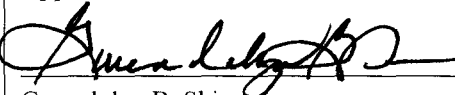


Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities & Addictive Diseases	DHR Online Directive Information System (ODIS) Directive # 6805-304 (Replaces Policy #7.105) Page 1 of 5
ODIS Policy: Provision of Care, Treatment, and Services in Division of MHDDAD Hospitals Subject: Process for Qualifying People for the Mental Health Planning List and Mental Health Olmstead List	
Applicability: Division of MHDDAD Hospitals	Original Policy Effective Date: February 1, 2007 Revised Date: December 15, 2008
References: Official Code of Georgia Annotated 37-2-4.1	Effective Date: December 24, 2008 Review Date: December 2010
Attachments: Attachment A – Flow Chart for MH Planning List and MH Olmstead List Attachment B – Mental Health Planning List and Mental Health Olmstead List Criteria, Needs, Services Worksheet Attachment C – Letter Regarding Placement on the MH Olmstead List Attachment D – Letter Regarding Not Being Placed on the MH Olmstead List Attachment E – How to Appeal Olmstead Decision Attachment F – Office of State Administrative Hearing (OSAH) Form 1	Approved:  Gwendolyn B. Skinner Director, Division of MHDDAD <u>12/22/08</u> Date

Process for Qualifying People for the Mental Health Planning List and Mental Health Olmstead List

The Division of MHDDAD maintains and regularly updates a list of people receiving services for mental illness and/or addictive diseases who have been in Division hospitals for longer than 60 days. Hospital treatment teams review the status of each person on this list at least every 30 days to identify those who are ready for transitioning to living in the community. The names of these people, along with information regarding their needed individual and community supports, are placed on the Mental Health (MH) Planning List. Those who are not hospitalized on a forensic status and who do not object to community placement are then placed on the MH Olmstead List. Everyone on the MH Planning List and MH Olmstead List is actively assisted in obtaining community placement.

A. Definitions

Mental Health Planning List is the list of individuals in DMHDDAD Hospital MH units who:

- Have been hospitalized for more than 60 days, and
- Have been assessed by clinical criteria and determined by the treatment team to be appropriate for transition to a less restrictive environment with appropriate supports.

Mental Health Olmstead List is the list of individuals in DMHDDAD Hospital MH units who:

- Have been placed on the MH Planning List, and
- Are not on a forensic legal status, and
- Do not object to community placement.

Voluntary Compliance Agreement (VCA) is an agreement entered into voluntarily between the U.S. Department of Health & Human Services - Office of Civil Rights and the State of Georgia - Departments of Human Resources and Community Health. The VCA is

intended to resolve complaints filed with the Office of Civil Rights alleging Georgia has failed to comply with the Olmstead Ruling of 1999. The allegations concerned the provision of community services for (a) persons with developmental disabilities currently institutionalized in State operated facilities and (b) persons with mental illness currently institutionalized in state operated facilities for longer than 60 days who do not oppose community placement and whose needs can be met in the most integrated setting consistent with their need for treatment and support.

B. Process for creation of Mental Health (MH) Planning List and MH Olmstead List:

The steps of the process for creation of the MH Planning List and MH Olmstead List are shown on **Attachment A: Flow Chart for MH Planning List and MH Olmstead List**.

The interdisciplinary treatment team that is assigned to each person who has been hospitalized for greater than 60 days has responsibility for determining whether the person meets the MH Planning List criteria. See **Attachment B: Mental Health Planning List and Mental Health Olmstead List Criteria, Needs, Services Worksheet**. Individuals who meet the criteria are then placed on the MH Planning List. The process for making this determination for each person is as follows:

1. Prior to the treatment team review for each person:
 - a. The social worker/case manager gathers information relevant for completion of page 1 of the **Mental Health Planning List and Mental Health Olmstead List Criteria, Needs, Services Worksheet** ("Criteria Worksheet") and completes the Demographic Data section of the Criteria Worksheet.
 - b. The members of the treatment team review the medical record and other information reflective of the person's clinical status and progress in treatment, and,
 - c. As appropriate, the team members talk with the person to gain additional information and explain the process to them. Those members prepare to offer their recommendations regarding the criteria outlined in the Clinical Status Review section of the Criteria Worksheet.
2. The social worker/case manager brings the Criteria Worksheet to the interdisciplinary treatment team meeting, where the team and person meet together.
3. The person's treatment team then makes the decision about placement on the MH Planning List after completion of the Clinical Status Review section on page 1 of the Criteria Worksheet.
4. Individuals who meet criteria for inclusion on the **MH Olmstead List** are those people who:
 - Have qualified for inclusion on the MH Planning List using the procedures included in this policy, and
 - Do not have a forensic legal status, and
 - Do not object to community placement.

