**FORM MHCA 04**

**DEPARTMENT OF HEALTH**

**APPLICATION TO THE HEAD OF HEALTH ESTABLISHMENT CONCERNED FOR ASSISTED OR INVOLUNTARY CARE, TREATMENT AND REHABILITATION**
**[Section 27(1) and 27(2) or 33(1) and 33(2) of the Act]**

(A staff member assisting the Applicant in completing this form must record his/her name, surname anddesignation)

Name, surname and designation of staff member-.....

**A. INFORMATION REGARDING THE USER**

I hereby apply for—.

assisted care ☐ orinvoluntary care ☐:

Surname of User: .....
First name(s) of User: .....
Date of birth: ..... or estimated age .....

Gender: Male ☐ Female ☐

Marital status: S ☐ M ☐ D ☐ W ☐

Employment: Yes ☐ or No ☐

Property: Yes ☐ or No ☐

Income source: Pension ☐

Grant ☐

Other ☐ (Specify).....

None ☐

Is there a reason to believe that an administrator or curator needs to be appointed to manage the financial affairs of the User Yes ☐ No ☐

Residential address and contact details: .....
.....
.....
.....

**B. INFORMATION REGARDING APPLICANT**

Surname of applicant: .....
First name(s) of applicant:.....
Date of birth of applicant: ..... (must be over 18 years of age)
Residential address and contact details: .....
.....
.....

**C. Relationship between applicant and mental health care user: (mark with a cross)**

Spouse ☐ Partner ☐ Associate ☐ Parent ☐

Guardian ☐ Heath care provider ☐ Other ☐ .....(specify)

(If User is under 18 this application must be made by the parent, caregiver, guardian or person with parental right and responsibilities)

I last saw the User on..... at .....
(date) (time) (place)

(The applicant must have seen the User within seven days of making this application)

**D. Why is the applicant the health care provider?:**

The spouse, next of kin, partner, associate, parent or guardian of the User is:

(i) Unwilling (State reasons for this conclusion):
.....
.....
.....
.....

or

(ii) Incapable (State Reasons for this conclusions for this conclusion):
.....
.....
.....
.....

or

(iii) Unknown/Untraceable (state efforts made to trace)
.....

.....
.....

**E. Reasons for the Application:**

I, the undersigned, am of the opinion that the above-mentioned person is suffering from a mental illness / intellectual disability for the following reasons(e.g, what did he/she do or say?):

.....
.....
.....
.....

**F. In the case of an application for involuntary care:**

In your opinion:

(i)Is the User a danger to self and others due to his/her mental illness?

Yes☐ No☐

(ii) Is the User willing to receive care, treatment and rehabilitation if needed?

Yes☐ No☐

(iii) Is the User able to make an informed decision?

Yes☐ No☐

I also attach the following information in support of my application (if available)

Medical certificates:..☐

History of past mental illness:☐ / intellectual disability:☐

Other:☐

.....
.....
.....

I wish to have representation/Legal Representation/Legal Aid

for myself Yes☐ No☐

oron behalf of the User Yes☐ No☐

Print initials and surname (Applicant).....

Signature (Applicant):.....

Date: .....

Place: .....

Note: Applicant must sign under oath

**F. OATH/AFFIRMATION**

I certify that:

iii. The deponent acknowledged to me that:
   a. He/she knows and understands the contents of this declaration;
   b. He/she has no objection to taking the prescribed oath;
   c. He/she considers the prescribed oath to be binding on his/her conscience;

iv. The deponent signed this declaration in my presence at ..... on this ..... day of ..... 20.....

_____

Signature: Commissioner of Oath: Ex-Officio

Name: .....

Rank / Designation: .....

**(Submit original to Review Board)**