

**PROBATE COURT OF BUTLER COUNTY, OHIO**

**IN THE INTEREST OF:** \_\_\_\_\_

**Case No.** \_\_\_\_\_

**PETITION FOR INVOLUNTARY TREATMENT FOR  
ALCOHOL AND OTHER DRUG ABUSE**

[R.C. 5119.93]

RESPONDENT'S Residence Address: \_\_\_\_\_

RESPONDENT'S Current Location (if different): \_\_\_\_\_

PETITIONER: \_\_\_\_\_

PETITIONER'S Address: \_\_\_\_\_

States that he/she is:

Spouse;      Relative \_\_\_\_\_      Guardian of the above named Respondent

PETITIONER further states that the name, address, and residence of person related to the Respondent are (if known)

Parents or guardian: \_\_\_\_\_  
Name and complete address

Spouse: \_\_\_\_\_  
Name and complete address

Person having custody of Respondent: \_\_\_\_\_  
Name and complete address

Nearest Relative: \_\_\_\_\_  
Name and complete address

Friend: \_\_\_\_\_  
Name and complete address

PETITIONER believes that Respondent is a person suffering from alcohol and/or other drug abuse because: (state facts to support belief)

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

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Petitioner also believes that the Respondent presents an imminent danger or imminent threat of danger to self, family, or others if not treated because: (state facts to support belief)

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

Check one:

Certificate of Physician is attached.

OR

Respondent has refused all requests made by me, the Petitioner, to undergo a physician's examination.

Petition is accompanied by:

- 1.) A security deposit in the amount of \$
- 2.) Guarantee of Payment form.

\_\_\_\_\_  
Signature of Attorney

\_\_\_\_\_  
Signature of Petitioner

\_\_\_\_\_  
Name of Attorney (Please Print)

\_\_\_\_\_  
Name of Petitioner (Please Print)

Sworn to me and signed in my presence on \_\_\_\_\_ of \_\_\_\_\_

\_\_\_\_\_  
Notary Public

**VERIFICATION OF TREATMENT BY PETITIONER**

**\*\*\*A statement from Facility MUST accompany this petition\*\*\***

\_\_\_\_\_, the petitioner, has arranged for the treatment of  
Name of Petitioner

\_\_\_\_\_ to be facilitated by:  
Name of Respondent

\_\_\_\_\_  
Name of Treatment Provider

\_\_\_\_\_  
Full Address of Treatment Provider (Street, City, State, Zip Code)

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**GUARANTEE OF PAYMENT**  
[R.C. 5119.93(D)(2)]

Pursuant to R.C. 5119.93(D)(2), either the Petitioner or other authorized person (spouse, relative or guardian) shall guarantee any and all costs and fees for examinations, hearing cost and treatment for the Respondent for alcohol and other drug abuse as may be herein after ordered by the Court. The GUARANTEE below shall be completed by either the Petitioner or other authorized person.

By my signature below, I do hereby assume responsibility for and GUARANTEE PAYMENT FOR ALL COSTS incurred on behalf of Respondent for all alcohol and other drug abuse treatment, including, but not limited to, initial examination and transportation costs, as hereinafter ordered by the Court.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Relationship to Respondent (Petitioner, Spouse, Relative, or Guardian)

\_\_\_\_\_  
Complete Billing Address

Sworn to me and signed in my presence on \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Notary Public