5. After an individual is determined as eligible for placement on the MH Planning List or MH Olmstead List, page 2 of the Criteria Worksheet is completed.
6. Decisions regarding placement on the MH Planning List and MH Olmstead List as well as information on page 2 of the Criteria Worksheet are documented and conveyed to the utilization manager via the Criteria Worksheet.
7. The treatment team provides information to the utilization manager (UM) who enters MH Planning List and MH Olmstead List information into the Expediter Information System (EXIS) no later than the 5th day of the following month. In addition, the UM enters status change information into EXIS for all individuals who were on the MH Planning List or MH Olmstead List during the preceding month, but who are not on the updated MH Planning List or MH Olmstead List. This includes those who have been discharged from the hospital, as well as those removed from the lists due to clinical reasons. The Hospital-Based Case Expediter is responsible for reviewing the data entered for the hospital to which they are assigned, and reporting any discrepancies to the UM for correction.
8. Documentation regarding the determination for MH Planning List or MH Olmstead List and the discussion with the person about the MH Olmstead List is placed in the person's record by a member of the treatment team via a progress note. This documentation includes the person's participation in and response to the discussion and any concerns or objections raised by the person, family and/or guardian. Upon determination that an individual is clinically ready for discharge, the UM is notified, and the individual's record is updated in the EXIS data base to indicate they are placed on the MH Planning List.
9. Those identified as meeting the criteria for placement on the MH Planning List or MH Olmstead List have their status updated in the EXIS database within 10 days of the treatment team review, and are reassessed no less than every 30 days or until discharged whichever comes first.
10. In accordance with the Voluntary Compliance Agreement (VCA), even in cases where the individual has a legal guardian, the wishes of the individual prevail over the wishes of the guardian regarding placement on the MH Olmstead List.
11. For any individual who has been determined as not meeting the clinical criteria, the assessment process is repeated when there is clinically relevant improvement in the individual's condition or at least every 30 days, whichever is sooner.
12. After determination of whether the person qualifies for the MH Olmstead List, the individual is notified in writing as to the decision that was made. This notification occurs each time they are assessed in accordance with this policy.
 - a. All persons placed on the MH Olmstead List receive a notice of their placement on the MH Olmstead List and the month of their anticipated

discharge; this notification occurs within 30 days after they are placed on the MH Olmstead List. The notice is provided in writing to the individual, and also conspicuously placed in the medical record of the individual. See **Attachment C: Letter Regarding Placement on MH Olmstead List**.

- b. All persons who are determined as not eligible for the MH Olmstead List receive a notice informing this of the decision; this notification occurs within 30 days after they are determined as not eligible for placement on the MH Olmstead List. See **Attachment D: Letter Regarding Not Being Placed on MH Olmstead List**. In addition, **Attachment E: How to Appeal Decisions About Placement on the Olmstead List** is also This notification includes information about the appeals process.
- c. These notices regarding the decision are also provided to the guardian and to the first and second representative. They may only be provided to family members or others in a manner consistent with the requirements of the Privacy Rule issued under the Health Insurance Portability and Accountability Act (HIPAA).

13. In accordance with the Voluntary Compliance Agreement (VCA), the steps in the appeal process for individuals who do not qualify for the MH Olmstead List are as follows:

