

Rule 13.35—Form 1: Application Alleging Substance-Related Disorder

	In the Iowa District Court for _	County where Application is filed
In the Matter of		No
Re	spondent Full name: first, middle, last	Application Alleging Substance- Related Disorder
Alleged to be a Person with a Substance-Related Disorder		Iowa Code § 125.75
1. I,		, allege Respondent is suffering from
	a substance-related disorder.	
2.	In support of this Application, I state:	
	☐ Check this box if you have attached additional po	ages.
3.	Based on the above facts, I believe Reslacks judgmental capacity due to a subs	spondent is a danger to self or others and stance-related disorder. ☐ Yes ☐ No
4.	I request that: Check one	
	A. Respondent be taken into immediate	te custody.
	B. Respondent not be taken into imme	ediate custody.
5.	In support of this Application, I have attacheck all that apply	ached:
	A. A written statement of a licensed phand surgeon or mental health process.	nysician and surgeon or osteopathic physician essional.
	B. One or more Affidavits corroboratin	g these allegations. See Rule 13.35—Form 2.
	designee. NOTE: This option is only ava	and reduced to writing by the clerk or the clerk's ailable when circumstances make it infeasible to obtain, or supplement, the information under either subparagraph

Continued on next page

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Attorney Help Check one							
A. An attorney d	d not help me prepare o	or fill in this pap	oer.				
B. An attorney h	elped me prepare or fill i ation:	n this paper If	you check B, you n	nust fill in the			
Name of attorney	or organization, if any	Attorney's PIN	Ask the attorney	,			
Business address	of attorney or organization	City	State	ZIP code			
() Attorney's phone	number	Attorney's ema	uil address – optional				
Oath and signature of applicant							
I,, have read this Application, and I certify under, Print your full name: first, middle, last							
	nd pursuant to the law dication is true and co		e of lowa that th	he information			
Month Day	Year Applicant's	signature*					
Mailing address		City	State	ZIP code			
()							

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^{*}This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.

In th	ne Iowa Dis	trict Co		ounty where A	ffidavit is filed		unty
In the Matter of			No				
Respondent Fu	ull name: first, m	iddle, last	,				Application ated Disorder
Alleged to be a Substance-Re							Iowa Code § 125.75
I, Full name: first, n		, stat	te that I a	m acquain	ted with R	esponder	nt who resides at
Street address			City		County	State	, ZIP code
and I believe R this belief, I sta							
Check this box if		hed additio	nal pages.				
Oath and signal, Print your full nan		e, last	, ha	ve read th	is Affidav	it, and I c	ertify under
penalty of perju this Affidavit is	true and co		he laws	of the Stat	e of Iowa	that the i	nformation in
Month	Day		Affiant's	signature*			
Mailing address				City		, State	ZIP code
() Phone number		Email ad	dress		Additiona	ıl email addı	ress, if applicable
*This form may be s the-public/court-form		using a dig	gitized signo	ature, see inst			* **

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Rule 13.35—Form 3: Application for Appointment of Counsel for Respondent and Financial Statement

In the lowa District Court for $\frac{1}{CC}$			County Where Application is filed				
In the Matter of		Matter of	No		_		
Respondent Full name: first, middle, last Alleged to be a Person with a Substance-Related Disorder		ed to be a Person with a	Application for Appointment of Counsel for Respondent and Financial Statement				
		ance-Related Disorder			Iowa Code § 125.78		
1.	Ι,			, s	tate that I am:		
	Ì	Print your full name: first, middle, last					
	Ch	neck one					
		Respondent					
		☐ Respondent's spouse					
		□ Next friend of Respondent					
	☐ Guardian of Respondent						
		nd I request the court appoint counsel ecause Respondent is financially unab		ent at p	ublic expense		
2.	Re	espondent's information					
	A.						
		Respondent's full name: first, middle, last					
		Street address	City	State	ZIP code		
		Marital status	Number of dependents	=			
	В.	Respondent's age:					
	C.	Is Respondent currently in custody?]Yes □No				
	D.	Respondent's employment status:					
		☐ Full-time					
		☐ Part-time (approximate hours per w	eek:)				
		☐ Unemployed	•				

Continued on next page

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3. Respondent's income

A. Income Respondent currently receives before taxes and deductions:

*How often received?

