CHAPTER 394

MENTAL HEALTH

PART I FLORIDA MENTAL HEALTH ACT (ss. 394.451–394.4789)

PART II INTERSTATE COMPACT ON MENTAL HEALTH (ss. 394.479–394.484)

PART III CHILDREN'S RESIDENTIAL AND DAY TREATMENT CENTERS (ss. 394.50–394.62)

PART IV COMMUNITY ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH SERVICES (ss. 394.65–394.907)

PART I

FLORIDA MENTAL HEALTH ACT

394.451 Short title.
394.453 Legislative intent; responsibilities of department.
394.455 Definitions.
394.457 Operation and administration.
394.4572 Persons not required to be refingerprinted or rescreened.
394.4573 Continuity of care management system; measures of performance; reports.
394.458 Introduction or removal of certain articles unlawful; penalty.
394.459 Rights of patients.
394.460 Rights of professionals.
394.461 Facilities; transfers of patients.
394.463 Involuntary examination.
394.465 Voluntary admissions.
394.467 Involuntary placement.
394.4672 Procedure for placement of veteran with federal agency.
394.4674 Plan and report.
394.468 Admission and release procedures.
394.469 Discharge of patients.
394.471 Validity of prior involuntary placement orders.
394.473 Attorney's fee; expert witness fee.
394.475 Acceptance, examination, and involuntary placement of Florida residents from out-of-state mental health authorities.
394.477 Residence requirements.
394.478 Autopsy of deceased patient.
394.4781 Residential care for psychotic and emotionally disturbed children.
394.4784 Minors; access to outpatient crisis intervention services and treatment.
394.4785 Minors; admission and placement in mental facilities.
394.4786 Intent.
394.4787 Definitions.
394.4788 Use of certain PMATF funds for the purchase of acute care mental health services.
394.4789 Establishment of referral process and eligibility determination.

394.451 Short title.—This part shall be known as "The Florida Mental Health Act" or "The Baker Act."

History.—s. 1, ch. 71-131.

394.453 Legislative intent; responsibilities of department.—

(1)(a) It is the intent of the Legislature to authorize and direct the Department of Health and Rehabilitative Services to evaluate, research, plan, and recommend to the Governor and the Legislature programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders. The department is directed to implement and administer mental health programs as authorized and approved by the Legislature, based on the annual program budget of the department. It is the further intent of the Legislature that programs of the department coordinate the development, maintenance, and improvement of receiving and community treatment facilities within the programs of the district as authorized by the Community Alcohol, Drug Abuse, and Mental Health Services Act, part IV of this chapter. Treatment programs shall include, but not be limited to, comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment in order to encourage them to assume responsibility for their treatment and recovery. It is intended that patients be provided with emergency service and temporary detention for evaluation when required; that patients be admitted to treatment facilities on a voluntary basis when extended or continuing care is needed and unavailable in the community; that involuntary placement be provided only when expert evaluation determines that it is necessary; that any involuntary treatment or examination be accomplished in a setting which is appropriate, most likely to facilitate proper care and treatment that would return the patient to the community as soon as possible, and the least restrictive of the patient's liberty; and that individual dignity and human rights be guaranteed to all persons admitted to mental health facilities or being detained under s. 394.463. It is further the intent of the Legislature that the least restrictive means of intervention be employed based on the individual needs of each patient within the scope of available services.

(b) It is the intent of the Legislature that all mental health personnel working in public or private mental health programs and facilities who have direct contact with unmarried patients under the age of 18 years shall be of good moral character.

(2) The Department of Health and Rehabilitative Services shall assume the responsibility for designing and distributing appropriate materials for the orientation and training of persons actively engaged in implementing the provisions of this chapter relating to the involuntary placement of persons alleged to be mentally ill. The department is further directed to ensure that no civil patient is admitted to a state treatment facility unless previously evaluated and found to meet the criteria for admission by a community-based public receiving facility or by a community mental health center or clinic in cases in which the public receiving facility is not a community mental health center or clinic. Nothing in this act shall be construed to affect any policies relating to admission to hospital staff.

History.—s. 2, ch. 71-131; s. 198, ch. 77-147; s. 1, ch. 79-298; s. 4, ch. 82-212; s. 2, ch. 84-285; s. 10, ch. 85-54; s. 1, ch. 91-249.

394.455 Definitions.—As used in this part, unless the context clearly requires otherwise, the term:

(1) "Hospital" means a public or private hospital or institution or part thereof licensed by the Agency for Health Care Administration and equipped to provide inpatient care and treatment facilities or any hospital under the supervision of the agency.

(2) With respect to the professionals referred to in this part:

(a) "Clinical psychologist" means a graduate of an accredited institution of higher learning with a doctor's degree in clinical psychology and 3 years of postdoctoral experience in the practice of clinical psychology, including experience prerequisite to licensure, who is licensed as a psychologist pursuant to the provisions of chapter 490.

(b) "Clinical social worker" means an individual who has received a master's degree or a doctor's degree, with a major emphasis in direct patient health care services, through a program of study which includes psychiatric social work, medical social work, social casework, psychotherapy, or group psychotherapy, from a graduate school of social work approved by the Council on Social Work Education, or that meets comparable standards, and who is licensed as a clinical social worker pursuant to the provisions of chapter 491.

(c) "Physician" means a medical practitioner licensed pursuant to chapter 458 or chapter 459 who has experience in the diagnosis and treatment of mental and nervous disorders.

(d) "Psychiatric nurse" means a registered nurse with a master's degree or a doctor's degree in psychiatric nursing and 2 years of post-master's clinical experience under the supervision of a physician.

(e) "Psychiatrist" means a medical practitioner licensed pursuant to chapter 458 or chapter 459 who has primarily diagnosed and treated mental and nervous disorders for a period of not less than 3 years, inclusive of psychiatric residency.

For the purpose of providing services described in this act to patients at facilities operated by the United States Department of Veterans Affairs, which facilities meet the requirements of receiving and treatment facilities, a physician or psychologist employed by the United States Department of Veterans Affairs shall be considered to have met the licensure requirements set forth in this subsection.

(3) "Mentally ill" means an impairment of the emotional processes, of the ability to exercise conscious control of one's actions, or of the ability to perceive reality or to understand, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology; except that, for the purposes of this act, the term does not include retardation or developmental disability as defined in chapter 393, simple intoxication, or conditions manifested only by antisocial behavior or drug addiction.

(4) "Department" means the Department of Health and Rehabilitative Services.

(5) "Secretary" means the secretary of the Department of Health and Rehabilitative Services.

(6) "Facility" means any state-owned or state-operated hospital or state-aided community facility designated by the department to be utilized for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who are mentally ill, and any other hospital within the state approved and designated for such purpose by the department.

(7) "Community facility" means a facility which receives funds from the state under the Community Alcohol, Drug Abuse, and Mental Health Services Act, part IV of this chapter.

(8) "Receiving facility" means a facility designated by the department to receive patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment, and also means a private facility when rendering services to a private patient pursuant to the provisions of this act. However, the term "receiving facility" does not include a county jail.

(9) "Treatment facility" means a state-owned, state-operated, or state-supported hospital, center, or clinic designated by the department for the treatment and hospitalization of persons who are mentally ill, including facilities of the United States Government, and also means a private facility when rendering services to a private patient pursuant to the provisions of this act. Patients treated in facilities of the United States Government shall be solely those whose care is the responsibility of the United States Department of Veterans Affairs.

(10) "Private facility" means any hospital or facility operated by a nonprofit corporation or association or a proprietary hospital approved by the department.

(11) "Patient" means any mentally ill person who seeks treatment under this part or any person for whom such treatment is sought.

(12) "Administrator" means the chief administrative officer of a receiving or treatment facility or his or her designee.

(13) "Staff member" means an employee of a receiving or treatment facility who has been designated as a staff member by the department.

(14) "Law enforcement officer" means any city police officer, officer of the Florida Highway Patrol, sheriff, deputy sheriff, correctional probation officer, or university police officer.

(15) "Guardian" means a natural guardian of a minor or a legal guardian appointed by a court to maintain custody and control of the person or of the property of an

incompetent. "Guardian advocate" is one to whom the court has entrusted the custody and control of the patient's competence to consent to treatment.

(16) "Representative" means a person appointed to receive notice of proceedings for and during hospitalization and to take actions for and on behalf of the patient.

(17) "Court," unless otherwise specified, means the circuit court.

(18) "Clinical record" means all parts of the record required to be maintained and includes all medical records, progress notes, charts, admission and discharge data, and all other information recorded by a facility which pertains to the patient's hospitalization and treatment.

