NEW YORK STATE | Office of Mental Health

APPLICATION FOR INVOLUNTARY ADMISSION ON CERTIFICATE OF A DIRECTOR OF COMMUNITY SERVICES OR DESIGNEE **(Mental Hygiene Law §9.37)**	*State and Federal laws prohibit discrimination based on race, ethnicity, national origin, age, gender, sexual orientation, or disability.*

I. GENERAL PROVISIONS FOR INVOLUNTARY ADMISSION ON CERTIFICATE OF A DCS OR DESIGNEE

A. Standard for Admission

If, in the opinion of a Director of Community Services (DCS) or an examining physician duly designated by them, a person has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to the person or others, the person may be admitted to a hospital providing such care and treatment, upon the certificate of the DCS or designee accompanied by an application for admission of the person.

"Likely to result in serious harm" means:

- a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to themself, or
- a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm, or
- a substantial risk of physical harm to the person due to an inability or refusal, as a result of their mental illness, to provide for their own essential needs such as food, clothing, necessary medical care, personal safety, or shelter

B. Application and Certification

The application made by the DCS or his or her designee must be supported and accompanied by a Certificate of Examination by Director of Community Services or Designee (Form 475A), except under the circumstances described in the next paragraph.

In counties with a population of less than 200,000, a DCS who is not a physician but who is a licensed psychologist or a licensed clinical social worker may apply for admission of a person without a medical examination by a designated examining physician, if:

- A hospital approved by the State Commissioner of Mental Health to admit patients pursuant to Section 9.39 of the Mental Hygiene law is not located within 30 miles of the person;
- The DCS has made a reasonable effort to locate a designated examining physician but such a designee is not immediately available; and
- The DCS's application is supported by a Certificate of Observation by Director of Community Services (Form 475B) which states that after personal observation of the person, the DCS reasonably believes that the person may have a mental illness which is likely to result in serious harm to himself or herself or others and that inpatient care and treatment in a hospital may be appropriate.

Examining physicians designated by the DCS must be approved by the State Commissioner of Mental Health. A person is disqualified from acting as an examining physician if:

- They are not licensed to practice medicine in New York State,
- They are a relative of the person certified to be in need of hospitalization,
- They are a manager, trustee, visitor, proprietor, officer, director, or stockholder of the hospital to which it is proposed to admit such person, or has any financial interest in such hospital other than receipt of fees, privileges or compensation for treating or examining patients in such hospital, or
- They are on the staff of a proprietary hospital to which it is proposed to admit such person.

C. Custody and Transport

After completing the application, the DCS or their designee is empowered to take into custody, detain, transport, and provide temporary care for the person. Upon request of the DCS or designee, it shall be the legal duty of peace officers, acting pursuant to their special duties, or police officers to take into custody and transport the person as directed by such DCS or designee. Alternatively, the DCS or designee may request that an ambulance service provide transportation.

D. Hospital Evaluation

If a person is to be admitted on the basis of Form 475A (Certificate of Examination by Director of Community Services or Designee), the need for immediate hospitalization must be confirmed by a staff physician of the hospital prior to admission.

If a person is to be admitted on the basis of Form 475B (Certificate of Observation by Director of Community Services), a staff physician must certify upon examination of the person prior to admission that the person has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to the person or others. The need for hospitalization must then be confirmed by another staff physician within twenty-four hours after admission, using Form 475C (Examination within 24 hours).

Following admission, the patient may be involuntarily retained beyond 72 hours (excluding Sundays and holidays) only if they are examined by another physician who is a staff psychiatrist, and Form 475D (Examination within 72 Hours) is completed.

If no request for a court hearing is made, the hospital director may retain the patient for up to 60 days from the date of admission without taking other action. If the hospital director determines that the condition of the patient requires hospitalization beyond 60 days:

- The patient may remain as a voluntary or informal patient if they are willing and suitable for such status.
- If the patient is unwilling or not suitable to remain as a voluntary or informal patient, the director must apply, before the end of the 60-day period, for a court order authorizing continued retention of the patient. The director must also inform the patient, the Mental Hygiene Legal Service, and others who received the original notice of the patient's commitment, that said director is applying for a court order, to give them the opportunity to request a hearing before the court, if they so desire.