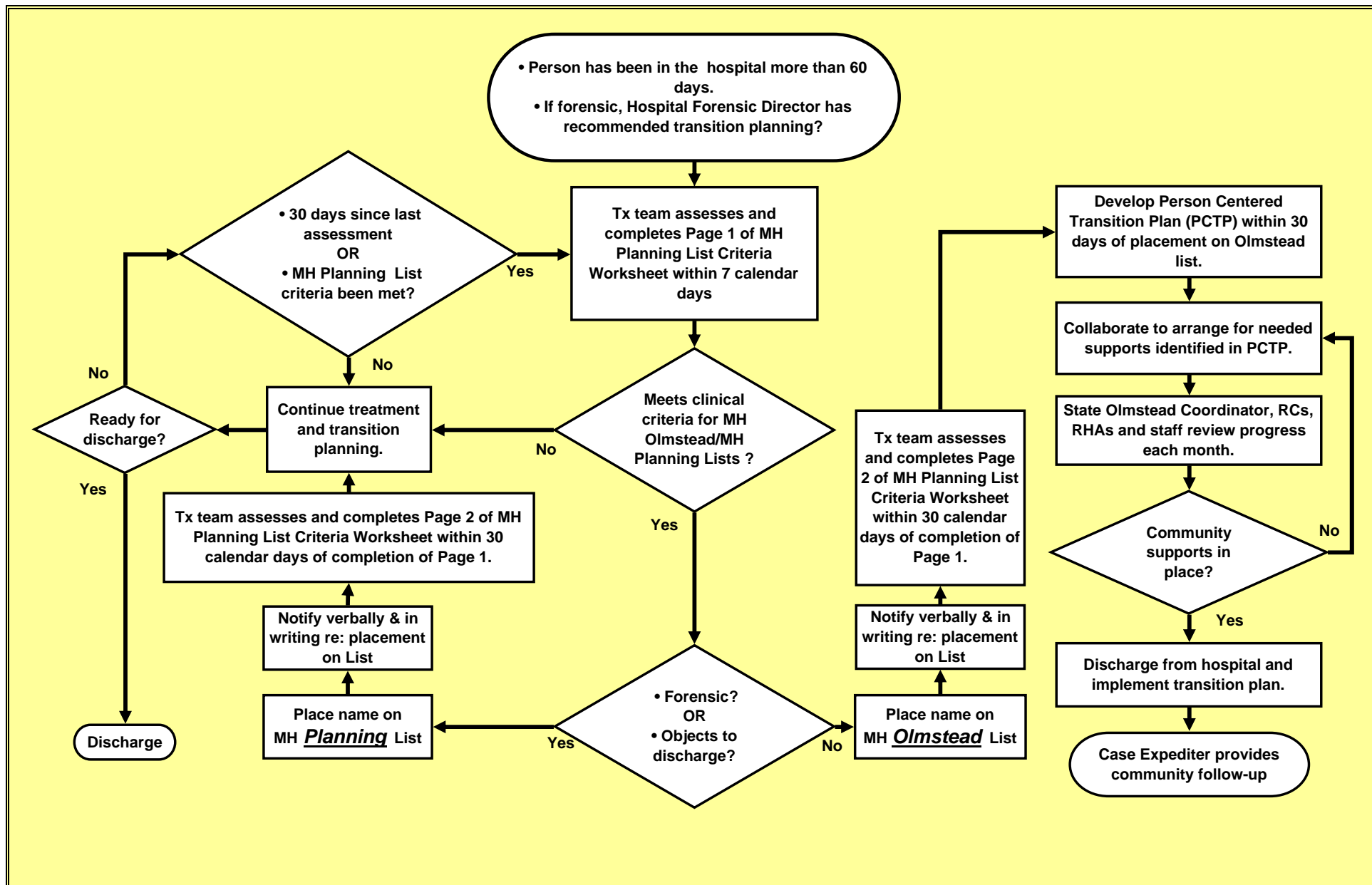
1. First appeal: Within 5 business days after the date that the individual receives the letter notifying of status regarding the Olmstead List, he/she may request to appeal the decision by filing a complaint with the Hospital's human rights committee. The Hospital's human rights committee reviews the appeal request within 10 working days and notifies the individual of their decision. In conducting its review, the human rights committee:
 - a. reviews the consumer's most recent MH Planning List and MH Olmstead List Criteria Needs Services Worksheet information;
 - b. gathers additional information from the consumer, the treatment team and/or others (as needed);
 - c. seeks clinical consultation (as needed); and
 - d. makes recommendations which may reflect such things as whether the process was followed properly, whether the consumer's rights were respected and whether the consumer should be reviewed prior to the next regularly scheduled 30-day review.
2. Second appeal: If the individual is not satisfied with the recommendation made by the human rights committee, he/she has 10 business days after receiving notification of the decision to ask the Regional Hospital Administrator (RHA) to review the appeal request. The RHA may have the Hospital's Clinical Director, or an appropriate staff member who has not been involved in this decision at this time, complete this second level review. The recommendation from this review is due within 15 days. The RHA notifies the individual of the decision within 3 business days after receiving the recommendation.