W = Weekly B = Bi-weekly (every other week) M = Monthly Y = Yearly

	Income		
Average current income for Respondent	How often received?* W, B, M, Y	Amount	
(1) Wages from employer			
Employer name:		\$	
Job title:		_	
(2) Wages from employer			
Employer name:		\$	
Job title:		Ψ	
(3) Unemployment assistance		\$	
(4) Family Investment Program		\$	
(5) Social Security		\$	
(6) Other		\$	
Identify: (7) Other			
(1) Other Identify:		\$	
(8) Other		\$	
Identify:		Ψ	
(9) Totals from attached pages, if any		\$	
Check this box if you have attached additional pages		Ψ	
regarding income sources.			
Total		\$	
Total income received by Respondent		*	

B.	Total income from the past 12 months from any source, before taxes and deductions:
	\$
C.	Is Respondent's spouse working? ☐ Yes ☐ No
	If yes, average wages before taxes and deductions: \$
	per: ☐ hour ☐ month ☐ year

Continued on next page

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4. Respondent's assets

A. Real estate

Type of real estate	Jointly owned?	Market value What it would sell for	Debt Total amount owed on debt and to whom owed	Net value Market value minus debt owed
(1) Homestead Address		\$	\$ to:	\$
(2) Other real estate Address		\$	\$ to:	\$

[☐] Check this box if you have attached additional pages.

B. Vehicles (includes cars, trucks, motorcycles, boats, and other motorized vehicles)

Vehicle Make (e.g., Ford), model, year	Jointly owned?	Market value What it would sell for	Debt Total amount owed on debt and to whom owed	Net Value Market value minus debt owed
(1)		\$	\$ to:	\$
(2)		\$	\$ to:	\$
(3)		\$	\$ to:	\$

	Check this box if you have attached additional pages.
C.	Other assets, if any:
	Check this box if you have attached additional pages.

Continued on next page

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5. Respondent's debts

Debts and liabilities of Respondent	Debts and liabilities	
Bests and hashines of Respondent	Amount	
(1) Mortgage	\$	
(2) Car loan	\$	
(3) Credit card debt	\$	
(4) Other Identify:	\$	
(5) Other Identify:	\$	
(6) Other <i>Identify:</i>	\$	
(7) Totals from attached pages, if any Check this box if you attached additional pages regarding debts and liabilities.	\$	
Total	\$	

6. Respondent's expenditures

Type of expense	Amount Check one monthly annual
(1) House payment or rent	\$
(2) Food	\$
(3) Insurance (health, dental, auto, etc.)	\$
(4) Utilities (gas, electric, water, internet, etc.)	\$
(5) Phone	\$
(6) Child support payments	\$
(7) Car payment	\$

Continued on next page

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7.

(9) Other expense Identify:	\$ \$	
(10) Other expense Identify:	\$	
(11) Other expense <i>Identify:</i>	\$	
(12) Totals from attached pages, if any Check this box if you have attached additional pages regarding expenses.	\$	
Total <i>Total expenditures</i>	\$	
Oath and signature		
I,, have read this App Print your full name: first, middle, last	olication, a	nd I certify unde
penalty of perjury and pursuant to the laws of the State o provided in this Application is true and correct. , 20	f lowa that	the information
Month Day Year Applicant's signature*		
Mailing address City	State	ZIP code
()		lress, if applicable

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<u>https://www.iowacourts.gov/for-the-public/court-forms/</u>, or by printing and hand-signing.

	In the Iowa District Court for	County where Application is filed	County
ln t	the Matter of	No	
Respondent Full name: first, middle, last Alleged to be a Person with a Substance-Related Disorder		Counsel for Appl	r Appointment of licant and Financial rement Iowa Code §§ 125.76, .78
1.	l,		, state that I am
	the Applicant in this case, and pursua 125.78(2), I request the court appoint because I am financially unable to en	ant to lowa Code sectior t counsel to represent m	ns 125.76 and
2.	Applicant's information A		
	Street address	City	State ZIP code
	Marital status	Number of dependents	_
	B. Applicant's age:		
	C. Applicant's employment status:		
	☐ Full-time		
	☐ Part-time (approximate hours pe	r week:)	
	☐ Unemployed		
3.	Applicant's income		
	A. Income currently received by Applica	ant, before taxes and dedu	ctions:
	*How often received? $W = Weekly B = Bi$ -weekly (every other wee	(k) M = Monthly Y = Yearly	