E. Use of Electronic Signatures

Forms 475, 475A, 475B, 475C, and 475D may be completed and signed electronically, pursuant to the Electronic Signatures and Records Act, including via a provider's electronic health record. Providers must ensure the forms can be printed and/or delivered in the approved format to the admitting hospital, appropriate Court, and Mental Hygiene Legal Services, and other approved recipients.

II. GENERAL INFORMATION

A. Mental Hygiene Legal Service

The Mental Hygiene Legal Service is an agency of the New York State Supreme Court which provides protective legal services, advice and assistance, including representation, to all patients admitted to psychiatric facilities. Patients are entitled to be informed of their rights regarding hospitalization and treatment, and have a right to a court hearing, to be represented by a lawyer, and to seek independent medical opinion.

There is a Mental Hygiene Legal Service office in many psychiatric hospitals. Where there is no office at the hospital, a representative of the Service visits periodically and frequently. Any patient or anyone on their behalf may see or communicate with a representative of the Service by telephoning or writing directly to the office of the Service or by requesting someone on the staff of the patient's ward to make such arrangements for them.

The Mental Hygiene Legal Service for the hospital may be reached at _____.

B. Reimbursement

The patient is legally responsible for the cost of care. Additionally responsible are the patient's spouse and in some cases the parents of a patient under the age of 21. Also legally responsible are the committee, guardian, or trustee of a trust fund established for support of the patient, or any fiduciary or payee of funds for the patient. Charges may be waived or reduced when there is inability to pay. Any person who applies for a waiver or reduction of charges must cooperate in a financial investigation to determine ability to pay.

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APPLICATION FOR INVOLUNTARY ADMISSION ON CERTIFICATE OF A DIRECTOR OF COMMUNITY SERVICES OR DESIGNEE (Mental Hygiene Law §9.37)	Name (Last, First, M.I.) _____ Gender _____ Date of Birth _____ MRN _____ Location/Facility _____
OMH Form 475	

PART A – APPLICATION FOR ADMISSION

I hereby request that _____ be admitted to
(Name of person)

_____
(Name of Hospital)

This request is made due to behavior and/or specific acts described below (choose one or more):

☐ Threats of or attempts at suicide or serious bodily harm or other conduct demonstrating danger to themselves

☐ Homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm

☐ Inability or refusal, due to mental illness, to provide for their own essential needs such as food, clothing, necessary medical care, personal safety, or shelter

Describe:

Under the penalty of perjury, I attest that the information supplied on this application is true to the best of my knowledge and belief.

Signature of DCS or Designee	Official Title	
Address/Contact Information	Date	Time (AM/PM)

PART B – CUSTODY TRANSPORT OF THE PERSON ALLEGED TO BE MENTALLY ILL (optional)

☐ I hereby direct, under the Mental Hygiene Law, that the peace/police officers of _____
(Department/Location)
take the above-named person into custody and transport them to the above-named hospital.

-OR-

☐ I hereby request, under the Mental Hygiene Law, that _____ transport the above-named person
(Name of Ambulance Service)
to the above-named hospital.

Physician's Signature	Date	Time (AM/PM)

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APPLICATION FOR INVOLUNTARY ADMISSION ON CERTIFICATE OF A DIRECTOR OF COMMUNITY SERVICES OR DESIGNEE **(Mental Hygiene Law §9.37)** OMH Form 475 continued	**Name (Last, First, M.I.)** _____ **MRN**_____

PART C – PHYSICIAN'S CONFIRMATION FOR IMMEDIATE HOSPITALIZATION

I am a physician on the staff of the above-named hospital providing services for persons with mental illness. I hereby confirm the following *(Check one)*:

☐ That the above-named person has been referred upon the application and certification of a Director of Community Services or Designee who is a **physician**, and that the above-named person is in need of immediate hospitalization.

☐ That the above named person has been referred upon the application and certification of a Director of Community Services or Designee who is a **non-physician**, and that I have examined the above-named person and determined that they have a mental illness for which immediate inpatient care and treatment in a mental hospital is appropriate and which is likely to result in serious harm (choose one or more):

- ☐ Threats of or attempts at suicide or serious bodily harm or other conduct demonstrating danger to themselves
- ☐ Homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm
- ☐ Inability or refusal, due to mental illness, to provide for their own essential needs such as food, clothing, necessary medical care, personal safety, or shelter.