(19) "Express and informed consent" means consent voluntarily given in writing after sufficient explanation and disclosure of the subject matter involved to enable the person whose consent is sought to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

(20) "Mental health personnel" includes all program directors, professional clinicians, staff members, and volunteers working in public or private mental health programs and facilities who have direct contact with unmarried patients under the age of 18 years. Students in the health care professions who are interning in a mental health facility licensed under chapter 395, where the primary purpose of the facility is not the treatment of minors, shall be exempt from the fingerprinting and screening requirements, provided they are under actual physical presence supervision of a licensed health care professional. Mental health personnel working in a facility licensed under chapter 395 who have less than 15 hours per week of direct contact with such patients or who are health care professionals licensed by the Agency for Health Care Administration or a board thereunder are exempt from the fingerprinting and screening requirements, except for those persons in mental health facilities where the primary purpose of the facility is the treatment of minors. A volunteer who assists on an intermittent basis for less than 40 hours per month is not included in the term "personnel" for the purposes of screening, if the volunteer is under direct and constant supervision by persons who meet the screening requirements of s. 394.457(6).

(21) "Screening" means the act of assessing the background of mental health personnel and includes, but is not limited to, employment history checks, local criminal records checks through local law enforcement agencies, fingerprinting for all purposes and checks in this subsection, statewide criminal records checks through the Department of Law Enforcement, and federal criminal records checks through the Federal Bureau of Investigation; except that screening for volunteers included under the definition of personnel includes only local criminal records checks through local law enforcement agencies for current residence and residence immediately prior to employment as a volunteer, if different, and statewide criminal records correspondence checks through the Department of Law Enforcement.

History.—s. 3, ch. 71-131; s. 1, ch. 72-396; s. 1, ch. 73-133; s. 25, ch. 73-334; s. 199, ch. 77-147; s. 2, ch. 79-298; s. 1, ch. 80-398; s. 5, ch. 82-212; s. 46, ch. 83-218; s. 3, ch. 84-285; s. 11, ch. 85-54; s. 11, ch. 86-145; s. 10, ch. 87-238; s. 17, ch. 87-252; s. 41, ch. 89-526; s. 28, ch. 90-306; s. 21, ch. 92-33; s. 65, ch. 93-268; s. 705, ch. 95-148; s. 54, ch. 95-228.

394.457 Operation and administration.—

(1) ADMINISTRATION.—The Department of Health and Rehabilitative Services is designated the "Mental Health Authority" of Florida. The department shall exercise executive and administrative supervision over all mental health facilities, programs, and services.

(2) RESPONSIBILITIES OF THE DEPARTMENT.—The department is responsible for the planning, evaluation, and coordination of a complete and comprehensive statewide program of mental health including community services, receiving and treatment facilities, child services, research, and training. The department is also responsible for the implementation of programs and coordination of efforts with other departments and divisions of the state government, county and municipal governments, and private agencies concerned with and providing mental health services. It is responsible for establishing standards, providing technical assistance, and exercising supervision of mental health programs of, and the treatment of patients at, state-supported community facilities, other facilities for the mentally ill, and any agency or facility providing services to patients pursuant to s. 394.463(2)(c). The department shall provide for the publication and distribution of an information handbook to facilitate understanding of this act, the policies and procedures involved in its implementation, and the responsibilities of the various providers of services under this act. It shall stimulate research by public and private agencies, institutions of higher learning, and hospitals in the interest of the elimination and amelioration of mental illness. The department may contract for residential and nonresidential services to be provided by receiving and treatment facilities and shall promulgate rules to implement any such services.

(3) POWER TO CONTRACT.—The department may contract to provide, and be provided with, services and facilities in order to carry out its responsibilities under this part with the following agencies: public and private hospitals; clinics; laboratories; departments, divisions, and other units of state government; the state colleges and universities; the community colleges; private colleges and universities; counties, municipalities, and any other governmental unit, including facilities of the United States Government; and any other public or private entity which provides or needs facilities or services. Services contracted for by the department may be reimbursed by the state at a rate up to 100 percent. The department shall make periodic audits and inspections to assure that the contracted services are provided and meet the standards of the department.

(4) APPLICATION FOR AND ACCEPTANCE OF GIFTS AND GRANTS.—The department may apply for and accept any funds, grants, gifts, or services made available to it by any agency or department of the Federal Government or any other public or private agency or individual in aid of mental health programs. All such moneys shall be deposited in the State Treasury and shall be disbursed as provided by law.

(5) RULES; PERSONNEL.—

(a) The department shall adopt rules necessary for administration of this part in accordance with the Administrative Procedure Act, chapter 120. No program subject to the provisions of this act shall be operated with-

out rules established to ensure the protection of the health, safety, and welfare of the patients treated through such program.

(b) The department shall, by regulation, establish standards of education and experience for professional and technical personnel employed in mental health programs.

[1](6) SCREENING OF MENTAL HEALTH PERSONNEL.—

(a) The department shall require employment screening pursuant to chapter 435, using the standards for level 1 screening set forth in that chapter.

(b) The department may grant exemptions from disqualification as provided in s. 435.06.

(7) HEARING OFFICERS.—

(a) One or more hearing officers shall be assigned by the Division of Administrative Hearings to conduct hearings for continued involuntary placement.

(b) Hearings on requests for orders authorizing continued involuntary placement filed in accordance with s. 394.467(4) shall be conducted in accordance with the provisions of s. 120.57(1), except that any order entered by the hearing officer shall be final and subject to judicial review in accordance with s. 120.68, except that orders concerning patients committed after successfully pleading not guilty by reason of insanity shall be governed by the provisions of s. 916.16.

(8) PAYMENT FOR CARE OF PATIENTS.—Fees and fee collections for patients in treatment facilities shall be according to s. 402.33.

(9) DESIGNATION OF TREATMENT FACILITIES.—Florida State Hospital located at Chattahoochee, Gadsden County; G. Pierce Wood Memorial Hospital located at Arcadia, DeSoto County; South Florida State Hospital located at Hollywood, Broward County; and Northeast Florida State Hospital located at Macclenny, Baker County; and such other facilities as may be established by law or designated by the department in order to ensure availability of the least restrictive environment, including facilities of the United States Government, if such designation is agreed to by the appropriate governing body or authority, are designated as treatment facilities.

(10) DESIGNATION OF APPROVED PRIVATE PSYCHIATRIC FACILITIES.—Private psychiatric facilities may be approved by the department to provide examination and treatment on an involuntary basis. Such facilities are authorized to act in the same capacity as receiving and treatment facilities and are subject to all the provisions of this part.

History.—s. 1, ch. 57-317; s. 1, ch. 59-222; s. 1, ch. 65-13; s. 3, ch. 65-22; s. 1, ch. 65-145; s. 1, ch. 67-334; ss. 11, 19, 31, 35, ch. 69-106; s. 4, ch. 71-131; s. 70, ch. 72-221; s. 2, ch. 72-396; s. 2, ch. 73-133; s. 25, ch. 73-334; s. 1, ch. 74-233; s. 200, ch. 77-147; s. 19, ch. 78-95; s. 3, ch. 78-332; s. 3, ch. 79-298; s. 6, ch. 82-212; s. 4, ch. 84-285; s. 12, ch. 85-54; s. 11, ch. 87-238; s. 2, ch. 90-225; s. 28, ch. 90-347; s. 7, ch. 91-33; s. 22, ch. 91-57; s. 89, ch. 91-221; s. 2, ch. 91-249; s. 11, ch. 93-156; s. 19, ch. 94-134; s. 19, ch. 94-135; s. 15, ch. 95-152; s. 37, ch. 95-228; s. 124, ch. 95-418.

[1]**Note.**—As amended by s. 37, ch. 95-228. This version is published here as the last expression of legislative will (see Journal of the Senate 1995, pp. 1011 and 1181). Subsection (6) was also amended by s. 15, ch. 95-152, and s. 124, ch. 95-418; and that version reads:

(6) SCREENING OF MENTAL HEALTH PERSONNEL.—

(a) The department shall establish minimum standards as to good moral character, based on screening, for mental health personnel. Such minimum standards for screening shall ensure that no mental health personnel have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

1. Section 782.04, relating to murder.
2. Section 782.07, relating to manslaughter.
3. Section 782.071, relating to vehicular homicide.
4. Section 782.09, relating to killing of an unborn child by injury to the mother.
5. Section 784.021, relating to aggravated assault.
6. Section 784.045, relating to aggravated battery.
7. Section 787.01, relating to kidnapping.
8. Section 787.02, relating to false imprisonment.
9. Section 787.04, relating to removing minors from the state or concealing minors contrary to court order.
10. Section 794.011, relating to sexual battery.
11. Chapter 796, relating to prostitution.
12. Section 798.02, relating to lewd and lascivious behavior.
13. Chapter 800, relating to lewdness and indecent exposure.
14. Section 806.01, relating to arson.
15. Section 812.13, relating to robbery.
16. Section 825.102, relating to abuse or neglect of a disabled adult or an elderly person.
17. Section 825.103, relating to exploitation of a disabled adult or an elderly person.
18. Section 826.04, relating to incest.
19. Section 827.03, relating to aggravated child abuse.
20. Section 827.04, relating to child abuse.
21. Section 827.05, relating to negligent treatment of children.
22. Section 827.071, relating to sexual performance by a child.
23. Chapter 847, relating to obscene literature.
24. Section 784.011, relating to assault, if the victim of the offense was a minor.
25. Section 784.03, relating to battery, if the victim of the offense was a minor.
26. Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.
27. Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

For the purposes of this subsection, a finding of delinquency or a plea of nolo contendere or other plea amounting to an admission of guilt to a petition alleging delinquency pursuant to part II, chapter 39, or similar statutes of another jurisdiction, for any of the foregoing acts has the same effect as a finding of guilt, regardless of adjudication or disposition.