	İr	Income		
Average current income for Applicant	How often received?* W, B, M, Y	Amount		
(1) Wages from employer				
Employer name:		\$		
Job title:		•		

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	(1)Wages from employer Employer name:		•
	Job title:		\$
	(2) Wages from employer		
	Employer name:		\$
	Job title:		
	(3) Unemployment assistance		\$
	(4) Family Investment Program		\$
	(5) Social Security		\$
	(6) Other <i>Identify:</i>		\$
	(7) Other Identify:		\$
	(8) Other		•
	Identify:		\$
	(9) Totals from attached sheets, if any		\$
	Check this box if you have attached additional pages regarding income sources.		Y
	Total Total income received by Applicant		\$
В.	Total income from the past 12 months from any so \$	ource, before taxe	es and deductions:
C.	Is Applicant's spouse working? ☐ Yes ☐ No		
	If yes, average wages before taxes and deduction	s: \$	
			_ month _ year

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C.

4. Applicant's assets

A. Real estate

Type of real estate	Jointly owned?	Market value What it would sell for	Debt Total amount owed on debt and to whom owed	Net value Market value minus debt owed
(1) Homestead Address		\$	\$ to:	\$
(2) Other real estate Address		\$	\$ to:	\$

Check this box if you have attached additional pages.

Check this box if you have attached additional pages.

B. Vehicles (includes cars, trucks, motorcycles, boats, and other motorized vehicles)

Vehicle <i>Make</i> (e.g., Ford), model, year	Jointly owned?	Market value What it would sell for	Debt Total amount owed on debt and to whom owed	Net Value Market value minus debt owed
(1)		\$	to:	\$
(2)		\$	\$ to:	\$
(3)		\$	\$ to:	\$

Other assets, if any:		

Check this box if you have attached additional pages.	
Check has box if you have anaened additional pages.	

Continued on next page

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5. Applicant's debts

Debts and liabilities of Applicant	Debts and liabilities	
Dobto and national of Approant	Amount	
(1) Mortgage	\$	
(2) Car loan	\$	
(3) Credit card debt	\$	
(4) Other Identify:	\$	
(5) Other Identify:	\$	
(6) Other Identify:	\$	
(7) Totals from attached sheets, if any Check this box if you attached additional pages regarding debts and liabilities.	\$	
Total	\$	

6. Applicant's expenditures

Type of expense	Amount Check one monthly annual
(1) House payment or rent	\$
(2) Food	\$
(3) Insurance (health, dental, auto, etc.)	\$
(4) Utilities (gas, electric, water, internet, etc.)	\$
(5) Phone	\$
(6) Child support payments	\$
(7) Car payment	\$

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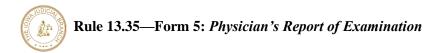


7.

(8) Credit card payn	nents		\$	
(9) Other expense				
Identify:			\$	
(10) Other expense <i>Identify:</i>			\$	
(11) Other expense <i>Identify:</i>			\$	
(12) Totals from atta	ched pages, if any		\$	
Check this box if you l	nave attached additional po	ages regarding expens	•	
Total <i>Total expenditures</i>			\$	
Oath and signature				
	ŀ	nave read this A	pplication, ar	ad Loortify unde
l,	, ,	iave read tills A		id i certilly unde
I, Print your full name: firs		lave read tills A	, , , , , , , , , , , , , , , , , , , ,	id i certily unde
Print your full name: firs penalty of perjury an provided in this Appl	t, middle, last d pursuant to the la ication is true and o	aws of the State correct.		•
Print your full name: firs penalty of perjury an provided in this Appl	t, middle, last d pursuant to the la ication is true and o, 20	aws of the State correct.		•
Print your full name: firs penalty of perjury an provided in this Appl Month Day	t, middle, last d pursuant to the la ication is true and o	aws of the State correct.		•
penalty of perjury an provided in this Appl	t, middle, last d pursuant to the la ication is true and o	aws of the State correct. 's signature* City	of lowa that	the information

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<u>https://www.iowacourts.gov/for-the-public/court-forms/</u>, or by printing and hand-signing.