ODIS Policy: Provision of Care, Treatment, and Services in Division of MHDDAD Hospitals Subject: Process for Qualifying People for the Mental Health Planning List and Mental Health Olmstead List	DHR Online Directive Information System (ODIS) Directive # 6805-304 <i>(Replaces Policy #7.105)</i>
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3. Third appeal: If the individual wishes to appeal the decision made by the RHA, within 5 business days of receiving notification of the decision of the RHA, he/she may request the Division Director conduct a review. The Division Director has the Division Medical Director or an appropriate staff member who has not been involved in this decision at this time, review the case and make a recommendation. This recommendation is made within 10 working days. If the Division Director needs to refer the case to the RHA for questions or additional review, that review will take no longer than 14 business days, and the individual is then notified of the Division Director's decision.

4. Fourth appeal: If the individual is still not satisfied with the decisions made in Steps 1-3 above, within 10 business days after receiving notification of the Division Director's decision in Step 3 above, he/she may initiate an appeal by informing the Regional Hospital Administrator. Within seven business days of receiving that request, the RHA and the Legal Services Officer (LSO) or Legal Status Manager are responsible to direct the individual's appeal to the Office of State Administrative Hearings (OSAH). LSO or Legal Status Manager completes **Attachment F: Office of State Administrative Hearings (OSAH) Form 1**, designating the request as an MH Olmstead List Appeal. The LSO or Legal Status Manager also gathers any other necessary documents and submits them to OSAH.

**Georgia Department of Human Resources
Division of MHDDAD
Mental Health Planning List and
Mental Health Olmstead List -- Process Flow Chart**



DEMOGRAPHIC DATA

Consumer First Name: Last Name: Avatar #: CID#: SSN: Legal Code: Expiration: DOB: Gender: Race: Consumer has a Legal Guardian: Hospital: Living Unit: MHDDAD Region: County of Residence: Lawfully Present in U.S.: Admit Date: Primary Language Spoken: Sensory Impairment: Traumatic Brain Injury: Insurance or Funding Source for Treatment/ Service: Anticipated Monthly Income: Total monthly income \$

Comments:

Review Date: CLINICAL STATUS REVIEW

The consumer's clinical status has been assessed for substantial risk for imminent harm to self, based on the following:

- 1. Are there recent deliberate attempts to commit suicide or to cause serious self-inflicted bodily injury?
2. Is there evidence of substantial suicide risk, as evidenced by a suicide risk assessment or the presence of recent serious threats with a realistic and imminent plan?
3. Is there evidence of substantial risk of serious harm to self, as evidenced by the presence of recent serious threats to commit deliberate and serious self-inflicted bodily injury with a realistic and imminent plan?
4. Are there current active threats of dangerous behavior that present a substantial risk to personal safety and that require 24-hour medical and nursing supervision?
5. Is there actual violent, impulsive and unpredictable dangerous behavior that presents a substantial risk to personal safety and that requires 24-hour medical and nursing supervision?

The consumer's clinical status has been assessed for substantial risk for imminent harm to others, based on the following:

- 6. Are there recent deliberate attempts to commit homicide or to cause serious bodily injury to others?
7. Is there evidence of substantial homicide risk, as evidenced by the presence of recent serious threats with a realistic and imminent plan?
8. Is there evidence of substantial risk of imminent harm to others, as evidenced by the presence of recent serious threats to commit deliberate and serious bodily injury to others with a realistic and imminent plan?
9. Are there current active threats of dangerous behavior that present a substantial risk to the safety of others and that require 24-hour medical and nursing supervision?
10. Is there actual violent, impulsive and unpredictable dangerous behavior that presents a substantial risk to the safety of others and that requires 24-hour medical and nursing supervision?