(b) Standards for screening shall also ensure that the person:

1. Has not been judicially determined to have committed abuse or neglect against a child as defined in s. 39.01(2) and (47); or
2. Does not have a confirmed report of abuse, neglect, or exploitation as defined in s. 415.102(6) or abuse or neglect as defined in [2]s. 415.503(6) which has been uncontested or upheld pursuant to the procedures of s. 415.1075 or [3]s. 415.504;
3. Does not have a proposed confirmed report that remains unserved and is maintained in the central abuse registry and tracking system pursuant to s. 415.1065(2)(c); or
4. Has not committed an act that constitutes domestic violence as defined in s. 741.28.

(c)1. For the following, the department may grant to any person an exemption from disqualification from working with children or the developmentally disabled:

a. Felonies, other than specified felonies, prohibited under any of the foregoing Florida Statutes cited in paragraph (a) or under similar statutes of other jurisdictions, committed more than 3 years previously. For the purposes of this subsubparagraph, "specified felony" means those felonies in the Florida Statutes enumerated in subparagraphs (a)1., 2., 4., 10., 11., 13., 16., 17., 18., 19., 20., 22., 23., 26., and 27., or under any similar statute of another jurisdiction;

b. Misdemeanors prohibited under any of the foregoing Florida Statutes cited in this subsection or under similar statutes of other jurisdictions;

c. Offenses which were a felony when committed but are now a misdemeanor;

d. Findings of delinquency as specified in this subsection;

e. Judicial determinations of abuse or neglect under chapter 39;

f. Confirmed reports of abuse, neglect, or exploitation under chapter 415 which have been uncontested or have been upheld pursuant to the procedures provided in s. 415.1075 or [3]s. 415.504; or

g. Commissions of domestic violence.

2. In order to grant an exemption to a person, the department must have clear and convincing evidence to support a reasonable belief that the person is of good character so as to justify an exemption. The person shall bear the burden of setting forth sufficient evidence of rehabilitation, including, but not limited to, the circumstances surrounding the incident, the time period that has elapsed since the incident, the nature of the harm occasioned to the victim, and the history of the person since the incident or such other circumstances that shall by the aforementioned standards indicate that the person will not present a danger to the safety or well-being of children. The decision of the department regarding an exemption may be contested through a hearing under chapter 120.

(d) The disqualification from employment provided in paragraph (a) shall not be removed from any person found guilty of, regardless of adjudication, or having entered a plea of nolo contendere or guilty to, any felony covered by paragraph (a) solely by reason of any pardon, executive clemency, or restoration of civil rights.

(e) The department shall ensure that mental health personnel meet the minimum standards for good moral character as contained in this section.

1. Each private or public mental health program and facility shall submit to the department a list of mental health personnel for whom a written assurance of compliance was provided by the department and identifying those mental health personnel who have worked on a continuous basis at the program or facility since submitting fingerprints to the department, identifying those mental health personnel who have recently begun working at the program or facility and are awaiting the results of the required fingerprint check along with the date of the submission of those fingerprints for processing. The department shall by rule determine the frequency with which programs and facilities shall submit such lists of mental health personnel and the frequency of requests to the Department of Law Enforcement to run state criminal records checks for such mental health personnel except for those mental health personnel awaiting the results of initial fingerprint checks for employment at the program or facility. The department shall review the records of the mental health personnel at the program or facility with respect to the crimes contained in this section and shall notify the program or facility of its findings. When disposition information is missing on a criminal record, it shall be the responsibility of the person being screened, upon request of the department, to obtain and supply within 30 days the missing disposition information to the department. Failure to supply missing information within 30 days or to show reasonable efforts to obtain such information shall result in automatic disqualification.

2. The program director of each public or private mental health program and facility shall sign an affidavit annually, under penalty of perjury, stating that all new mental health personnel have been fingerprinted and that the program's or facility's remaining mental health personnel either have worked at the program or facility on a continuous basis since being initially screened at that program or facility or have a written assurance of compliance from the department.

(f) As a prerequisite to operating a new public or private mental health program or facility:

1. The owner or program director shall submit to the department a complete set of fingerprints, taken by an authorized law enforcement agency or an employee of the department who is trained to take fingerprints, for the program director of the program or facility;

2. The department shall submit the fingerprints to the Department of Law Enforcement for state processing and for federal processing by the Federal Bureau of Investigation; and

3. The department shall review the record of the program director with respect to the crimes contained in this section and shall notify the owner or program director of its findings. When disposition information is missing on a criminal record, it shall be the responsibility of the program director, upon request of the department, to obtain and supply within 30 days the missing disposition information to the department. Failure to supply missing information within 30 days or to show reasonable efforts to obtain such information shall result in automatic disqualification.

(g) The public or private mental health program or facility shall automatically terminate the employment of any of its mental health personnel found to be in noncompliance with the minimum standards for good moral character as contained in this section.

(h) Mental health personnel shall, within 5 working days after starting to work at a public or private mental health program or facility, submit to the program or facility for submission, within 48 hours, to the department a complete set of fingerprints taken by an authorized law enforcement agency or an employee of the department who is trained to take fingerprints. The department shall submit the fingerprints to the Department of Law Enforcement for state processing and for federal processing by the Federal Bureau of Investigation. The department shall review the record of the person being screened with respect to the crimes contained in this section and shall notify the program or facility of its findings. When disposition information is missing on a criminal record, it shall be the responsibility of the person being screened, upon request of the department, to obtain and supply within 30 days the missing disposition information to the department. Failure to supply missing information within 30 days or to show reasonable efforts to obtain such information shall result in automatic disqualification.

1. Under the penalty of perjury, such mental health personnel shall attest to compliance with the minimum standards for good moral character as contained in this section.

2. New mental health personnel shall be on probationary status pending a determination of compliance with minimum standards for good moral character.

3. The department, upon request of a program or facility, shall provide written assurance of compliance with this section for new mental health personnel who have been fingerprinted and screened for the program or facility at which they previously worked. However, if the person has been unemployed for more than 60 days, screening shall be required.

(i) The costs of processing fingerprints and the state criminal records checks shall be borne by the program or facility or the mental health personnel being screened.

(j) When the department has reasonable cause to believe that grounds for denial or termination of employment exist, it shall notify, in writing, the program or facility and the mental health personnel affected, stating the specific record which indicates noncompliance with the standards in this section. The procedures established for hearing under chapter 120 shall be available to the program or facility and the mental health personnel affected in order to present evidence relating either to the accuracy of the basis of exclusion or to the denial of an exemption from disqualification.

(k) The department or a mental health program or facility may not use the criminal records, juvenile records, or abuse registry information of a person obtained under this subsection for any purpose other than determining if that person meets the minimum standards for good moral character for mental health personnel. The criminal records, juvenile records, or abuse registry information obtained by the department or a mental health program or facility for determining the moral character of mental health personnel are exempt from s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with [4]s. 119.14.

(l) It is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, for any person willfully, knowingly, or intentionally to:

1. Fail, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose in any application for voluntary or paid employment a material fact used in making a determination as to such person's qualifications to be a program director, staff member, or volunteer in a public or private mental health program or facility;

2. Operate or attempt to operate a public or private mental health program or facility with mental health personnel who are in noncompliance with the minimum standards for good moral character as contained in this section; or

3. Use information from the criminal records or central abuse registry obtained under this section for any purpose other than screening that person for employment as specified in this section or release such information to any other person for any purpose other than screening for employment as specified in this section.

(m) It is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, for any person willfully, knowingly, or intentionally to use information from the juvenile records of a person obtained under this section for any purpose other than screening for employment as specified in this section or to release information from such records to any other person for any purpose other than screening for employment as specified in this section.

[2]**Note.**—Repealed by s. 43, ch. 95-228.

[3]**Note.**—As amended by s. 44, ch. 95-228, s. 415.504 does not provide procedures for contesting a report.

[4]**Note.**—

A. Repealed by s. 1, ch. 95-217.

B. Section 4, ch. 95-217, provides that "[n]otwithstanding any provision of law to the contrary, exemptions from chapter 119, Florida Statutes, or chapter 286, Florida Statutes, which are prescribed by law and are specifically made subject to the Open Government Sunset Review Act in accordance with section 119.14, Florida Statutes, are not subject to review under that act, and are not abrogated by the operation of that act, after October 1, 1995."