	In the Iowa District Court for _	County where Report is filed	County
 In	the Matter of	No	
Re	spondent Full name: first, middle, last	Physician's Report of Examinat	
Alleged to be a Person with a Substance-Related Disorder			Iowa Code § 125.80 Iowa Ct. R. 13.13
1.	Date and time of examination:		$\underline{\phantom{aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa$
2.	Respondent's information:		
	A. Name:		
	Full name: first, middle, last		
	B. Address:	City	State ZIP code
	C. Date of birth:	•	Sittle ZIF Code
	D. Place of birth:		
	E. Sex:		
	F. Occupation:		
	G. Marital status:		
	H. Number of children: Name(s		
			D.L. C.
	Name: first, last		Relationship
	Street address	City	State ZIP code
3.	Is this an examination under Iowa Code	e section 125.80?	□ Yes □ No
4.	Did facility personnel assist with this ex	cam?	□Yes □No
	If yes, provide that person's name:	lity personnel's name	
	Business address	City State	ZIP code
	Attach the facility personnel's report, if written		

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ġ.	20	٠,	3)	
ĸ	i e, e	0	7	

	Continued on next page		
10.	Is full-time hospitalization necessary for evaluation?	☐Yes	□No
	Check this box if you have attached additional pages.		
9.	Can Respondent, without danger to self or others, be released to the relative or friend during the course of evaluation? Basis for answer	custody ☐ Yes	
	Check this box if you have attached additional pages.		
8.	☐ Check this box if you have attached additional pages. Can Respondent be evaluated on an outpatient basis? Basis for answer	□Yes	□No
7.	In your judgment, is Respondent treatable and would likely benefit from treatment? If yes, state recommendations and basis for recommendations	□Yes	□No
	Check this box if you have attached additional pages.		
	and other relevant facts		
6.	In your judgment, is Respondent a danger to self or others and lacks capacity due to a substance-related disorder? If yes, state what recent overt acts by Respondent lead you to this conclusion, including appropriate to the state of the s	□Yes	□No
	Check this box if you have attached additional pages.		
5.	In your judgment, is Respondent a person with a substance-related disorder as defined by the American Psychiatric Association? If yes, state diagnosis including supporting facts, symptoms, and overt acts	□Yes	□No

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Does Respondent have a prior history of other substance-related disorders or physical or mental illness? Yes N If yes, specify				
Check this box if you h	ave attached	additional pag	ges.	
Was Respondent m If yes, provide name(s) of effects on Respondent				? ☐ Yes ☐ No ime administered, and probable
Check this box if you h	ave anacnea	aaamonat pag	es.	
Signature*			Printed name	
Title**			Name of facility	
14 11 11				
Mailing address				
City			, State	ZIP code
			State	ZIP code
City ()			_ 	ZIP code l address, if applicable
City () Phone number		., 20	_ 	

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^{*}This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.

 $^{**} The \ Report \ of \ Examination \ must \ be \ filled \ out \ by \ a \ court-designated \ licensed \ physician \ and \ surgeon \ or$ osteopathic physician and surgeon or mental health professional. Iowa Code § 125.80(2).



Rule 13.35—Form 6: Stipulation Regarding Respondent's Presence

	In the Iowa District Court for	County where Stipu	Lation is filed			
In t	the Matter of					
Re	spondent Full name: first, middle, last	- Stipulati	Stipulation Regarding Respondent's Presence			
	eged to be a Person with a bstance-Related Disorder		Iowa Code § 125.82 Iowa Ct. R. 13.19(2)			
1.	I,, I am a	an attorney rep	resenting Respondent in this			
	matter and stipulate that Respondent determine whether Respondent is a p	•	<u> </u>			
2.	On, $\underline{\phantom{aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa$	I conversed w	ith Respondent about the			
	hearing and Respondent's absence for	rom the hearin	g.			
3.	In my judgment,					
	A. Respondent can make no meaningful contribution to the hearing.					
	B. Respondent has waived the right to be present at the hearing.					
	I base this judgment on the following	grounds:				
	Check this box if you have attached additional	l pages.				
4.	Attorney's signature					
	Printed Income	/s/_				
	Printed name	Signatu	re			
	Law firm, if applicable					
	Mailing address					
	City	State	ZIP code			
	()					
	Phone number	Attorney P	IN number			
	Email address	Additional	email address, if applicable			
	<i>Month Day</i> , 20	Year				