ABILITY TO CARE FOR SELF & RECEIVE TREATMENT IN LESS RESTRICTIVE ENVIRONMENT

- 11. Is the consumer able to perform activities of daily living necessary to basic survival and maintenance of adequate health, either independently, or if necessary community supports were made available?
12. Does the treatment team believe the consumer's condition can safely be treated in a less restrictive level of care: If No, explain
13. Are there other clinical or medical issues not specified above that preclude community placement? If Yes, explain
14. Is there a need for a safety plan? (if yes briefly explain:

CONSUMER OBJECTION

- 15. Does the consumer object to community placement?

FORENSIC STATUS

- 16. Does the consumer have a forensic legal status?

KEY TO ITEM SCORING FOR PLACEMENT ON MH PLANNING LIST OR MH OLMSTEAD LIST

MH Planning List: Items 1-10 = No; Item 11& 12 = Yes; Item 13 = No; Item 14 = Yes or No; Item 15 = Yes OR Item 15 = No AND Item 16 = Yes.
MH Olmstead List: Items 1-10 = No; Item 11& 12 = Yes; Item 13 = No; Item 14 = Yes or No; Item 15 = No AND Item 16 = No.

Individual's Name: _____
Date of Review: _____

Page 2 is completed for all individuals whose clinical status as recorded on Page 1 of this document indicates that the individual qualifies for the Mental Health Planning List or Mental Health Olmstead List.

Please note: If question 14 on page 1 is answered YES, a safety plan should be incorporated into the Person Centered Transition Plan and implemented upon discharge.

For Individuals placed on the MH OLMSTEAD LIST, Date Person Centered Transition Plan Developed with individual and treatment team: _____

OLMSTEAD NOTIFICATIONS

Date consumer notified of placement on Olmstead List: _____

If appropriate, date legal guardian notified of placement on Olmstead List: NA _____

COMMUNITY TRANSITION PLANNING

Anticipated Discharge Date: _____

Provider Prior To Admission: _____

Is Consumer homeless: No Yes

Previous Admits: _____

KEY NEEDS for Community Living

Referrals will be needed to access these supports in the community

- Housing assistance
- Financial assistance
- Food & clothing assistance
- Employment assistance
- Life skills development
- Assistance in treatment or services due to language or communication needs
- Integrated MH & Substance Abuse Treatment
- Integrated MH/DD Services
- Support to access & follow-thru with treatment, including meds
- Support to avoid &/or handle crisis situations
- Support/advocacy to have educational needs addressed
- Other (specify) _____

SERVICES NEEDED (including natural supports)

NOTE: For definitions and details about each of these services, see Provider Manual.

- Core Services:**
- Behavioral Health Assessment
 - Crisis Intervention
 - Diagnostic Assessment
 - Nursing Assessment & Health
 - Group Counseling
 - Individual Counseling
 - Medication Administration
 - Psychiatric Treatment
 - Assertive Community Treatment (ACT)
 - Consumer and Family Assistance
 - Adult** - Crisis Stabilization Program (CSP) or Unit (CSU)
 - C&A** - Crisis Stabilization Program (CSP) or Unit (CSU)
 - Independent Housing with Supports
 - Intensive Family Intervention (IFI)
 - Community Living Arrangement
 - MH Intensive Day Treatment
 - Peer Support
 - Psychosocial Rehabilitation
 - Residential Services, Independent
 - Residential Services, Semi-Independent
 - Residential Services, Intensive
 - SA Day Treatment
 - Supported Employment
 - Community Supports Individual (CSI)
 - Natural Supports
 - Other (specify) _____

SPECIALIZED APPROACHES NEEDED:

- Integrated MH & Substance Abuse Treatment
- Integrated MH & DD Approach to Services
- Wraparound/Systems of Care Approach to Services for Children and Adolescents

Comments or Additional Information:

DATE: _____

TO: _____

FROM: Dr. _____ and Your Treatment Team

RE: Planning for Living in the Community

Dear _____

You have made a lot of progress and we want to help you prepare for living in the community. As part of your treatment and discharge planning, our team wants to insure that your choices and desires to live in the community are known and that we can help you in your recovery. During our team meeting on ____/____/20____, we talked with you about what you want to happen when you are discharged from the hospital. As part of this meeting, we talked about the next steps that will include:

- Reviewing the progress you have made in reaching your treatment goals.
- Identifying specific services and programs that you will need when you leave the hospital.
- Giving you information and education about programs/services in the community that could be helpful once you are discharged.
- Identifying the people who you would like to be involved in your transition planning.

