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| **PART I** | **PAGE 1** |
|  |  |
| **AFFIDAVIT FOR INVOLUNTARY EMERGENCY HOSPITALIZATION** | **FOR HOSPITAL USE ONLY** |
| **FOR MENTAL ILLNESS AND ORDER OF DETENTION** | Date Admitted: |
|  |  |
| STATE OF SOUTH CAROLINA | ) |  | Hospital Register No. |
| COUNTY OF  |       | ) |  |  |
|  | Approval of Hospital Official |
|  |       |  |       |
|  | Signature | Date |
| IN THE MATTER OF: (Person Alleged to be Mentally Ill) |  |  |
|       |  |   |  |       |  |   |  |       |  |     |  |      |  |      |  |     |  |       |
| First Name |  | Middle Initial |  | Last Name |  | Sex |  | Birthdate |  | Age |  | Race |  | Height |  | Weight |  | Marital Status |
|       |  |       |  |    |  |       |  |       |  |       |
| Residence (if known) |  | City |  | State |  | Zip |  | Phone Number |  | Length of Time Residing There |
|  |
|  |  |
| If residence is unknown, where is the person alleged to be mentally ill currently located or where was he/she found prior to presentment to the Affiant: |
|       |  |       |  |       |  |    |  |       |  |       |
| Location Name or Description |  | Address |  | City |  | State |  | Zip |  | County |
|  |
| TO THE HOSPITAL DIRECTOR: Application is hereby made for the INVOLUNTARY EMERGENCY ADMISSION of the above-named person to a Psychiatric Hospital for the following reasons:  |
|  |
| 1. | The undersigned believes that the above-named person is mentally ill, and because of this mental condition is likely to cause serious harm to self or others if not immediately hospitalized.  |
|  |  |
| 2. | The specific type of harm thought probable is:  |
|  |
|  | (a) | [ ]  | Threats and/or attempts at suicide or serious bodily harm,  |
|  |
|  | (b) | [ ]  | Homicidal or violent behaviors that could cause serious harm, |
|  |
|  | (c)  | [ ]  | Self-neglect, inability to care for self, and/or protect self if not immediately hospitalized, and/or  |
|  |
|  | (d) |  [ ]  | Other:  |       |
|  |  |  |  |
| 3.  | The Affiant bases his/her belief that the above-named person needs INVOLUNTARY EMERGENCY ADMISSION to a hospital based on the following grounds (provide specific details of the suspected harm and/or details of the harmful actions he/she has exhibited in front of you):  |
|  |       |
|  |       |
|  |  |
| 4. | The Affiant is: |
|  |
|  | (a) | [ ]  | Able to have the person alleged to be mentally ill examined by a physician pursuant to S.C. Code § 44-17-410(2).  |
|  |  |  |
|  | (b) | [ ]  | Unable to have the person alleged to be mentally ill examined by a physician and he/she will need to be taken into custody pursuant to S.C. Code § 44-17-430 for the examination to occur.  |
|  | (i) | The reason for this is: |
|  |       |
|  |
|  | (ii) | A law enforcement officer can find the alleged mentally ill person at the following address:  |
|       |  |       |  |       |  |    |  |       |  |       |
| Location Name or Description |  | Address |  | City |  | State |  | Zip |  | County |
|  |
| The next-of-kin of the person alleged to be mentally ill is: |  |
|       |  |       |  |       |  |       |  |    |  |       |  |       |
| Name |  | Relationship |  | Address |  | City |  | State |  | Zip |  | Phone Number |
|  |
| If the next-of-kin of the person alleged to be mentally ill cannot be contacted, notify:  |
|       |  |       |  |       |  |       |  |    |  |       |  |       |
| Name |  | Relationship |  | Address |  | City |  | State |  | Zip |  | Phone Number |
|  |
| **SWORN** to before me this |  | **WHEREFORE,** the undersigned requests that the person named above be admitted to a psychiatric hospital for treatment as authorized by law. |
|  |  |  |  |  |  |  |
|  | **day of** |  | **, 20** |  | . |  |
|  |  | AFFIANT’S SIGNATURE (This must be signed by the person providing the above information) |
|  |  |
|  |       |
| Notary Public for the State of |  |  | Name of Affiant (type or print) |
|  |  |  |  |
| My Commission Expires: |  |  |       |
|  |  |  | Address of Affiant |