	In the lowa District Co		re Notice is filed
1 t	he Matter of	No	
e	espondent Full name: first, middle, last		Notice of Medication
	eged to be a Person with a ostance-Related Disorder		Iowa Code § 125.82(1)
•	Physician's name	Include the name(s) o	inform the court that Respondent was f the medication (including chemotherapy),
	Check this box if you have attached	additional pages.	
	This medication may cause th	e following effec	ets on Respondent:
•			ets on Respondent:
	This medication may cause the Check this box if you have attached to Physician's signature		ets on Respondent:
	Check this box if you have attached	additional pages.	ets on Respondent:
	Check this box if you have attached a Physician's signature	additional pages.	·
	Check this box if you have attached a Physician's signature Printed name	additional pages.	·
	Check this box if you have attached a Physician's signature Printed name Name of facility	additional pages.	nature*
	Check this box if you have attached a Physician's signature Printed name Name of facility Mailing address City ()	additional pages. Sig	nature*

https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.



Rule 13.35—Form 8: Application for Extension of Time for Evaluation

	County where Application is	County	
the Matter of	No	<u></u>	
spondent Full name: first, middle, last	Application for Extension of Time for Evaluation		
eged to be a Person with a		valuation	
bstance-Related Disorder		Iowa Code § 125.8	
I,, chief medi	cal officer of	or facility	
request an extension of time not to execute evaluation of Respondent.	ceed seven days in o	order to complete the	
I request this extension because:			
-			
☐ Check this box if you have attached additional	pages.		
		interests.	
It is my opinion that this extension is in		interests.	
		interests.	
It is my opinion that this extension is in		interests.	
It is my opinion that this extension is in Chief medical officer's signature	Respondent's best	interests.	
It is my opinion that this extension is in Chief medical officer's signature	Respondent's best	interests.	
It is my opinion that this extension is in Chief medical officer's signature Printed name	Respondent's best	interests.	
It is my opinion that this extension is in Chief medical officer's signature Printed name Name of facility	Respondent's best	interests. ZIP code	
It is my opinion that this extension is in Chief medical officer's signature Printed name Name of facility Mailing address	Respondent's best		
It is my opinion that this extension is in Chief medical officer's signature Printed name Name of facility Mailing address	Respondent's best		
It is my opinion that this extension is in Chief medical officer's signature Printed name Name of facility Mailing address City ()	Respondent's best	ZIP code	
It is my opinion that this extension is in Chief medical officer's signature Printed name Name of facility Mailing address City (Signature*	ZIP code	

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Rule 13.35—Form 9: Report of Substance Abuse Evaluation

	In the lowa District Court for _	County
	C	County where Report is filed
In	the Matter of	No
Re	spondent Full name: first, middle, last	Report of Substance Abuse Evaluation
	eged to be a Person with a bstance-Related Disorder	Iowa Code § 125.84 Iowa Ct. R. 13.24
1.	I,, of	
	I,, of	facility
	and for the Report of Substance Abuse following.	Evaluation of Respondent, state the
2.	Date and time of evaluation:	$\underline{\phantom{aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa$
	Month	Day Year Time p.m.
3.	State treatment Respondent received d	luring the present evaluation period:
	Check this box if you have attached additional po	ages.
4.	Was Respondent medicated at the time If yes, provide name(s) of the medication, dosage, effects on Respondent	e of evaluation?
	Check this box if you have attached additional pe	ages.
5.	In your opinion, is Respondent a person disorder as defined by the American Ps If yes, state diagnosis including supporting facts, syn	sychiatric Association?
	Check this box if you have attached additional pe	ages.

