

**NOTICE OF CERTIFICATION OF UP TO 30 DAYS OF ADDITIONAL INTENSIVE TREATMENT**

(Rev. 04/2020)

Confidential Patient Information  
See Welfare & Institutions Code  
Section 5328 and Penal Code 11142

HIPAA Privacy Rule  
45 C.F.R. § 164.508

The authorized agency providing evaluation services in the County of \_\_\_\_\_ has evaluated the condition of:

Name \_\_\_\_\_

Address \_\_\_\_\_

Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

We, the undersigned, allege that the above-named person is, as a result of a mental disorder or impairment by chronic alcoholism:

Gravely disabled as defined in subdivision (h) of Section 5008 of the Welfare & Institutions Code

The specific facts which form the basis for our opinion that the above-named person meets the classification indicated above are as follows:

The above-named person has been informed of this evaluation, and has been advised of the need for, but has not been able or willing to accept treatment on a voluntary basis, or to accept referral to, the following services:

We, therefore, certify the above-named person to receive intensive treatment related to the mental disorder or impairment by chronic alcoholism beginning this (date 30-day hold was initiated, or, if the patient was voluntary, date the 14-day hold would have ended) \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, in the intensive treatment facility herein named: \_\_\_\_\_

\_\_\_\_\_  
Date of Assessment

Signature	Printed Name	Title/Discipline	Date
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Signature	Printed Name	Title/Discipline	Date
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I hereby state that I delivered a copy of this notice this day to the above-named person and that I informed him or her that unless judicial review is requested, a certification review hearing will be held within four days of the date on which the person is certified for a period of intensive treatment and that an attorney or advocate will visit him or her to provide assistance in preparing for the hearing or to answer questions regarding his or her commitment or to provide other assistance. The court has been notified of this certification on this day.

I have advised the individual of their right to judicial review (writ hearing), and the individual  DOES  DOES NOT request a writ hearing. (Please contact the Public Defender at 619-338-4617 to schedule a hearing.)

Signature	Printed Name	Title/Discipline	Date
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Copies: Person Certified - Personally delivered Person's Attorney Patient Advocate	Superior Court, Counselor in Mental Health County Counsel Facility Providing Intensive Treatment	Public Defender, if any	
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