Note.—Former s. 965.01(3), s. 402.10.

[1]394.4572 Persons not required to be refingerprinted or rescreened.—Any provision of law to the contrary notwithstanding, human resource personnel who have been fingerprinted or screened pursuant to chapters 393, 394, 397, 402, and 409, and teachers who have been fingerprinted pursuant to chapter 231, who have not been unemployed for more than 90 days thereafter, and who under the penalty of perjury attest to the completion of such fingerprinting or screening and to compliance with the provisions of this section and the standards for good moral character as contained in such provisions as ss. 110.1127(3), 393.0655(1), 394.457(6), 397.451, [2]402.305(1), and 409.175(4), shall not be required to be refingerprinted or rescreened in order to comply with any caretaker screening or fingerprinting requirements.

History.—s. 1, ch. 87-128; s. 1, ch. 87-141; s. 23, ch. 93-39.

[1]**Note.**—Also published at s. 409.1757.

[2]**Note.**—Redesignated as s. 402.305(2) by s. 2, ch. 91-300.

394.4573 Continuity of care management system; measures of performance; reports.—

(1) For the purposes of this section:

(a) "Case management" means those activities aimed at assessing client needs, planning services, linking the service system to a client, coordinating the various system components, monitoring service delivery, and evaluating the effect of service delivery.

(b) "Case manager" means an individual who works with clients, and their families and significant others, to provide case management.

(c) "Client manager" means an employee of the department who is assigned to specific provider agencies and geographic areas to ensure that the full range of needed services is available to clients.

(d) "Continuity of care management system" means a system that assures, within available resources, that clients have access to the full array of services within the mental health services delivery system.

(2) The Department of Health and Rehabilitative Services is directed to implement a continuity of care management system for the provision of continuity of mental health care, through the provision of client and case management, including clients referred from state treatment facilities to community mental health facilities. Such system shall include a network of client managers and case managers throughout the state designed to:

(a) Reduce the possibility of a client's admission or readmission to a state treatment facility.

(b) Provide for the creation or designation of an agency in each county to provide single intake services for each person seeking mental health services. Such agency shall provide information and referral services necessary to ensure that clients receive the most appropriate and least restrictive form of care, based on the individual needs of the person seeking treatment. Such agency shall have a single telephone number, manned 24 hours per day, 7 days per week, where practical, at

a central location, where each client will have a central record.

(c) Advocate on behalf of the client to ensure that all appropriate services are afforded to the client in a timely and dignified manner.

(3) The department is directed to develop and include in contracts with service providers measures of performance with regard to goals and objectives as specified in the state plan. Such measures shall use, to the extent practical, existing data collection methods and reports and shall not require, as a result of this subsection, additional reports on the part of service providers. The department shall plan monitoring visits of community mental health facilities with other state, federal, and local governmental and private agencies charged with monitoring such facilities.

(4) The department is directed to submit a report to the Legislature, prior to April 1 of each year, outlining departmental progress towards the implementation of the minimum staffing patterns' standards in state mental health treatment facilities. The report shall contain, by treatment facility, information regarding goals and objectives and departmental performance toward meeting each such goal and objective.

History.—ss. 3, 4, 5, ch. 80-384; s. 5, ch. 84-285; s. 1, ch. 89-211.

394.458 Introduction or removal of certain articles unlawful; penalty.—

(1)(a) Except as authorized by law or as specifically authorized by the person in charge of each hospital, it is unlawful to introduce into or upon the grounds of any mental health hospital under the supervision or control of the Department of Health and Rehabilitative Services, or to take or attempt to take or send therefrom, any of the following articles, which are hereby declared to be contraband for the purposes of this section:

1. Any intoxicating beverage or beverage which causes or may cause an intoxicating effect;
2. Any controlled substance as defined in chapter 893; or
3. Any firearms or deadly weapon.

(b) It is unlawful to transmit to, or attempt to transmit to, or cause or attempt to cause to be transmitted to, or received by, any patient of any hospital any article or thing declared by this section to be contraband, at any place which is outside of the grounds of such hospital, except as authorized by law or as specifically authorized by the person in charge of such hospital.

(2) Whoever violates any provision of this section is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

History.—s. 1, ch. 75-253; s. 201, ch. 77-147; s. 1, ch. 77-174.

394.459 Rights of patients.—

(1) RIGHT TO INDIVIDUAL DIGNITY.—The policy of the state is that the individual dignity of the patient shall be respected at all times and upon all occasions, including any occasion when the patient is taken into custody, detained, or transported. Procedures, facilities, vehicles, and restraining devices utilized for criminals or those accused of crime shall not be used in connection with the noncriminal mentally ill except for the protection of the patient or others. The noncriminal mentally ill shall not be detained or incarcerated in the jails of this state. No person who is receiving treatment for mental illness in a facility shall be deprived of any constitutional rights. However, if such a person is adjudicated incompetent pursuant to the provisions of chapter 744, his or her rights may be limited to the same extent the rights of any incompetent person are limited by general law.

(2) RIGHT TO TREATMENT.—

(a) The policy of the state is that the department shall not deny treatment for mental illness to any person, and that no services shall be delayed at a receiving or treatment facility because of inability to pay. However, every reasonable effort to collect appropriate reimbursement for the cost of providing mental health services to persons able to pay for services, including insurance or third-party payments, shall be made by facilities providing services pursuant to this act.

(b) It is further the policy of the state that the least restrictive appropriate available treatment be utilized based on the individual needs and best interests of the patient and consistent with optimum improvement of the patient's condition.

(c) Each person who is admitted to a receiving or treatment facility, and each person who remains at a facility for a period in excess of 12 hours, shall be given a physical examination by a health practitioner authorized by law to give such examinations within 24 hours after arrival at any such facility.

(d) Every patient in a treatment facility shall be afforded the opportunity to participate in activities designed to enhance self-image and the beneficial effects of other treatments, as determined by the facility.

(e) Not more than 5 days after admission to a treatment facility, each patient shall have and receive an individualized treatment plan in writing which the patient has had an opportunity to assist in preparing and to review prior to its implementation.

(3) RIGHT TO EXPRESS AND INFORMED PATIENT CONSENT.—

(a) Each patient entering a facility shall be asked to give express and informed consent for admission and treatment. If the patient is under 18 years of age, express and informed consent for admission and treatment shall also be requested from the guardian. Express and informed consent for admission and treatment from a guardian of a patient under 18 years of age shall be required except pursuant to the provisions of s. 394.4784. Express and informed consent for admission and treatment given by a patient who is under 18 years of age shall not be a condition of admission when the guardian of the patient gives express and informed consent for the patient's admission pursuant to s. 394.463 or s. 394.467. Prior to giving express and informed consent, the following information shall be disclosed to the patient, or the guardian of the patient if the patient is incompetent, and to both the patient and the guardian if the patient is under 18 years of age: the reason for admission, the purpose of the treatment to be provided, the common side effects thereof, alternative treatment modalities, the approximate length of care, and that any consent given by a patient may be revoked orally or in writing prior to or during the treatment period by the patient or the guardian. If a voluntary patient refuses to

consent to or revokes consent for treatment, such patient shall be discharged within 3 days or, in the event the patient meets the criteria for involuntary placement, such proceedings shall be instituted within 3 days. If any patient refuses treatment and is not discharged as a result, emergency treatment may be rendered such patient in the least restrictive manner, upon the written order of a physician when it is determined that such treatment is necessary for the safety of the patient or others. If any patient refuses to consent to treatment or revokes consent previously provided and the treatment not consented to is essential to appropriate care for the patient, then the administrator shall immediately petition the court for a hearing to determine the competency of the patient to consent to treatment. A patient is incompetent to consent to treatment if the patient's judgment is so affected by his or her mental illness that he or she lacks the capacity to make a well-reasoned, willful, and knowing decision concerning treatment. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate. A guardian advocate appointed pursuant to the provisions of this act shall meet the qualifications of a guardian contained in part IV of chapter 744, except that no professional referred to in this act, department employee, or facility administrator shall be appointed.

(b) In addition to the provisions of paragraph (a), in the case of surgical procedures requiring the use of a general anesthetic or electroconvulsive treatment, and prior to performing the procedure, written permission shall be obtained from the patient, if he or she is legally competent, from the parent or guardian of a minor patient, or from the guardian of an incompetent patient. The facility administrator or his or her designated representative may, with the concurrence of the patient's attending physician, authorize emergency surgical treatment if such treatment is deemed lifesaving and permission of the patient and his or her guardian or representative cannot be obtained.

(c) When the department is the legal guardian or representative of a patient, or is the custodian of a patient whose physician is unwilling to perform surgery based solely on the patient's consent and whose parent or legal guardian is unknown or unlocatable, a court of competent jurisdiction shall hold a hearing to determine the appropriateness of the surgical procedure. The patient shall be physically present, unless the patient's medical condition precludes such presence, represented by counsel, and provided the right and opportunity to be confronted with, and to cross-examine, all witnesses alleging the appropriateness of such procedure. In such proceedings, the burden of proof by clear and convincing evidence shall be on the party alleging the appropriateness of such procedure.