Continued on next page

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from to	r opinion, is Respondent treatable and would likely benefit reatment?	□Yes	□No
ij yes, si	ate recommendations and basis for recommendations		
Chec	k this box if you have attached additional pages.		
treatm	r opinion, does Respondent have the capacity to understand ent? ate basis for answer	d the need ☐ Yes	for ☐ No
Chec	k this box if you have attached additional pages.		
capac	r opinion, is Respondent a danger to self or others and lacks ity due to a substance-related disorder?	☐Yes	□No
	ate what recent overt acts by Respondent lead you to this conclusion, including er relevant facts	approximate d	iaie(s)
and othe	er relevant facts	approximate (mie(s)
and othe	er relevant facts k this box if you have attached additional pages.	approximate (uuie(s)
Chec	er relevant facts k this box if you have attached additional pages. esed treatment and placement r opinion,	approximate (uuie(s)
☐ Chec Propo	er relevant facts k this box if you have attached additional pages. esed treatment and placement r opinion,		
Check o	er relevant facts k this box if you have attached additional pages. psed treatment and placement r opinion, ne Respondent does not, as of the date of this Report, require further	er treatment	for -time
Check o	exer relevant facts The k this box if you have attached additional pages. The seed treatment and placement Topinion, The substance abuse. Iowa Code § 125.84(1). Respondent is a person with a substance-related disorder and in custody, care, and treatment in a facility and is likely to benefit from the substance and the substance and in custody, care, and treatment in a facility and is likely to benefit from the substance.	er treatment	for -time
Check o	Respondent does not, as of the date of this Report, require further substance abuse. Iowa Code § 125.84(1). Respondent is a person with a substance-related disorder and in custody, care, and treatment in a facility and is likely to benefit from Code § 125.84(2).	er treatment	for -time
Check o	Respondent does not, as of the date of this Report, require further substance abuse. Iowa Code § 125.84(1). Respondent is a person with a substance-related disorder and in custody, care, and treatment in a facility and is likely to benefit from Code § 125.84(2).	er treatment	for -time

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1	Name of	N.
W	Δ.	13
le.	36.	3
K.	-	37

C. □	Respondent is a person but does not require full-			order and in need of treatmen lowa Code § 125.84(3).	
	Recommended treatme	nt on an outp	patient or other a	ppropriate basis:	
	Check this box if you have	e attached addit	ional pages.		
D. 🗌	Respondent is a person but is not responding to			order and in need of treatment a Code § 125.84(4).	
	Recommended alternati	ive placemen	nt:		
	Check this box if you have	e attached addit	ional pages.		
	e facts and reasons supporting your recommended treatment and that the ment is the least restrictive and effective for Respondent:				
	ck this box if you have attached	d additional pag	ges.		
Signa	iture				
Printed	l name		Signature*		
Title			Name of facilit	y	
Mailing	g address				
City			State	ZIP code	
Phone 1	_) number				
Email a	address		Additional ema	il address, if applicable	
Month	Dav	, 20 <u></u> 	_		
	Day orm may be signed either by us		- sionature see i	nstri	

*This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.



Rule 13.35—Form 10: Periodic Report (Respondent Inpatient)

In the lowa District Court for $\frac{1}{C}$	County Where Report is filed
e Matter of	No
oondent Full name: first, middle, last	Periodic Report (Respondent Inpatient)
jed to be a Person with a stance-Related Disorder	Iowa Code § 125.86(1)
,, of Full name Hospital or	facility
and for the Periodic Report of Respond	
An order for continued treatment of Resentered $\frac{1}{Month}$, $\frac{1}{Day}$, $\frac{1}{Yea}$	
State treatment Respondent received d	uring the present evaluation period:
Check this box if you have attached additional po	
n the opinion of the chief medical office $oldsymbol{a}$. \square Has improved.	er, Respondent's condition:
3. Remains unchanged.	
Explanation	
☐ Check this box if you have attached additional porn your opinion, is Respondent a persor lisorder as defined by the American Pset yes, state diagnosis including supporting facts and	n with a substance-related sychiatric Association?
Check this box if you have attached additional po	ages.
l	isorder as defined by the American Ps

Continued on next page

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 Rule 13.35—Form 10
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6.	from tr	r opinion, is Respondent treatable and would likely benefit reatment? ate recommendations and basis for recommendations	□Yes	□No
	Chec	k this box if you have attached additional pages.		
7.	In you	r opinion, does Respondent have the capacity to understand	I the need t ☐ Yes	for □No
	Chec	k this box if you have attached additional pages.		
3.	capaci	r opinion, is Respondent a danger to self or others and lacks ity due to a substance-related disorder? ate basis for answer	s judgmenta	al □ No
	Chec	k this box if you have attached additional pages.		
).	Propo	sed treatment and placement		
	In you Check or	r opinion,		
	A. 🗆	Respondent does not, as of the date of this Report, require further substance abuse. Iowa Code § 125.84(1). <i>Explanation</i>	er treatment	for
	_	Check this box if you have attached additional pages.		
	STOP If y	ou checked $9(A)$, stop and sign below.		