|  |  |  |  |
|  |  |  |       |
|  |  |  | Telephone Number of Affiant |
|  |  |  |  |
|  |  |  |       |
|  |  |  | Relation to the Person Alleged to be Mentally Ill or Title |
| **PART I** | **PAGE 2** |
|  |  |
| **AFFIDAVIT FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR MENTAL ILLNESS AND ORDER OF DETENTION** |
|  |  |
| **IMPORTANT NOTICE:**  | All patients receiving treatment in a State Department of Mental Health facility will be charged the established fee as approved by the South Carolina Mental Health Commission.  |
| **PERTINENT FINANCIAL RESPONSIBILITY INFORMATION** |
| Full Name: | Full Name at Birth, if Different:     |
|       |       |
| Social Security Number: | Occupation: | Monthly Income: |
|       |       | $      |
| Employer’s Name:  | Address:  | If not employed, source of income:  |
|       |       |       |
|  |  | Retirement: | Public Assistance: | Other: |
| $      | $      | $     |
| **HOSPITALIZATION INSURANCE** Coverage including group insurance, Medicare, Medicaid, Military medical care, etc. |
| Policy No. or HIB: | Name of Insurance Co. | Address: | If group insurance, name & address of firm: |
|       |       |       |       |
| **MILITARY SERVICE** |
| Branch: | Service Number:  | Dates of Service | Type of Discharge | Monthly Pension | VA Claim Number |
|       |       |       |       | $       |       |
| **FINANCIAL REPRESENTATIVE**  | (if applicable) Please list the name, address, and telephone numbers of the person to receive financial statements and other media related to the personal financial affairs on behalf of the patient. |
| Full Name: | Relation to Patient: | Address (Street, City, State, and Zip) | Telephone #: |
|       |       |       |       |
|  |  |  |  |
|  |  |  |  |
| **NOTE:** | **ADMINISTRATIVE PROCEDURE – FORMS:** Pursuant to S.C. Code § 44-17-430, if an Affidavit of Emergency Admission (Part I) has been completed, but the person cannot be examined by a licensed physician to complete the Certificate of Licensed Physician (Part II) without being taken into custody, a copy of Part I should be presented to the probate judge for the county in which the individual is present. The probate judge may issue an Order of Detention. Upon taking the person alleged to be mentally ill into custody, the law enforcement officer must take the person along with the original Affidavit of Emergency Admission (Part I) to be examined by a licensed physician. |
| **SCDMH FORM APR. 89 (REV. APR. 18) MH-FCC-2 M-130** |
|  |
| STATE OF SOUTH CAROLINA | ) | **IN THE PROBATE COURT** |
| COUNTY OF |       | ) |  |
|  |  | ) |  |
| EX PARTE: |  | ) |  |
|  | ) | **ORDER OF DETENTION**  |
|       | ) |  |
| (Affiant) | ) |  |
| IN THE MATTER OF: | ) |  |
|  | ) |  |
|       | ) |  |
| (A Person Alleged to be Mentally Ill) | ) |  |
|  |  |  |
| Upon reading the attached Affidavit dated this  |      | day of  |       | , 20 |    | , it is  |
|  |
| **ORDERED, ADJUDGED, and DECREED** that: |
|  |
|  | A. | That any officer of the peace shall take  |       | , a person alleged to be mentally ill,  |
|  |  | into custody for a period not to exceed twenty-four (24) hours, during which detention said person shall be examined by a licensed physician. If within the twenty-four (24) hours the person in custody is not examined by a licensed physician or, if upon examination, the physician does not execute the certification required, the proceedings must be terminated and the individual in custody must be immediately released, pursuant to S.C. Code § 44-17-430. |
|  |  |  |
|  | B. | The Order automatically expires after seventy-two (72) hours from the date and time of issuance. If the above-named person is not taken into custody within those seventy-two hours, this Order is no longer valid.  |
|  |  |  |
| Dated this  |      | day of  |  |  |
|  |  | Judge of Probate Court or Special Probate Judge for the above-named County |
|       | , 20 |    | . |  |
|  |  |  |
|       | , South Carolina |  |
|  |  |  |
| Time of Issuance: |       |  |