(4) QUALITY OF TREATMENT.—Each patient in a facility shall receive treatment suited to his or her needs, which shall be administered skillfully, safely, and humanely with full respect for the patient's dignity and personal integrity. Each patient shall receive such medical, vocational, social, educational, and rehabilitative services as his or her condition requires to bring about an early return to his or her community. In order to achieve this goal, the department is directed to coordinate its mental health programs with all other programs of the department and other appropriate state agencies.

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS.—

(a) Each patient in a facility pursuant to the provisions of this part has the right to communicate freely and privately with persons outside the facility unless it is determined that such communication is likely to be harmful to the patient or others.

(b) Each patient hospitalized under the provisions of this part shall be allowed to receive, send, and mail sealed, unopened correspondence; and no patient's incoming or outgoing correspondence shall be opened, delayed, held, or censored by the facility unless there is reason to believe that it contains items or substances which may be harmful to the patient or others, in which case the administrator may direct reasonable examination of such mail and may regulate the disposition of such items or substances.

(c) If a patient's right to communicate is restricted by the administrator, written notice of such restriction shall be served on the patient and his or her guardian or representatives; and such restriction shall be recorded on the patient's clinical record with the reasons therefor. The restriction of a patient's right to communicate shall be reviewed at least every 90 days.

(d) Each facility shall establish reasonable rules governing visitors, visiting hours, and the use of telephones by patients in the least restrictive possible manner.

(e) Each patient receiving mental health treatment in any facility shall have ready access to a telephone in order to report an alleged abuse. The facility staff shall verbally and in writing inform each patient of the procedure for reporting abuse. A written copy of that procedure, including the telephone number of the abuse registry and reporting forms, shall be posted in plain view.

(f) The department shall adopt rules providing a procedure for reporting abuse. Facility staff shall be required, as a condition of employment, to become familiar with the procedures for the reporting of abuse.

(6) CARE AND CUSTODY OF PERSONAL EFFECTS OF PATIENTS.—A patient's right to his or her clothing and personal effects shall be respected. The administrator may take temporary custody of such effects when required for medical and safety reasons. Custody of such personal effects shall be recorded in the patient's clinical record.

(7) VOTING IN PUBLIC ELECTIONS.—A patient in a facility who is eligible to vote according to the laws of the state has the right to vote in the primary and general elections. The department shall establish rules and regulations to enable patients to obtain voter registration forms, applications for absentee ballots, and absentee ballots.

(8) EDUCATION OF CHILDREN.—The department shall provide education and training appropriate to the needs of all children in treatment facilities. Efforts shall be made to provide this education and training in the least restrictive setting available.

(9) CLINICAL RECORD; CONFIDENTIALITY.—A clinical record for each patient shall be maintained. The record shall include data pertaining to admission and such other information as may be required under rules

of the department. A clinical record is confidential and exempt from the provisions of s. 119.07(1). Unless waived by express and informed consent by the patient or the patient's guardian or, if the patient is deceased, by the patient's personal representative or by that family member who stands next in line of intestate succession, the confidential status of the clinical record shall not be lost by either authorized or unauthorized disclosure to any person, organization, or agency. No part of the clinical record shall be released, except:

(a) The record may be released to such persons and agencies as designated by the patient or the patient's guardian. A medical discharge summary of the clinical record of any patient committed to, or to be returned to, the Department of Corrections from the Department of Health and Rehabilitative Services shall be released to the Department of Corrections without charge upon its request. The Department of Corrections shall treat such information as confidential and shall not release such information except as provided in this section.

(b) The record shall be released to persons authorized by order of court, excluding matters privileged by other provisions of law. In determining whether there is good cause for disclosure, the court shall weigh the need for the information to be disclosed against the possible harm of disclosure to the person to whom such information pertains.

(c) The record or any part thereof may be disclosed to a qualified researcher, a staff member of the facility, or an employee of the department when the administrator of the facility or secretary of the department deems it necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, or evaluation of programs.

(d) Information from the clinical records may be used for statistical and research purposes if the information is abstracted in such a way as to protect the identity of individuals.

(e) Whenever a patient has declared an intention to harm other persons, such declaration may be disclosed.

(f) Any law enforcement agency, treatment facility, or other governmental agency that receives information pursuant to this subsection shall maintain such information as confidential and exempt from the provisions of s. 119.07(1) as provided herein.

(g) Any agency or private mental health practitioner who acts in good faith in releasing information pursuant to this subsection is not subject to civil or criminal liability for such release.

(h) Nothing in this subsection is intended to prohibit the parent of a mentally ill person who is hospitalized in, or is being treated by, a mental health facility or program from requesting and receiving information limited to that person's treatment plan and current physical and mental condition. Release of such information shall be in accordance with the code of ethics of the profession involved.

The exemptions contained in this subsection are subject to the Open Government Sunset Review Act in accordance with [1]s. 119.14.

(10) HABEAS CORPUS.—

(a) At any time, and without notice, a person detained by a facility, or a relative, friend, guardian, representative, or attorney on behalf of such person, may petition for a writ of habeas corpus to question the cause and legality of such detention and request that the circuit court issue a writ for release. Each patient admitted to a facility for involuntary placement shall receive a written notice of the right to petition for a writ of habeas corpus.

(b) A patient or his or her guardian or representatives may file a petition in the circuit court in the county where the patient is hospitalized alleging that the patient is being unjustly denied a right or privilege granted herein or that a procedure authorized herein is being abused. Upon the filing of such a petition, the circuit court shall have the authority to conduct a judicial inquiry and to issue any appropriate order to correct an abuse of the provisions of this part.

(11) TRANSPORTATION.—

(a) If neither the patient nor any person legally obligated or responsible for the patient is able to pay for the expense of transporting the patient to a treatment facility, the governing board of the county from which the patient is hospitalized shall arrange for such required transportation and, pursuant thereto, shall ensure the safe and dignified transportation of any such patient. County law enforcement and correctional personnel and equipment and municipal law enforcement and correctional personnel and equipment shall not be used to transport patients adjudicated mentally incompetent or found by the court to meet the criteria for involuntary placement pursuant to s. 394.467(1), except in small rural counties where there are no cost-efficient alternatives.

(b) The governing board of each county is authorized to contract with private transport companies for the transportation of such patients to and from a treatment facility.

(c) Any company that transports a patient pursuant to this section is considered an independent contractor and is solely liable for the safe and dignified transportation of the patient. Any transport company that contracts with a governing board of a county for the transport of patients as provided for in this section must be insured and provide no less than $100,000 in liability insurance with respect to the transportation of the patients.

(d) Any company that contracts with a governing board of a county to transport patients shall comply with the applicable rules of the department to ensure the safety and dignity of the patients.

(12) DESIGNATION OF REPRESENTATIVES; NOTICE OF ADMISSION.—

(a) At the time a patient is admitted to a facility for an involuntary examination or treatment, or when a petition for involuntary placement is filed with respect to a patient who has been voluntarily admitted to a facility, the names and addresses of two representatives or one guardian shall be entered in the patient's clinical record.

1. A treatment facility shall give written notice of such patient's admission or petition filing to his or her guardian or representatives.

2. A receiving facility shall give notice of admission to the patient's guardian or representatives by telephone or in person within 24 hours.

(b) If the patient has no guardian, he or she may designate one representative; the second representative, or both in the absence of designation of one representative by the patient, shall be selected by the facility. The first representative selected by the facility shall be made from the following in the order of listing:

1. The patient's spouse;
2. An adult child;
3. Parent;
4. Adult next of kin;
5. Adult friend;
6. Appropriate human rights advocacy committee; or
7. The department.

The second representative selected by the facility shall be without regard to the order of listing, except that the department shall only be selected as the representative of last resort in cases where the patient is receiving service in a state-operated facility. If the facility can locate only one person from the categories listed above, it shall only be required to select one representative.

(c) The patient shall be consulted with regard to the appointment of a representative and have authority to request that an appointed representative be replaced.

(d) Unless otherwise provided, notice to the patient's guardian or representatives shall be served by registered or certified mail or receipted hand delivery, and the date on which such notice was mailed shall be entered on the patient's clinical record.

(e) At the time a patient is voluntarily admitted to a facility, the identity and contact information of a person to be notified in case of emergency shall be entered in the patient's clinical record. No notice of a voluntary patient's admission shall be given to any person except in case of emergency as determined by the facility.

(13) LIABILITY FOR VIOLATIONS.—Any person who violates or abuses any rights or privileges of patients provided by this act is liable for damages as determined by law. Any person who acts in good faith in compliance with the provisions of this part is immune from civil or criminal liability for his or her actions in connection with the admission, diagnosis, treatment, or discharge of a patient to or from a facility. However, this section does not relieve any person from liability if such person is guilty of negligence.