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	B.		Respondent is a person with a substance-related disorder and in need of full-time custody, care, and treatment in a facility and is considered likely to benefit from treatment. Iowa Code § 125.84(2).
		(1)	Estimated further length of time that Respondent will require treatment in a facility: <i>Check one</i>
			a. 🗌 Is
			b. Cannot be determined at this time.
		(2)	Recommended further treatment:
			Check this box if you have attached additional pages.
	C.		Respondent is a person with a substance-related disorder and in need of treatment but does not require full-time placement in a facility. Iowa Code § 125.84(3).
			Recommended treatment on an outpatient or other appropriate basis:
			Check this box if you have attached additional pages.
	D.		Respondent is a person with a substance-related disorder and in need of treatment but is not responding to the treatment provided. Iowa Code § 125.84(4).
			Recommended alternative placement:
			Check this box if you have attached additional pages.
10.			facts and reasons supporting your recommended treatment and that the ent is the least restrictive and effective for Respondent:
		Chec	k this box if you have attached additional pages.
	_		

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11. Signature

Printed name	Signature*		
Title	Name of facility		
Mailing address			
City	State	ZIP code	
() Phone number			
Email address	Additional emai	l address, if applicable	
Month Day Year	_		

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^{*}This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.



Rule 13.35—Form 11: Periodic Report (Respondent Outpatient)

	In the lowa District Court for $\frac{1}{C}$	ounty where Report is filed	County	
In the Matter of		No		
Re	spondent Full name: first, middle, last	Periodic Re (Respondent Out	-	
	eged to be a Person with a bstance-Related Disorder		Iowa Code § 125.86(2)	
1.	I,, of			
	and for the Periodic Report of Respond	ent, state the following.		
2.	An order for continued treatment of Resentered ${Month}$ ${Day}$, ${Yea}$	•	S	
3.	State treatment Respondent received d	uring the present evaluation	on period:	
4.	☐ Check this box if you have attached additional pool in the opinion of the chief medical office A. ☐ Has improved. B. ☐ Remains unchanged. C. ☐ Has deteriorated. Explanation		:	
	Check this box if you have attached additional po	1000		
5.	In your opinion, is Respondent a persor disorder as defined by the American Ps If yes, state diagnosis including supporting facts and	n with a substance-related sychiatric Association?	□Yes □No	
	Check this box if you have attached additional po	ages.		

Continued on next page

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 Rule 13.35—Form 11
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6.	In your opinion, is Respondent treatable and would likely benefit from treatment? If yes, state recommendations and basis for recommendations Yes No
	Check this box if you have attached additional pages.
7.	In your opinion, does Respondent have the capacity to understand the need for treatment?
	Check this box if you have attached additional pages.
3.	In your opinion, is Respondent a danger to self or others and lacks judgmental capacity due to a substance-related disorder? Yes No If yes, state basis for answer
	☐ Check this box if you have attached additional pages. Proposed treatment and placement
•	In your opinion, Check one
	A. Respondent does not, as of the date of this Report, require further treatment for substance abuse. Iowa Code § 125.84(1). *Explanation*
	Check this box if you have attached additional pages.
	STOP If you checked 9(A), stop and sign below.

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les.	200	澍
18		9

	B.		Respondent is a person with a substance-related disorder and in need of full-time custody, care, and treatment in a facility and is considered likely to benefit from treatment. Iowa Code § 125.84(2).
			Recommended further treatment:
			Check this box if you have attached additional pages.
	C.		Respondent is a person with a substance-related disorder and in need of treatment but does not require full-time placement in a facility. Iowa Code § 125.84(3).
		(1)	Estimated further length of time Respondent will require treatment on an outpatient or other appropriate basis: Check one
			a. 🗌 Is
			b. Cannot be determined at this time.
		(2)	Recommended further treatment:
			Check this box if you have attached additional pages.
	D.		Respondent is a person with a substance-related disorder and in need of treatment but is not responding to the treatment provided. Iowa Code § 125.84(4).
			Recommended alternative placement:
			Check this box if you have attached additional pages.
10.			facts and reasons supporting your recommended treatment and that the ent is the least restrictive and effective for Respondent:
		Chec	k this box if you have attached additional pages.

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11. Signature

Printed name			Signature*			
Title**			Name of facility			
Mailing address						
City			State	ZIP code		
() Phone number						
Email address			Additional email	l address, if applicable		
Month		, 20 Year	_			

An advanced registered nurse practitioner who is not certified as a psychiatric advanced registered nurse practitioner but who meets the qualifications of a mental health professional may complete this Periodic Report. Iowa Code § 125.86(3)(b).