Describe:

Physician's Signature	Date	Time (AM/PM)

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APPLICATION FOR INVOLUNTARY ADMISSION ON CERTIFICATE OF A DIRECTOR OF COMMUNITY SERVICES OR DESIGNEE **(Mental Hygiene Law §9.37)** **CERTIFICATE OF EXAMINATION BY DCS OR DESIGNEE (PHYSICIAN)** OMH Form 475A	**Name (Last, First, M.I.)** _____ **Gender** _____ **Date of Birth** _____ MRN _____ **Location/Facility** _____

I _____ hereby certify that:
(Name of DCS or Designee)

a. On _____, I personally examined _____,
(date) (name of person)

who was located at _____,

and in my opinion this person has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate.

b. It is my opinion that this person's mental illness is likely to result in serious harm to themself or others. By "likely to result in serious harm," I mean: (Check one or more)

☐ Threats of or attempts at suicide or serious bodily harm or other conduct demonstrating danger to themselves

☐ Homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm

☐ Inability or refusal, due to mental illness, to provide for their own essential needs such as food, clothing, necessary medical care, personal safety, or shelter

c. The behavior or specific act(s) of this person on which I base my opinion is (are) described in Part A of Form 475, "Application for Involuntary Admission on Certificate of a Director of Community Services or Designee".

d. (Check appropriate statement below and complete)

☐ I am a physician licensed to practice medicine in New York State and am the Director of Community Services of

_____ -OR-
(City or County)

☐ I am a physician licensed to practice medicine in New York State and have been designated by the DCS of

_____ to conduct examinations on their behalf.
(City or County)

e. I certify that this person's hospital admission is medically necessary.

Signature of DCS or Designee	Official Title	
Telephone/Contact Information	Date	Time (AM/PM)
Address		

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APPLICATION FOR INVOLUNTARY ADMISSION ON CERTIFICATE OF A DIRECTOR OF COMMUNITY SERVICES OR DESIGNEE
(Mental Hygiene Law §9.37)

CERTIFICATE OF OBSERVATION BY DIRECTOR OF COMMUNITY SERVICES (NON-PHYSICIAN)

OMH Form 475B

Name (Last, First, M.I.) _____

Gender _____ **Date of Birth** _____

MRN _____

Location/Facility _____

I _____ hereby certify that:
(Name of DCS)

a. On _____, I personally observed _____,
(date) (name of person)

who was located at _____,

and in my opinion inpatient care and treatment of this person in a hospital may be appropriate.

b. It is my opinion that this person may have a mental illness which is likely to result in serious harm to themself or others. By "likely to result in serious harm," I mean: (Check one or more)

☐ Threats of or attempts at suicide or serious bodily harm or other conduct demonstrating danger to themselves

☐ Homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm

☐ Inability or refusal, due to mental illness, to provide for their own essential needs such as food, clothing, necessary medical care, personal safety, or shelter

c. The behavior or specific act(s) of this person on which I base my opinion is (are) described in Part A of Form 475, "Application for Involuntary Admission on Certificate of a Director of Community Services or Designee".

d. I am the Director of Community Services for the County of _____, which has a population of less than 200,000 persons.

e. I am:

☐ a licensed psychologist

☐ a licensed clinical social worker

f. I believe that a hospital approved by the State Commissioner of Mental Health to admit patients pursuant to Section 9.39 of the Mental Hygiene Law is not located within 30 miles of this person.

g. I have made a reasonable effort to locate a designated examining physician but one is not immediately available.
(Describe the measures taken to locate such a physician and the reason why one is not immediately available, for example: unsuccessful attempt to contact by telephone or visit; unavailable due to illness, distance, medical duties, etc. if more space is needed, add additional page.)

h. I believe that this person's hospital admission may be appropriate.

Signature of DCS or Designee	Official Title	
Telephone/Contact Information	Date	Time (AM/PM)
Address		

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APPLICATION FOR INVOLUNTARY ADMISSION ON CERTIFICATE OF A DIRECTOR OF COMMUNITY SERVICES OR DESIGNEE **(Mental Hygiene Law §9.37)** **EXAMINATION WITHIN 24 HOURS** To Confirm the Need for Hospitalization of a Patient Admitted on a Certificate of Observation by a Director of Community Service OMH Form 475C	**Name (Last, First, M.I.)** _____ **Gender** _____ **Date of Birth** _____ MRN _____ **Location/Facility** _____

INSTRUCTIONS - To be completed by a staff physician, other than the admitting physician, within 24 hours after admission.

