



Case No. \_\_\_\_\_  
Court \_\_\_\_\_ District \_\_\_\_\_  
County Hopkins  
Division \_\_\_\_\_

IN THE INTEREST OF: )  
 )  
 )  
 \_\_\_\_\_ )  
 Respondent )  
 )  
 \_\_\_\_\_ )  
 Residence )  
 )  
 \_\_\_\_\_ )  
 Current Location )  
 )  
 \_\_\_\_\_ )  
 Social Security Number / Date of Birth )  
 )

**VERIFIED PETITION  
FOR  
INVOLUNTARY HOSPITALIZATION  
(Mental Illness)  
OR  
INVOLUNTARY ADMISSION  
(Intellectual Disability)**

1. PETITIONER, \_\_\_\_\_, states that he/she is:  
(Please print)  
 a reputable resident of \_\_\_\_\_ County, Kentucky, at \_\_\_\_\_  
(Address)  
\_\_\_\_\_, \_\_\_\_\_, and is associated with the  
(Phone No.)  
Respondent as \_\_\_\_\_, OR  
(Relationship)  
 a Qualified Mental Health Professional  a Qualified Intellectual Disabilities Professional located at  
\_\_\_\_\_, Kentucky, and is associated with the Respondent as \_\_\_\_\_,  
employed at \_\_\_\_\_,  
(Hospital/Facility, etc.) (Phone No.)
2. PETITIONER states that the Respondent:  has been hospitalized in a hospital or a forensic psychiatric facility for a period of 30 days within the preceding six (6) months under the provisions of KRS 202A or 504 (if 360 day proceeding)  is a person with a mental illness  is a person with an intellectual disability, and that he/she presents a danger or threat of danger to self, family or others if not immediately restrained.
3. PETITIONER further states that the name, address, and residences of persons related to the Respondent are:  
(If unknown, so state)  
Parents or guardian: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Person having custody: \_\_\_\_\_  
Near relative: \_\_\_\_\_  
Other: \_\_\_\_\_

4. PETITIONER believes that the Respondent is  a person with a mental illness  a person with an intellectual disability because: *(state reasons)*
5. PETITIONER states the following facts to indicate belief that Respondent is a danger or threat of danger to self, family or others because: *(state reasons)*
6. **Intellectual Disability proceedings only:** Petitioner must attach to this Petition documentation establishing that the Respondent has an intellectual disability, INCLUDING the findings of a psychological examination or assessment completed in a reasonable time prior to the filing of this Petition that documents a Full Scale IQ in the moderate to severe range of an intellectual disability. KRS 202B.100(4)(f).
7. PETITIONER requests that the Respondent be detained for examination, evaluation and hospitalization/ admittance if he/she meets the criteria for:
- a)  involuntary hospitalization and that Respondent be hospitalized for  60 Days or  360 Days; or
  - b)  involuntary admission and that Respondent be admitted for an indeterminate period, to be reviewed within five (5) years of entry of this admission order.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Petitioner

\* \* \* \* \*

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_,

\_\_\_\_\_  
Name/Title

\_\_\_\_\_  
County, Kentucky



**PERSONAL IDENTIFIER DATA SHEET**  
(Mental Health/Disability/Incompetency)

Case No. \_\_\_\_\_  
Court \_\_\_\_\_  
County Hopkins  
Division \_\_\_\_\_

\*\*\*\*For use in actions brought or proceedings conducted pursuant to KRS Chapters 202A (Involuntary hospitalization of the mentally ill); 202B (Involuntary intellectual disability admission); 222.430 et seq. (Involuntary treatment for alcohol and other drug abuse); 387.500 et seq. (Guardianship and conservatorship for disabled persons); 504 (Responsibility, incompetency/insanity/mental illness); and, 645 (Involuntary hospitalization of the mentally ill child).

TO THE PETITIONER IN A MENTAL HEALTH OR DISABILITY PROCEEDING

TO THE DEFENDANT OR HIS/HER ATTORNEY IN A CHAPTER 504 PROCEEDING

**The Court requires that you provide the following information about the Respondent/Defendant in this case:**

RESPONDENT/DEFENDANT: *Please Print*   
First Middle Last

Also known as: \_\_\_\_\_

Street address: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Respondent's/Defendant's Identifiers:

Sex	Race	Date of Birth	Height	Weight	Eyes	Hair	Social Security #	Drivers License #	State

I understand that the information requested herein is intended to be entered into the official court record of this matter, and that its accuracy is of the utmost importance. The information I have provided above is true and accurate to the best of my knowledge and belief.

Date \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Printed Name)

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 Rev. 5-12  
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 Commonwealth of Kentucky  
 Court of Justice [www.courts.ky.gov](http://www.courts.ky.gov)  
 KRS 202A.051; 202B



**EXAMINATION AND  
 TRANSPORT ORDER  
 (FOR 72 HOUR HOSPITALIZATION)**

Case No. \_\_\_\_\_  
 Court \_\_\_\_\_ District \_\_\_\_\_  
 County Hopkins  
 Division \_\_\_\_\_

IN THE INTEREST OF: )  
 )  
 )  
 \_\_\_\_\_ Respondent )  
 )  
 \_\_\_\_\_ Residence )  
 )  
 \_\_\_\_\_ Current Location )  
 )  
 \_\_\_\_\_ Telephone )

A verified petition for involuntary hospitalization having been filed, the Court having reviewed the allegations therein and having examined the petitioner under oath and it appearing to the Court that there is probable cause to believe the Respondent presents a danger or a threat of danger to himself/herself, family or others and should be hospitalized;

AND the Court having no objection and no objection having been made by any party to examination of the Respondent, IT IS THEREFORE ORDERED that:

1. The Respondent be delivered to \_\_\_\_\_ Hospital/Psychiatric Facility, without unnecessary delay by the Sheriff or other Peace Officer of this county to be examined by a Qualified Mental Health Professional who is employed by a community mental health center.
2. Following said examination, the Qualified Mental Health Professional shall file a certification with this Court.

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Judge

Attorney's Address:  
 Hopkins County Attorney's Office  
 25 East Center Street, Madisonville, Kentucky 42431  
 Telephone No.:  
 270-821-3164

Please print or type name of Judge in the space provided below:  
 \_\_\_\_\_

**EXECUTION**

Executed by delivering the Respondent to:  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature / Title

Distribution:  
 Original - Court File  
 Copy - Respondent's Attorney  
 4 Copies - Peace Officer:  
 Respondent  
 Peace Officer's file and return  
 Qualified Mental Health Professional (Attach to this copy the completed AOC Form 710, Verified Petition for Involuntary Hospitalization and a blank AOC Form 712, Certification of QMHP).