Admission Date

FORMAL VOLUNTARY ADMISSION APPLICATION - ADULT

Michigan Department of Health and Human Services

To the Director of _____

I _____ , consent to the formal voluntary admission and mental health treatment of _____ . I understand the admission is temporary and discharge will occur when, in the hospital director's opinion, inpatient treatment is no longer required.

DISCLOSURE OF INFORMATION

I agree to disclose such information, as is required by law, to determine the individual's and other legally responsible individual's ability to pay for mental health services. The applicant understands that, if the mental health services are state supported, determination of ability to pay will be made subsequent to admission and a notice of the determination and appeal procedure will be sent to the individual and other legally liable persons as required by law.

The applicant has been informed as to whether the community mental health services program serving the county in which the recipient lives contracts with this hospital for inpatient care. If it does, I further understand that information concerning admission and treatment will be shared with them.

CONSENT AND AUTHORIZATION

The applicant consents to and authorizes the hospital to provide treatment including medication but understands that consent to electroshock, psychosurgery, experimental drugs, and surgical procedures must be obtained separately by the hospital.

PERSON TO BE ADMITTED

Name		
Address	City	State
Phone Birth Date	County Residence	
Name of Applicant		
The applicant is the: ☐ Recipient ☐ Guardian ☐ Patient Advocate designated in Psychiatric Advance Directive		
Signature of Adult Applicant	Date	Time

ACKNOWLEDGEMENT OF PROVISION OF A WRITTEN AND ORAL EXPLANATION OF THE RIGHTS OF RECIPIENT OF MENTAL HEALTH SERVICES (MCL 330.1416; MCL 330.1706)

Signature of Recipient	Date	Time
Signature of Guardian/Advocate	Date	Time

The required oral explanation to the individual was not given at this time since it is my opinion that the individual is not presently capable of comprehending the explanation because:		
Name of Person Providing Explanation	Date	Time

ACKNOWLEDGEMENT OF THE RECIPIENT OF A COPY OF THIS APPLICATION (MCL 330.1416)

Signature of Adult Applicant	Date	Time
Signature of Guardian/Advocate	Date	Time

ADDITIONAL PERSON DESIGNATED BY APPLICANT TO RECEIVE A COPY OF THIS APPLICATION

Name		
Address	City	State

ACTION BY THE HOSPITAL

A determination of clinical suitably for formal voluntary admission shall be based on one of the following criteria:

a) The individual has a condition that the hospital director determines can benefit from the inpatient treatment that is offered by the hospital;

b) Appropriate alternatives to hospitalization have been considered by the hospital, and, with the consent of the individual, the Community Mental Health program in the individual's county of residence;

c) Adequate alternative treatment is not available or suitable at the time of admission as determined by the hospital and, with the consent of the individual, the Community Mental Health program in the individual's county of residence.

☐ **Clinically Suitable for Admission**	☐ **Not Clinically Suitable for Admission**

If determined to be not clinically suitable, describe rationale for this decision (indicate the outpatient programs that the recipient is being referred to)		
Physician Name		
Physician Signature	Date	Time

Authority: Public Act 258 of 1974 as amended. Administrative Rule Code 330.4031
Information contained on this form is covered by Federal and
State privacy and confidentiality laws.
THIS LEGAL FORM IS APPROVED BY THE
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND CANNOT BE ALTERED OR ABRIDGED WITHOUT FORMAL APPROVAL.