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^{*}This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.

^{**}A psychiatric advanced registered nurse practitioner treating Respondent may complete this Periodic Report. Iowa Code § 125.86(3)(a).

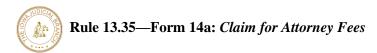
In the l	owa District C		County ounty where Report is filed		
In the Matter of			No		
Respondent Full name: first, middle, last			Report of Respondent's Discharge		
Alleged to be a Po Substance-Relate			Iowa Code § 12:		
		, adm			
Name			Facility		
inform the court the	at Respondent	was disch	arged from this	facility or treatment on	
		_, 20 Year	•		
Month	Day	Year			
Signature					
Printed name			Signature*		
Title			Name of facility	,	
Mailing address					
City			State	ZIP code	
()					
Phone number					
Email address			Additional ema	il address, if applicable	
		_, 20	<u></u>		
Month	Day	Year			
*Tl.:- C l:-	1 -: 41 1:	1: - :4: 1 - :		1.44 ////	

^{*}This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.

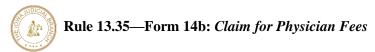


	In the Iowa District Court for	County where Notice is filed
In ·	the Matter of	No
Re	spondent Full name: first, middle, last	Notice of Appeal from Findings of Magistrate or Judicial Hospitalization
	eged to be a Person with a bstance-Related Disorder	Referee
		Iowa Code § 229.21(3)
1.	To: The clerk of the district court for _	County.
		ounty where Notice is filed
3.	disorder, made on $\underline{\qquad}_{Month} \underline{\qquad}_{Day}$ Respondent requests a review of this accordance with lowa Code section 2	matter by a judge of the district court in
4.	Signature	
	Printed name	Signature*
	Date:	20 Year
	Signed by: Check one	
	☐ Respondent	
	☐ Attorney	
	□ Next friend of Respondent	
	☐ Guardian of Respondent	
	*This form may be signed either by using a digitize https://www.jowacourts.gov/for-the-public/court-	

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	In the lowa District Court for $\frac{1}{C}$	ounty this Claim is filed	Co	ounty	
ln 1	the Matter of	No			
Re	spondent Full name: first, middle, last	Claim for A	Attorne	y Fees	
	eged to be a Person with a bstance-Related Disorder			Iowa Code § 125.78(1)	
1.	I, the undersigned attorney, state that the Respondent, alleged to be a person with lowa Code section 125.78(1), and that I Respondent in this matter as set forth in Claim and that I have not directly or indirective any compensation for such services.	h a substance-related have completed reprint the itemized statement in the itemized statement in the itemized or entrices from any source	d disord resenta ent prov tered in es.	ler, pursuant to tion of vided with this to a contract to	
2.	I request an order to be compensated in Code section 125.78(1).	n accordance with the	provisi	ions of Iowa	
3.	Oath and signature				
	I, Print your full name: first, middle, last penalty of perjury and pursuant to the laprovided in this Claim is true and correct	aws of the State of lovet.			
	Month Day Year Claimant's signature				
	Mailing address	City	State	ZIP code	
	() Phone number	Email address			
	Additional email address, if applicable	Attorney PIN number			



	In the low	a District Court for	County where Claim	is filed Co	ounty
In t	the Matter of		No		
Re	spondent Full name:	first, middle, last	Cla	im for Physicia	an Fees
	eged to be a Pers bstance-Related				Iowa Code § 125.80(1)
1.	examined Respo and that services provided with this	d physician, state that indent, alleged to be a s have been completed s Claim and that I have receive any compens	person with a description in a set forth in a set forth in a continuity of the conti	a substance-rela n the itemized s or indirectly rece	ated disorder, statement eived or entered
2.	I request an orde Code section 128	er to be compensated i 5.80(1).	n accordance	with the provis	ions of Iowa
3.	Oath and signature				
	l,	e: first, middle, last	, have read	d this Claim, and	d certify under
		y and pursuant to the li Claim is true and corre		ate of lowa that	the information
		Day, 20, Z10 Claimant			
	Month I	Day Year Claimant	's signature*		
	Mailing address	Email address	City	, State	ZIP code

*This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.