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IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON  
IN AND FOR THE COUNTY OF SNOHOMISH

IN RE THE DETENTION OF Cause No.  
, PETITION FOR ASSISTED OUTPATIENT  
Respondent. TREATMENT  
(PTAOT)

1. **Petitioner’s Name & Relationship to Respondent.** I, *(name of Petitioner)*  
\_\_\_\_\_, am filing this petition for assisted  
outpatient treatment to ask the court to order that Respondent participate in an  
assisted outpatient treatment program.

- I am *(choose only one)*:
- The director or director’s designee of a hospital where the respondent is hospitalized;
  - The director or director’s designee of a behavioral health service provider providing behavioral health care or residential services to the respondent;
  - The respondent’s treating mental health professional or someone who has evaluated them;
  - The respondent’s treating substance use disorder professional or someone who has evaluated them;
  - A designated crisis responder (DCR);
  - A release planner from a correctional facility; or
  - An emergency room physician.

My contact information is:  
Agency/Hospital:  
\_\_\_\_\_  
Phone number:  
\_\_\_\_\_  
Email:  
\_\_\_\_\_

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Respondent is an (*choose only one*):

- Adult (RCW 71.05.148)
- Adolescent (age 13-17) (RCW 71.34.815)

**2. Respondent Interview.** To determine whether Respondent would voluntarily receive the appropriate treatment:

- I personally interviewed Respondent on (*date*) \_\_\_\_\_, but found them unwilling to voluntarily receive treatment.
- I was unable to personally interview Respondent because they refused to be interviewed.

**3. Length of AOT Order.** I am requesting that the court issue an order for assisted outpatient treatment for \_\_\_\_\_ months (the maximum is 18 months).

**4. Reasons for Assisted Outpatient Treatment.**

a. Respondent has a (*check applicable box*):

- Mental disorder
- Substance use disorder
- Co-occurring disorder

b. Based on a clinical determination and in view of the respondent's treatment history and current behavior, at least one of the following is true:

- The respondent is unlikely to survive safely in the community without supervision and their condition is substantially deteriorating; or
- The respondent is in need of treatment to prevent relapse or deterioration that would likely result in grave disability or a likelihood of serious harm to the person or others.

c. The respondent has a history of lack of compliance with treatment for their behavioral health disorder, in that at least one of the following is true:

- At least twice within the last 36 months has been a significant factor in necessitating hospitalization of the person, or the person's receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, provided that the 36-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the 36-month period;
- At least twice within the last 36 months has been a significant factor in necessitating emergency medical care or hospitalization for behavioral health-related medical conditions including overdose, infected abscesses, sepsis, endocarditis, or other maladies, or significant factor in behavior which resulted in the person's incarceration in a state or local correctional facility; or

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Resulted in one or more violent acts, threats, or attempts to cause serious physical harm to the person or another within the 48 months prior to the filing of the petition, provided that the 48-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred during the 48-month period.

d. Participation in assisted outpatient treatment program would be the least restrictive alternative necessary to ensure the person's recovery and stability; and

e. The person will benefit from the assisted outpatient treatment.

f. Statement of the circumstances under which the respondent's condition was made known to the petitioner and the basis for the opinion that the person is in need of assisted outpatient treatment (*attach additional pages, if necessary*):

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g. Provide the specific facts based on the petitioner's personal observation, evaluation, or investigation that the respondent is in need of assisted outpatient treatment (*attach additional pages, if necessary*):

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h. Other sources of information that the petitioner has relied upon, with consideration to reliability and credibility of any person providing information material to the petition, to form the belief that the respondent is in need of assisted outpatient treatment (*attach additional pages, if necessary*):

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**5. Required Declaration/s (file separately).** A physician, physician assistant, advanced registered nurse practitioner, or the respondent's treating mental health or substance use disorder professional who has examined the respondent no more than 10 days prior to the submission of this petition must provide a declaration. If the respondent's treating mental health or substance use disorder professional provides a declaration, then it must be cosigned by a supervising physician, physician assistant, or advanced registered nurse practitioner who certifies they reviewed the declaration. Use *Declaration* form, **MP 003**.

Declarant: (name) \_\_\_\_\_  
Title & Agency: \_\_\_\_\_

Declarant: (name) \_\_\_\_\_  
Title & Agency: \_\_\_\_\_

**6. Optional Declaration/s (file separately) (use Declaration form, MP 003).**

Witness: (name) \_\_\_\_\_

Witness: (name) \_\_\_\_\_

Witness: (name) \_\_\_\_\_

Witness: (name) \_\_\_\_\_

**7. Treatment Information.** Provide information for the agency, provider, or facility that agrees to provide less restrictive alternative treatment if the petition is granted.

**Name of Agency, Provider, or Facility:**  
\_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone number:** \_\_\_\_\_

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**Email (if available):** \_\_\_\_\_

**8. Reentry & Transition.** Respondent is detained in a state hospital, inpatient treatment facility, jail, or correctional facility at the time of the filing of this petition. Their anticipated release date is \_\_\_\_\_. The following information may be necessary to help Respondent transition into the community successfully (*attach additional pages, if needed*):

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**9. Respondent's Contact Information.**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Known Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Alternate Whereabouts, if Known: \_\_\_\_\_

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signed at \_\_\_\_\_ Date: \_\_\_\_\_  
*City State*

▶ \_\_\_\_\_

*Sign here*

\_\_\_\_\_

*Print name*