We have scheduled a meeting on ____/____/20____ to work with you to develop your Person Centered Transition Plan. Based on your progress towards recovery, we have now placed your name on the Mental Health Olmstead **OR** Mental Health Planning List.

Placement of your name on this list indicates that your treatment team believes that it is time to firm up plans for your living in the community. We estimate that your discharge date from the hospital will be ____/____/20____. Please note that this date is only an estimate and your actual date of discharge may vary.

If you have any questions, your Social Worker _____ or any member of your treatment team will be happy to talk to you. Your family members can also call this person at the following number: (____) _____

Sincerely,

Please sign below to let us know that you have read this important letter.

Signature: _____ Date: _____

Please give us information about anyone you would like to receive a copy of this letter:

Name: _____

Address: _____

Phone: _____

Copy distributed to Consumer, Guardian, 1st Representative, 2nd Representative, Other Person(s) identified by consumer; Original to consumer's record

By: _____ Date: _____

DATE: _____

TO: _____

FROM: Dr. _____ **and Your Treatment Team**

RE: Planning List Review Notification

Dear _____

The Treatment Team has assessed your progress towards meeting your treatment goals and as of ____/____/20____, the Team has determined that you must remain in the hospital to continue working on your goals prior to moving back to the community. The Team supports your recovery and will assist you to return to the community as quickly as it is possible for you to do so safely.

If you have any questions about this decision, please talk with Doctor _____ or your Social Worker _____. They can discuss what is necessary in order for you to transition to the community. If you want a written statement of the team's reasons for this determination, you may ask your Social Worker for one.

After you speak with the members of your team, if you would like to speak with someone else about the decision of your team, the Social Worker can assist you in notifying the Hospital's human rights committee about your wishes. Attached to this letter is an explanation of your rights and the process for appealing the decision of the Treatment Team.

We want to encourage you to continue working on your treatment goals. You will continue to meet regularly with your Treatment Team and within the next 30 days you will be assessed again to determine if you have met your treatment goals and are ready to begin work on transitioning to the community. This reassessment can occur sooner if you make significant progress towards meeting your goals. Please let us know what we can do to best support your recovery.

Sincerely,

Please sign below to let us know that you have read this important letter.

Signature: _____ Date: _____

Please give us information about anyone you would like to receive a copy of this letter:

Name: _____

Address: _____

Phone: _____

Copy distributed to: Consumer, Guardian, First Representative, Second Representative, Person(s) identified by consumer, Original to consumer's record

By: _____ Date: _____

HOW TO APPEAL DECISIONS ABOUT PLACEMENT ON THE MENTAL HEALTH OLMSTEAD LIST

Here are the steps in the appeal process for individuals who do not qualify for the Mental Health Olmstead List and wish to appeal. If you need assistance, you may speak with your Social Worker:

1. **Within 5 business days** after the date that you receive your letter notifying you of your status regarding the Olmstead List, you may request to appeal the decision by filing a complaint with the human rights committee. Then the Hospital's human rights committee will review the appeal request within 10 working days, and you will be notified.
2. If you are not satisfied with the recommendation made by the human rights committee, **within 10 business days** after you receive notification of the decision at Step 1 above, you may ask the Regional Hospital Administrator (RHA) will review your appeal request. The RHA may have the Hospital's Clinical Director, or an appropriate staff member who has not been involved in this decision at this time, complete this second level review. The recommendation from this review is due within 15 days. The RHA will notify you of his/her decision at this stage within 3 business days after receiving the recommendation.
3. If you wish to appeal the decision made by the RHA in Step 2 above, **within 5 business days** of receiving notification of the decision of the RHA, you may ask the Division Director for a review. The Division Director will have the Division Medical Director or an appropriate staff member who has not been involved in this decision at this time, to review your case and make a recommendation. This recommendation is made within 10 working days. If the Division Director needs to refer the case to the RHA for questions or additional review, that review will take no longer than 14 business days, and you will be notified of the Division Director's decision.
4. If you are still not satisfied with the decisions made in Steps 1-3 above, **within 10 business days** after receiving the Division Director's decision in Step 3 above, you may initiate an appeal by informing the Regional Hospital Administrator. Within seven business days of receiving your request, the RHA and the Legal Services Officer or Legal Status Manager will direct your appeal to the Office of State Administrative Hearings with an OSAH Form 1.

