surrogate/proxy for ____________________________________, a person who is incapacitated or incompetent to consent to treatment in this facility,

☐ refuses consent ☐ revokes previous consent for: ☐ All treatment, **or** ☐ The following treatment:

____

____

____

____

The reason given for this refusal/revocation, if any, is:

____

____

____

____ ______________ ____________ am pm

Signature of Competent Adult (or staff if oral refusal) Date Time

____ ______________ ____________ am pm

If incompetent, signature of ☐ Guardian, ☐ Guardian Advocate, ☐ Health Care Surrogate, ☐ Health Care Proxy Date Time

PART II Facility Response

A person on voluntary status who has been admitted to a facility and who refuses to consent to or revokes consent to treatment shall be discharged within 24 hours after such refusal or revocation, unless transferred to involuntary status or unless the refusal or revocation is freely and voluntarily rescinded by the person. The guardian, guardian advocate, or health care surrogate/proxy has the right to refuse or revoke consent to treatment. The decision of the guardian, guardian advocate, or health care surrogate/proxy may be reviewed by the court, upon petition of the person's attorney, the person's family, or the facility administrator.

The facility's response to the refusal/revocation of consent was:

____

____

____

____

____

_________ ____

Staff Signature Profession

____ ____________________________ ____________ am pm

Typed or Printed Name of Staff Date Time

PART III Withdrawal of Refusal or Revocation of Consent to Treatment

I, ____, freely and voluntarily rescind my previous refusal or revocation of consent to treatment for the following reason(s):

____

____

____

____ ____________________ ____________ am pm

Signature of Authorized Decision-Maker Date Time

☐ Person, ☐ Guardian, ☐ Guardian Advocate,
☐ Health Care Surrogate, ☐ Health Care Proxy

____ ________________ ________________ ________ am pm

Signature of Witness Credentials Date Time

See s. 394.4625(2)(b), Florida Statutes
DCF-MH 3105, Feb 05 (obsoletes previous editions) (Recommended Form)

Homeless Legal Rights

The following website has a **very important document** that all homeless TI's should make themselves aware of the laws. **Website: www.nichp.org/documents/Housing-Not-Handcuffs**

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