(14) RIGHT TO PARTICIPATE IN TREATMENT AND DISCHARGE PLANNING.—The patient shall be provided the opportunity to participate in treatment and discharge planning and shall be notified in writing of his or her right, upon release or discharge from the facility, to seek treatment from the professional or agency of the patient's choice.

History.—s. 5, ch. 71-131; s. 3, ch. 73-133; s. 25, ch. 73-334; s. 2, ch. 74-233; s. 202, ch. 77-147; s. 1, ch. 78-434; s. 12, ch. 79-3; s. 4, ch. 79-298; s. 10, ch. 79-320; s. 1, ch. 80-171; s. 7, ch. 82-212; s. 6, ch. 84-285; s. 27, ch. 85-167; s. 1, ch. 88-307; s. 16, ch. 88-398; s. 11, ch. 90-347; s. 1, ch. 91-170; s. 71, ch. 95-143; s. 706, ch. 95-148.

[1]**Note.**—

A. Repealed by s. 1, ch. 95-217.

B. Section 4, ch. 95-217, provides that "[n]otwithstanding any provision of law to the contrary, exemptions from chapter 119, Florida Statutes, or chapter 286, Florida Statutes, which are prescribed by law and are specifically made subject to the Open Government Sunset Review Act in accordance with section 119.14, Florida Statutes, are not subject to review under that act, and are not abrogated by the operation of that act, after October 1, 1995."

394.460 Rights of professionals.—No professional referred to in this act shall be required to accept patients for treatment of mental, emotional, or behavioral disorders. Such participation shall be voluntary.

History.—s. 4, ch. 73-133; s. 5, ch. 79-298; s. 8, ch. 82-212.

394.461 Facilities; transfers of patients.—

(1) RECEIVING FACILITY.—The Department of Health and Rehabilitative Services may designate any community facility as a receiving facility to provide examination and emergency, short-term treatment. The governing board of any county is authorized to contract with the department to set aside an area of any facility of the department to function, and be designated, as the receiving facility. Any other facility within the state, including a federal facility, may be so designated by the department at the request of and with the consent of the governing officers of the facility.

(2) TREATMENT FACILITY.—Any state-owned, state-operated, or state-supported facility may be designated by the department as a treatment facility. Any other facility, including a federal facility, may be so designated by the department at the request of, or with the consent of, its governing officers.

(3) TRANSFERS OF PATIENTS.—

(a) Any patient who has been admitted to a treatment or receiving facility on a voluntary basis and is able to pay for treatment in a private facility may apply to the department for transfer at his or her expense to such private facility. A patient may apply to the department for transfer from a private facility to a public facility. An involuntary patient may be transferred at the discretion of the department or upon application by the patient or the guardian of the patient.

(b) When the medical needs of the patient or efficient utilization of the facilities of the department require, a patient may be transferred from one facility of the department to another or, with the express and informed consent of the patient and his or her guardian or representatives, to a facility in another state.

(c) When any patient is to be transferred, notice shall be given to his or her guardian or representatives prior to the transfer.

(4) CRIMINALLY CHARGED OR CONVICTED MENTALLY ILL PERSONS.—

(a) No receiving facility shall be required to accept for examination and treatment any person with pending felony charges involving a crime of violence against another person.

(b) When law enforcement custody for a mentally ill person is based on either noncriminal behavior or minor criminal behavior, the law enforcement authority shall transport the person to a receiving facility for evaluation. When a law enforcement officer has arrested a person for a felony involving a crime of violence against another person, such person should be processed in the same manner as any other criminal suspect, notwithstanding the fact that the arresting officer has reasonable grounds for believing that the person's behavior meets statutory guidelines for involuntary examination pursu-

ant to s. 394.463. When a law enforcement officer has arrested a person for a felony involving a crime of violence against another person and it appears that the person meets the statutory guidelines for involuntary examination or involuntary placement, the law enforcement agency shall immediately notify the designated receiving facility, which facility shall be responsible for promptly arranging for evaluation and treatment of the patient. The law enforcement agency shall subsequently notify the receiving facility in writing. The costs of evaluation and treatment incurred under this subsection may be recovered as provided in s. 901.35.

History.—s. 6, ch. 71-131; s. 3, ch. 72-396; s. 5, ch. 73-133; s. 1, ch. 77-90; s. 203, ch. 77-147; s. 6, ch. 79-298; ss. 1, 2, ch. 80-384; s. 9, ch. 82-212; s. 7, ch. 84-285; s. 42, ch. 85-167; s. 707, ch. 95-148.

394.463 Involuntary examination.—

(1) CRITERIA.—A person may be taken to a receiving facility for involuntary examination if there is reason to believe that he or she is mentally ill and because of his or her mental illness:

(a)1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or

2. The person is unable to determine for himself or herself whether examination is necessary; and

(b)1. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or

2. There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

(2) INVOLUNTARY EXAMINATION.—

(a) *Initiation of involuntary examination.*—An involuntary examination may be initiated by any one of the following means:

1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to the nearest receiving facility for involuntary examination. The order of the court shall be made a part of the patient's clinical record.

2. A law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to the nearest receiving facility for examination. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, and the report shall be made a part of the patient's clinical record.

3. A physician, psychologist licensed pursuant to chapter 490, psychiatric nurse, or clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer shall take the person named in the certificate into custody and deliver him or her to the nearest available receiving facility for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate shall be made a part of the patient's clinical record.

(b) *Transportation for involuntary examination.*—Each county shall designate a single law enforcement agency within the county, or portions thereof, which shall take a person into custody upon the entry of an ex parte order or the execution of a certificate by an authorized professional and which shall transport that person to the nearest receiving facility for examination. If the law enforcement officer believes that the person is suffering from an emergency medical condition as defined in s. 395.002, the person may be transported to a hospital for emergency medical treatment regardless of whether the hospital is a receiving facility designated under this chapter. The law enforcement agency designated for the area in which the person in need of transport for involuntary examination is situated may thereafter decline to transport the person to a receiving facility only if:

1. The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service for transportation of persons to receiving facilities pursuant to this section at the sole cost of the county; and

2. The law enforcement agency and transport service agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.

(c) *Examination.*—A patient who is provided an examination at a receiving facility shall be examined by a physician or clinical psychologist without unnecessary delay and may be given emergency treatment pursuant to s. 394.459(3)(a). The least restrictive form of treatment shall be made available when determined to be necessary by a facility physician or clinical psychologist. Any person for whom involuntary examination has been initiated pursuant to paragraph (a) shall not be released by the receiving facility or its contractor without the documented approval of a person who is qualified under the provisions of this chapter to initiate an involuntary examination. However, a patient may be detained at a receiving facility for involuntary examination no longer than 72 hours. A person who is being involuntarily examined under paragraph (a) and is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or

2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

(d) *Disposition upon examination.*—Within the examination period, one of the following actions shall be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is under criminal charges, in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released, subject to the provisions of subparagraph 1., for outpatient treatment;
3. The patient shall be asked to give express and informed consent to placement as a voluntary patient; or
4. A petition for involuntary placement shall be executed by the facility administrator when treatment is deemed necessary; in which case, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available.

(3) NOTICE OF RELEASE.—Notice of the release shall be given to the patient's guardian or representative, to any person who executed a certificate admitting the patient to the receiving facility, and to any court which ordered the patient's evaluation.

History.—s. 7, ch. 71-131; s. 6, ch. 73-133; s. 204, ch. 77-147; s. 7, ch. 79-298; s. 10, ch. 82-212; s. 8, ch. 84-285; s. 59, ch. 91-221; s. 3, ch. 91-249; s. 69, ch. 92-289; s. 708, ch. 95-148.

394.465 Voluntary admissions.—

(1) AUTHORITY TO RECEIVE PATIENTS.—

(a) A facility may receive for observation, diagnosis, or treatment any individual 18 years of age or older making application by express and informed consent for admission or any individual age 17 or under for whom such application is made by his or her parent or guardian pursuant to s. 394.467. If found to show evidence of mental illness and to be suitable for treatment, such person 18 years of age or older may be admitted to the facility.

(b) A facility may admit for evaluation, diagnosis, or treatment any individual who makes application by express and informed consent therefor; however, any individual age 17 or under may be admitted only after a hearing to verify the voluntariness of the consent. If such individual is under 18 years of age, his or her parent or guardian may apply for the individual's discharge, and the administrator shall release the patient within 3 days of such application for discharge.

