Certification of Ability to Provide Express and Informed Consent
For Voluntary Admission and Treatment of Selected Individuals
From Facilities Licensed under Chapter 400, F.S.

On _____, at _____ (a.m.) (p.m.) _____,
Date Time Print Name of the Individual

who resides at _____
Individual's Residence Name and Address

made application by express and informed consent for voluntary admission to _____

facility located at _____.
Address of Facility

He or she is: (Check the box that applies)

☐ An individual 60 years of age or older diagnosed as suffering with dementia for whom transfer is being sought from a nursing home, assisted living facility, adult day-care center, or adult family-care home.

☐ An individual 60 years of age or older for whom emergency transfer is being sought from a nursing home pursuant to s. 400.0255(12).

☐ An individual for whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy designated under Chapter 765, F.S.

He/she	☐ does	or	☐ does not	have the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.
He/she	☐ has	or	☐ has not	consented in writing, after sufficient explanation and disclosure of the need for admission, without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

The observations on which I have reached this conclusion are:

_____

_____

_____

_____	_____	_____ am pm
Signature of Assessor *	Date of Assessment	Time of Assessment
_____	_____	_____
Typed or Printed Name of Assessor	Profession	License Number (if any)*

*** If publicly funded assessor is not licensed, specify the name, profession and license number of supervising professional:**
Name: _____ Profession: _____ License #: _____

Name of Mental Health Overlay Program (a service provided under contract with the Department of Children & Families and attached to a public receiving facility):

_____

Continued on Page 2

Certification of Ability to Provide Express and Informed Consent
For Voluntary Admission and Treatment of Selected Individuals
From Facilities Licensed Under Chapter 400, F.S. (Page 2)

Name of Mobile Crisis Response Service (a service provided under contract with the Department of Children & Families and attached to a public receiving facility):

_____

Name of Community Mental Health Center or Clinic (publicly funded, not-for-profit center that subcontracts with the Department of Children & Families): _____

When an initial assessment of the ability of an individual to give express and informed consent to treatment is required and a mobile crisis response service does not or cannot respond to the request for an assessment within two (2) hours after the request is made, the requesting facility may arrange for assessment by any licensed professional authorized to initiate an involuntary examination, pursuant to s. 394.463 who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made. I certify that the mobile crisis service, if one exists, has been contacted and cannot respond within the 2-hour period and that I have no conflict of interest as defined above.

NOTICE: Under the provisions of s. 400 F.S. and 394.4625(1)(c), it is unlawful for this assessment to be conducted by any professional who is employed by, under contract with, or who has a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made.

The individual applying for voluntary admission ☐ does or ☐ does not have the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.

He/she ☐ has or ☐ has not consented in writing, after sufficient explanation and disclosure of the need for admission, without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

The observations on which I have reached this conclusion are:

_____

_____

_____

_____

_____

_____	_____	_____ am pm
Signature of Independent Professional	Date	Time of Assessment
_____	_____	_____
Typed or Printed Name of Professional	Profession *	License Number

Continued on Page 3

Certification of Ability to Provide Express and Informed Consent
For Voluntary Admission and Treatment of Selected Individuals
From Facilities Licensed Under Chapter 400, F.S. (Page 3)

The licensed professional authorized to initiate an involuntary examination pursuant to s 394.463 includes a Psychiatrist, Physician (but not a Psychiatrist), Clinical Psychologist, Psychiatric Nurse, Clinical Social Worker, Mental Health Counselor, Marriage and Family Therapist, Physician Assistant, and Advanced Practice Registered Nurse under s. 464.0123 F.S.

Distribution:
- ☐ Original to the Receiving Facility for retention in individual's clinical record
- ☐ Facility at which the individual was assessed
- ☐ Assessor

BAKER ACT