1. Pertinent and Significant Factors in Psychiatric and Medical History:

2. Physical Condition (including any laboratory, imaging, and other diagnostic test findings):

3. Psychiatric signs and symptoms:

4. Mental Status Exam:

5. Collateral Information:

6. Does the patient act in a way that is likely to result in serious harm (choose one or more):
   - ☐ Threats of or attempts at suicide or serious bodily harm or other conduct demonstrating danger to themselves
   - ☐ Homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm
   - ☐ Inability or refusal, due to mental illness, to provide for their own essential needs such as food, clothing, necessary medical care, personal safety, or shelter

   If yes, explain:

7. Psychiatric differential diagnosis: _____

   Contributing co-occurring diagnoses: _____

I, _____ (physician's name), do certify as follows:

a. I have with care and diligence personally examined the above-named patient on _____ (date)
   and as a result of such examination, find and hereby certify:
   - that the patient is in need of involuntary care and treatment in a hospital providing inpatient services for the mentally ill; and
   - that as a result of their mental illness, the patient poses a substantial threat of harm to self or others (The determination may be supported by any relevant clinical factors, including but not limited to the person's current signs and symptoms; recent behaviors; patterns of relapse, recurrence, or decompensation; or a history of dangerous conduct in the context of inconsistent adherence to mental health treatment, where such history, considered together with the reasons for the current presentation, indicates a substantial risk of serious harm).

b. I have formed this opinion based on the case history and my examination of the patient as detailed above.

c. I hereby certify that the facts stated and information contained in this certificate are true to the best of my knowledge and belief.

Physician's Signature	Print Name	Date	Time (AM/PM)

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APPLICATION FOR INVOLUNTARY ADMISSION ON CERTIFICATE OF A DIRECTOR OF COMMUNITY SERVICES OR DESIGNEE
(Mental Hygiene Law §9.37)

EXAMINATION WITHIN 72 HOURS
To Retain a Patient Admitted on a Certificate of Examination or a Certificate of Observation by a Director of Community Services

OMH Form 475D

Name (Last, First, M.I.) _____

Gender _____ **Date of Birth** _____

MRN _____

Location/Facility _____

INSTRUCTIONS - To be completed within 72 hours after admission, excluding Sundays and holidays, by a psychiatrist, other than the admitting physician or the physician who completed Form 475C, Examination Within 24 hours (if applicable)

1. Pertinent and Significant Factors in Psychiatric and Medical History:

2. Physical Condition (including any laboratory, imaging, and other diagnostic test findings):

3. Psychiatric signs and symptoms:

4. Mental Status Exam:

5. Collateral Information:

6. Does the patient act in a way that is likely to result in serious harm (choose one or more):
   - ☐ Threats of or attempts at suicide or serious bodily harm or other conduct demonstrating danger to themselves
   - ☐ Homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm
   - ☐ Inability or refusal, due to mental illness, to provide for their own essential needs such as food, clothing, necessary medical care, personal safety, or shelter

   If yes, explain:

7. Psychiatric differential diagnosis: _____

   Contributing co-occurring diagnoses: _____

I, _____, do certify as follows:
(psychiatrist's name)

a. I have with care and diligence personally examined the above-named patient on _____
(date)

and as a result of such examination, find and hereby certify:
- that the patient is in need of involuntary care and treatment in a hospital providing inpatient services for the mentally ill; and
- that as a result of their mental illness, the patient poses a substantial threat of harm to self or others (The determination may be supported by any relevant clinical factors, including but not limited to the person's current signs and symptoms; recent behaviors; patterns of relapse, recurrence, or decompensation; or a history of dangerous conduct in the context of inconsistent adherence to mental health treatment, where such history, considered together with the reasons for the current presentation, indicates a substantial risk of serious harm).

b. I have formed this opinion based on the case history and my examination of the patient as detailed above.

c. I hereby certify that the facts stated and information contained in this certificate are true to the best of my knowledge and belief.

Psychiatrist's Signature	Print Name	Date	Time (AM/PM)