(2) RIGHT OF VOLUNTARY PATIENTS TO DISCHARGE.—

(a) A facility shall discharge a voluntary patient who has sufficiently improved so that retention in the facility is no longer desirable. A patient may also be discharged to the care of a community facility. A voluntary patient or his or her guardian, representative, or attorney may request discharge in writing at any time following admission to the facility. This request may be submitted to a member of the staff of the facility for transmittal to the administrator. If the patient, or another on his or her behalf, makes an oral request for release to a staff member, such request shall be immediately entered in the patient's clinical record, and the patient must within 8 hours be given counseling and assistance in preparing a written request. If a written request is submitted to a staff member, it shall be delivered to the administrator within 16 hours. Within 3 days of delivery of a written request for release to the administrator, the patient must be discharged from the facility or a plan instituted for a discharge of the patient. Such plan shall be approved by the patient. If the administrator determines that the patient meets the criteria for involuntary placement, proceedings for involuntary placement must be initiated within 3 days of delivery of the written request, exclusive of weekends and legal holidays. If the patient was admitted on his or her own application and the request for discharge is made by a person other than the patient, the discharge may be conditioned upon the express and informed consent of the patient. If the patient is under the age of 18, the patient's parent or guardian may act for him or her.

(b) If the administrator, upon the advice of the patient's attending physician or clinical psychologist, determines that the patient needs to be transferred to a long-term treatment facility and the patient refuses to go as a voluntary patient, the administrator shall be authorized to file a petition for involuntary placement.

(3) NOTICE OF RIGHT TO RELEASE.—At the time of his or her admission and each 6 months thereafter, a voluntary patient and the patient's guardian or representatives shall be notified in writing of his or her right to apply for a discharge.

(4) TRANSFER TO VOLUNTARY STATUS.—Staff members of all treatment facilities shall encourage an involuntary patient to give express and informed consent to transfer to voluntary status unless the patient is under criminal charge, or unless the patient is unable to understand the nature of voluntary placement, or unless voluntary placement would be harmful to the patient, in which case a finding to this effect shall be entered in the patient's clinical record. Any involuntary patient who applies shall be transferred to voluntary status immediately, unless such transfer would not be in the best interest of the patient, in which case such finding shall be entered in the patient's clinical record and shall be subject to review every 90 days. When transfer to voluntary status occurs, notice shall be given to the patient and his or her guardian or representatives and, if the patient is involuntarily placed under an order of court, to the court which entered such order.

(5) TRANSFER TO INVOLUNTARY STATUS.—A patient who has, while at the receiving facility, given express and informed written consent to be hospitalized as a voluntary patient and who, upon arrival at the treatment facility, refuses to remain as a voluntary patient may be detained by the treatment facility and provided emergency treatment pursuant to s. 394.459(3)(a), if express and informed consent to treatment is refused or revoked, for a period not to exceed 3 days while the administrator of the treatment facility initiates procedures for involuntary placement.

History.—s. 8, ch. 71-131; s. 7, ch. 73-133; s. 109, ch. 73-333; s. 8, ch. 79-298; s. 11, ch. 82-212; s. 709, ch. 95-148.

394.467 Involuntary placement.—

(1) CRITERIA.—A person may be involuntarily placed for treatment upon a finding of the court by clear and convincing evidence that:

(a) He or she is mentally ill and because of his or her mental illness:

1.a. He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or

b. He or she is unable to determine for himself or herself whether placement is necessary; and

2.a. He or she is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or

b. There is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and

(b) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

(2) ADMISSION TO A TREATMENT FACILITY.—

(a) A patient may be involuntarily placed in a treatment facility, after notice and hearing, upon recommendation of the administrator of a receiving facility where the patient has been examined. When a patient is not an inpatient in a receiving facility, the administrator of a designated receiving facility may make a recommendation for involuntary placement of a patient who has been given an examination, evaluation, or treatment by staff of the receiving facility or a private mental health professional upon receipt of the opinions referred to in paragraph (b). In a proceeding involving a person 18 years of age or older, the hearing may be waived by express and informed consent in writing by the patient after the advice of counsel. In a proceeding involving a person under the age of 18, the hearing shall not be waived; however, if, at the hearing, the court finds that attendance at the hearing is not consistent with the best interests of the patient, the court may waive the presence of the patient from all or any portion of the hearing.

(b) The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 5 days, that the criteria for involuntary placement are met; however, in counties of less than 50,000 population, if the administrator certifies that no psychiatrist or clinical psychologist is available to provide the second opinion, such second opinion may be provided by a licensed physician with postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse. Such recommendation shall be entered on an involuntary placement certificate, which certificate shall authorize the receiving facility to retain the patient pending transfer to a treatment facility or completion of a hearing. The certificate shall be filed with the court in the county where the patient is located and shall serve as a petition for a hearing on involuntary placement. A copy of the certificate shall also be filed with the department; and copies shall be served on the patient and his or her guardian or representatives, accompanied by:

1. A written notice, in plain and simple language, that the patient or his or her guardian or representative may apply at any time for a hearing on the issue of the patient's need for involuntary placement if he or she has previously waived such a hearing.

2. A petition for such hearing, which requires only the signature of the patient or his or her guardian or representative for completion.

3. A written notice that the petition may be filed with a court in the county in which the patient is hospitalized and the name and address of the judge of such court.

4. A written notice that the patient has the right to be represented by counsel in the proceeding and that the patient or his or her guardian or representative may apply immediately to the court to have an attorney appointed if the patient cannot afford one.

The petition may be filed in the county in which the patient is involuntarily placed at any time within 6 months of the date of the certificate. The hearing shall be held in the same county, and one of the patient's physicians at the facility shall appear as a witness at the hearing.

(c) If the hearing is waived, the court shall order that the patient be transferred to the least restrictive type of treatment facility based on the individual needs of the patient or, if he or she is at a treatment facility, that the patient be retained there. The patient may be immediately transferred to the treatment facility by waiving his or her hearing without awaiting the court order. If the patient waives his or her hearing, the involuntary placement certificate shall serve as authorization for the patient to be transferred to a treatment facility and as authorization for the treatment facility to admit the patient.

(d) The treatment facility may retain a patient for a period not to exceed 6 months from the date of the order for involuntary placement. If continued involuntary placement is necessary at the end of that period, the administrator shall apply to the hearing examiner for an order authorizing continued involuntary placement.

(3) PROCEDURE FOR HEARING ON INVOLUNTARY PLACEMENT.—

(a) If the patient does not waive his or her right to a hearing on involuntary placement, or if the patient, his or her guardian, or a representative files a petition for such a hearing after having waived it as provided in paragraph (2)(c), the court shall serve notice on the administrator of the facility in which the patient is placed and on the patient. The notice of hearing shall specify the date, time, and place of hearing; the basis for detention; and the name of each examining expert and of every other person testifying in support of continued detention and the substance of their proposed testimony. The court shall serve notice on the state attorney

of the judicial circuit of the county in which the patient is placed, who shall represent the state. The court shall hold the hearing within 5 days unless a continuance is granted. The hearing shall be as convenient to the patient as may be consistent with orderly procedure and should be conducted in physical settings not likely to be injurious to the patient's condition. The court may appoint a master to preside. The patient, his or her guardian or representative, or the administrator may apply for a change of venue for the convenience of parties or witnesses or because of the condition of the patient. Venue may be ordered changed within the discretion of the court. The patient and his or her guardian or representative shall be informed of the right to counsel by the court. If the patient cannot afford an attorney, the court shall appoint one. The patient's counsel shall have access to facility records and to facility personnel in defending the patient. One of the professionals who executed the involuntary placement certificate shall be a witness. The patient and his or her guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall provide for one.

(b) If the court concludes that the patient meets the criteria for involuntary placement, it shall order that the patient be transferred to a treatment facility or, if the patient is at a treatment facility, that he or she be retained there or that he or she be treated at any other appropriate facility or service on an involuntary basis. The order shall adequately document the nature and extent of the patient's mental illness.

(c) At the hearing on involuntary placement, the court shall consider testimony and evidence regarding the patient's competence to consent to treatment. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate who shall act on the patient's behalf relating to the provision of express and informed consent to treatment. A member of the Human Rights Advocacy Committee who is serving as the patient's representative pursuant to s. 394.459(12), may not be appointed as a guardian advocate.

(d) The court may adjudicate a person incompetent pursuant to the provisions of chapter 744 at the hearing on involuntary placement.

(e) The treatment facility may accept and retain a patient admitted involuntarily for a period not to exceed 6 months whenever the patient is accompanied by a court order and adequate documentation of the patient's mental illness. Such documentation shall include a psychiatric evaluation and any psychological and social work evaluations of the patient. If further involuntary placement is necessary at the end of that period, the administrator shall apply to the hearing examiner for an order authorizing continued involuntary placement.

(f) The court shall provide a court order, a psychiatric evaluation, and other adequate documentation of each patient's mental illness to the administrator of a treatment facility whenever a patient is ordered for involuntary placement, whether by civil or criminal court. The administrator of a treatment facility may refuse admission to any patient directed to its facilities on an involuntary basis, whether by civil or by criminal court order, who is not accompanied at the same time by adequate orders and documentation.