For your information, here are contact numbers for advocacy groups:

Georgia Advocacy Organization (GAO):

In metro Atlanta, call (404) 885-1234 (Voice/TTY).

Other areas, call toll free (800) 537-2329 (Voice/TTY)

Atlanta Legal Aid: (404) 524-5811

OSAH FORM 1

This form is available online at <http://www.osah.ga.gov> or by telephone request at (404) 657-2800

OSAH USE ONLY DOCKET NUMBER	AGENCY CODE MHDDAD	CASE TYPE	DOCKET NUMBER	COUNTY	JUDGE
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DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND ADDICTIVE DISEASES (MHDDAD) (ALL MH EXCEPT CER, COC & DUIRISK)

Patient or Client's County of Residence Prior to admission to the Facility:

County In Which Facility is Located:

THE CURRENT ORDER WILL EXPIRE ON

(UNLESS A NEW ORDER EXTENDS THE PERIOD OF INVOLUNTARY TREATMENT OR HABILITATION)

SELECT ONE CASE TYPE:

<input type="checkbox"/> JLJR Juvenile extension of commitment hearing DHR v J.R. et al. <input type="checkbox"/> MIH Mentally ill extension of commitment hearing OCGA § 37-3-83 <input type="checkbox"/> MIR Mentally ill extension of commitment desk review OCGA § 37-3-83 <input type="checkbox"/> MRH Mentally retarded extension of habilitation hearing OCGA § 37-4-42	<input type="checkbox"/> MRR Mentally retarded extension of habilitation desk review OCGA § 37-4-42 <input type="checkbox"/> OUTPATH Outpatient extension of commitment hearing OCGA. § 37-3-81.1, 37-3-83 and 37-3-93 specifically <input type="checkbox"/> OUTPATR Outpatient extension of commitment desk review OCGA. § 37-3-81.1, 37-3-83 and 37-3-93 specifically <input type="checkbox"/> SA Substance abuse involuntary outpatient treatment
--	--

PATIENT (Mentally Ill) CLIENT (Mentally Retarded) JUVENILE OUTPATIENT SUBSTANCE ABUSE PARTY (CHECK ONE)

NAME		TREATING PHYSICIAN	DOES PATIENT/CLIENT WANT AN ATTORNEY? <input type="checkbox"/> YES <input type="checkbox"/> NO
CLERK SHOULD INSERT FACILITY'S MAILING ADDRESS FOR THE PATIENT/CLIENT UNLESS SPECIFICALLY NOTED OTHERWISE		COMMITTED TO DEPARTMENT ON BY: (COUNTY/COURT)	IS PATIENT/CLIENT INDIGENT ACCORDING TO AGENCY REPORTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
PRIMARY DIAGNOSIS	SUGGESTED HEARING SITE	AMOUNT OF RESOURCES	PATIENT/CLIENT SOURCE OF INCOME AND AMOUNT
GUARDIAN AD LITEM/ GUARDIAN/ ATTORNEY NAME		TEL NO	FAX NO
ADDRESS INCLUDING ZIP CODE		GEORGIA BAR NO	EMAIL
1st REPRESENTATIVE		TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE		RELATIONSHIP TO PATIENT OR CLIENT	EMAIL
2nd REPRESENTATIVE		TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE		RELATIONSHIP TO PATIENT OR CLIENT	EMAIL

FACILITY

NAME OF FACILITY	TEL NO	FAX NO
	EMAIL	EMAIL
CURRENT ADDRESS (Street, City, State, Zip Code)	NAME OF CONTACT PERSON:	CONTACT PERSON'S DIRECT TELEPHONE NUMBER:
ATTORNEY NAME	SUPERVISOR'S NAME	SUPERVISOR'S DIRECT TELEPHONE NUMBER:
ADDRESS INCLUDING ZIP CODE	TEL NO	FAX NO
CHECK DOCUMENTS ATTACHED: <input type="checkbox"/> Petition to Extend Involuntary Hospitalization/Continued Habilitation/Outpatient Commitment <input type="checkbox"/> Committee Report <input type="checkbox"/> Individualized Treatment Plan <input type="checkbox"/> Other: (please specify)	GEORGIA BAR NO	EMAIL