FORM MHCA 04

DEPARTMENT OF HEALTH

APPLICATION TO THE HEAD OF HEALTH ESTABLISHMENT CONCERNED FOR ASSISTED OR INVOLUNTARY CARE, TREATMENT AND REHABILITATION
[Section 27(1) and 27(2) or 33(1) and 33(2) of the Act]

(A staff member assisting the Applicant in completing this form must record his/her name, surname anddesignation)

Name, surname and designation of staff member-……

A. INFORMATION REGARDING THE USER

I hereby apply for─.

assisted care ☐ orinvoluntary care ☐:

Surname of User: .....
First name(s) of User: .....
Date of birth: ..... or estimated age .....

Gender: Male ☐ Female ☐

Marital status: S ☐ M ☐ D ☐ W ☐

Employment: Yes ☐ or No ☐

Property: Yes ☐ or No ☐

Income source: Pension ☐

Grant ☐

Other ☐ (Specify)……..

None ☐

Is there a reason to believe that an administrator or curator needs to be appointed to manage the financial affairs of the User Yes ☐ No ☐

Residential address and contact details: .....
……..
……
.....

B**. INFORMATION REGARDING APPLICANT**

Surname of applicant: .....….....
First name(s) of applicant:.....
Date of birth of applicant: ..... (must be over 18 years of age)
Residential address and contact details: .....
……
……

C. Relationship between applicant and mental health care user: (mark with a cross)

Spouse ☐ Partner ☐ Associate ☐ Parent ☐

Guardian ☐ Heath care provider ☐ Other ☐.....(specify)

(If User is under 18 this application must be made by the parent, caregiver, guardian or person with parental right and responsibilities)

I last saw the User on..... at .....……
(date) (time) (place)

(The applicant must have seen the User within seven days of making this application)

D. Why is the applicant the health care provider?:

The spouse, next of kin, partner, associate, parent or guardian of the User is:
(i) Unwilling (State reasons for this conclusion):
.....
……
……
……
or
(ii) Incapable (State Reasons for this conclusions for this conclusion):
……
……
……
.....
or
(iii) Unknown/Untraceable (state efforts made to trace)
……

……
……

E. Reasons for the Application:

I, the undersigned, am of the opinion that the above-mentioned person is suffering from a mental illness / intellectual disability for the following reasons(e.g, what did he/she do or say?):

.....
.....
.....
.....

F. In the case of an application for involuntary care:

In your opinion:

(i)Is the User a danger to self and others due to his/her mental illness?

Yes☐ No☐

(ii) Is the User willing to receive care, treatment and rehabilitation if needed?

Yes☐ No☐

(iii) Is the User able to make an informed decision?

Yes☐ No☐

I also attach the following information in support of my application (if available)

Medical certificates:..☐

History of past mental illness:☐ / intellectual disability:☐

Other:☐

.....
……..
……..

I wish to have representation/Legal Representation/Legal Aid

for myself Yes☐ No☐

oron behalf of the User Yes☐ No☐

Print initials and surname (Applicant).....

Signature (Applicant):……

Date: .....

Place: .....

Note: Applicant must sign under oath

F. OATH/AFFIRMATION

I certify that:

iii. The deponent acknowledged to me that:
   a. He/she knows and understands the contents of this declaration;
   b. He/she has no objection to taking the prescribed oath;
   c. He/she considers the prescribed oath to be binding on his/her conscience;

iv. The deponent signed this declaration in my presence at …… on this …… day of ……. 20…….

_____

Signature: Commissioner of Oath: Ex-Officio

Name: …….

Rank / Designation: ……..

(Submit original to Review Board)