(4) PROCEDURE FOR CONTINUED INVOLUNTARY PLACEMENT.—

(a) If continued placement of an involuntary patient is necessary, the administrator shall, prior to the expiration of the period during which the treatment facility is authorized to retain the patient, request an order authorizing continued involuntary placement. This request shall be accompanied by a statement from the patient's physician or clinical psychologist justifying the request and a brief summary of the patient's treatment during the time he or she was involuntarily placed. In addition, the administrator shall submit an individualized plan for the patient for whom he or she is requesting continued involuntary placement. Notification of this request for retention shall be mailed to the patient and his or her guardian or representative along with a completed petition, requiring only a signature, for a hearing regarding the continued hospitalization and a waiver-of-hearing form. The waiver-of-hearing form shall require express and informed consent and shall state that the patient is entitled to a hearing under the law; that he or she is entitled to be represented by an attorney at the hearing and, if he or she cannot afford an attorney, that one will be appointed; and that, if it is shown at the hearing that the patient does not meet the criteria for involuntary placement, he or she is entitled to be released. In a proceeding involving a person 18 years of age or older, the hearing may be waived by express and informed consent in writing by the patient after the advice of counsel. If the patient or his or her guardian or representative does not sign the petition, or if the patient does not sign a waiver within 15 days, the hearing officer shall notice a hearing with regard to the patient involved in accordance with s. 120.57(1). In a proceeding involving a person under the age of 18, the hearing shall not be waived; however, if, at the hearing, the hearing examiner finds that attendance at the hearing is not consistent with the best interests of the patient, he or she may waive the presence of the patient from all or any portion of the hearing.

(b) Any time continued involuntary placement is requested, the hearing officer may, on his or her own motion, notice a hearing.

(c) Any time continued involuntary placement is requested by the administrator, the administrator may request a hearing; and the hearing officer shall hold a hearing within 30 days of such request.

(d) The administrator shall not transfer any patient to voluntary status when he or she has reasonable cause to believe that the patient is dangerous to himself or herself or others. In any case in which the administrator has reasonable cause to believe that an involuntary patient is dangerous to himself or herself or others, the administrator shall request continued involuntary placement. In any case in which a request for continued involuntary placement is necessary, but the administrator after reviewing the case believes there is not reasonable cause to believe that the patient meets the criteria for involuntary placement at the time of application for transfer to voluntary status and the patient needs continued placement, the patient shall be transferred to a voluntary status.

(e) If the patient or his or her guardian or representative returns the signed petition noted in paragraph (a), the hearing officer shall notice a hearing in accordance with s. 120.57(1). The patient and his or her guardian or representative shall be informed of the right to counsel by the hearing officer. In the event a patient cannot afford counsel in a hearing before a hearing officer, the public defender in the county where the hearing is to be held shall act as attorney for the patient. The hearing shall be conducted in accordance with chapter 120.

(f) If the patient by express and informed consent waives his or her hearing after the advice of counsel or if at a hearing it is shown that the patient continues to meet the criteria for involuntary placement, the hearing officer shall sign the order for continued involuntary placement. The treatment facility shall be authorized to retain the patient for a period not to exceed 6 months. The same procedure shall be repeated prior to the expiration of each additional 6-month period the patient is retained.

(g) If continued involuntary placement is necessary for an individual admitted while serving a criminal sentence, but whose sentence is about to expire, or for an individual involuntarily placed while a minor, but who is about to reach the age of 18, the administrator shall petition the hearing officer for an order authorizing continued involuntary placement.

(h) At any hearing hereunder for a patient who has been previously adjudicated incompetent to consent to treatment, the hearing examiner shall consider testimony and evidence regarding the patient's competence. If the hearing examiner finds evidence that the patient is competent to consent to treatment, he or she may issue to the court in which the patient was adjudicated incompetent to consent to treatment a recommended order that the patient's competence be restored and that any guardian advocate previously appointed be discharged.

History.—s. 9, ch. 71-131; s. 8, ch. 73-133; ss. 3, 4, ch. 74-233; s. 1, ch. 75-305; s. 17, ch. 77-121; s. 205, ch. 77-147; s. 1, ch. 77-174; ss. 2, 8, ch. 77-312; s. 19, ch. 78-95; s. 1, ch. 78-197; s. 9, ch. 79-298; s. 2, ch. 79-336; ss. 2, 4, ch. 80-75; s. 12, ch. 82-212; s. 9, ch. 84-285; s. 28, ch. 85-167; s. 105, ch. 89-96; s. 70, ch. 90-271; s. 710, ch. 95-148.

394.4672 Procedure for placement of veteran with federal agency.—

(1) Whenever, in any proceeding under this part for the placement of a person alleged to be mentally ill and in need of involuntary placement, it is determined by the court that such person meets the criteria for involuntary placement and it appears that the person is eligible for care or treatment by the United States Department of Veterans Affairs or other agency of the United States Government, the court, upon receipt of a certificate from the United States Department of Veterans Affairs or such other agency showing that facilities are available and that the person is eligible for care or treatment therein, may place that person with the United States Department of Veterans Affairs or other federal agency. The person whose placement is sought shall be personally served with notice of the pending placement proceeding in the manner as provided in this part, and nothing in this section shall affect his or her right to appear and be heard in the proceeding. Upon placement, the person, when admitted to any facility operated by any such agency within or without this state, shall be subject to the rules and regulations of the United States Department of Veterans Affairs or other federal agency.

(2) The judgment or order of placement by a court of competent jurisdiction of another state or of the District of Columbia, placing a person with the United States Department of Veterans Affairs or other agency of the United States Government for care or treatment, shall have the same force and effect as to the person while in this state as in the jurisdiction in which is situated the court entering the judgment or making the order; and the courts of the placing state or of the District of Columbia shall be deemed to have retained jurisdiction of the person so placed. Consent is hereby given to the application of the law of the placing state or district in respect to the authority of the chief officer of any facility of the United States Department of Veterans Affairs or of any institution operated in this state by any other agency of the United States to retain custody or to transfer, parole, or discharge the person.

(3) Upon receipt of a certificate of the United States Department of Veterans Affairs or such other agency of the United States that facilities are available for the care or treatment of any person heretofore placed in any hospital or other institution for the care or treatment of mentally ill persons and that the person is eligible for care or treatment, the administrator of the receiving or treatment facility may cause the transfer of that person, with notice pursuant to s. 394.461(3), to the United States Department of Veterans Affairs or other agency of the United States for care or treatment. Upon effecting such transfer, the committing court or proper officer shall be notified thereof by the transferring agency. No person shall be transferred to the United States Department of Veterans Affairs or other agency of the United States if he or she is confined pursuant to the conviction of any felony or misdemeanor or if he or she has been acquitted of the charge solely on the ground of insanity, unless prior to transfer the court placing such person enters an order for the transfer after appropriate motion and hearing and without objection by the United States Department of Veterans Affairs.

(4) Any person transferred as provided in this section shall be deemed to be placed with the United States Department of Veterans Affairs or other agency of the United States pursuant to the original placement.

History.—s. 15, ch. 14579, 1929; CGL 1936 Supp. 2146(16); s. 1, ch. 21795, 1943; s. 4, ch. 84-62; s. 18, ch. 93-268; s. 711, ch. 95-148.

Note.—Former s. 293.16.

394.4674 Plan and report.—

(1) The Department of Health and Rehabilitative Services is directed to develop a comprehensive plan for the deinstitutionalization of those state mental health hospital patients over age 55 who do not meet the criteria for involuntary hospitalization pursuant to s. 394.467. The plan shall include, but need not be limited to, the projected numbers of patients, the timetables for deinstitutionalization, and the specific actions to be taken to accomplish the deinstitutionalization.

(2) The department shall prepare and submit a semiannual report to the Legislature, until the conditions specified in subsection (1) are met, which shall include, but not be limited to:

(a) The status of compliance with the deinstitutionalization plan;

(b) The specific efforts to stimulate alternative living and support resources outside the hospitals and all documentation of the success of these efforts;

(c) The specific efforts to facilitate the development and retention of daily living skills identified by the department as being necessary for living outside an institution and any evidence of the success of these efforts;

(d) The specific plans for new efforts to accomplish the deinstitutionalization of patients in this age group; and

(e) Any evidence of involvement between the Alcohol, Drug Abuse, and Mental Health Program Office and other program offices within the department and between the department and other state and private agencies and individuals to accomplish the deinstitutionalization of patients in this age group.

History.—s. 2, ch. 80-293; s. 245, ch. 81-259; s. 6, ch. 81-290.

394.468 Admission and release procedures.—Admission and release procedures and treatment policies of the department are governed solely by this act. Such procedures and policies shall not be subject to control by court procedure rules. The matters within the purview of this act are deemed to be substantive, not procedural.

History.—s. 9, ch. 77-312.

394.469 Discharge of patients.—

(1) POWER TO DISCHARGE.—At any time a patient is found no longer to meet the criteria for involuntary placement, the administrator may:

(a) Discharge the patient, unless the patient is under a criminal charge, in which case he or she shall be transferred to the custody of the appropriate law enforcement officer;

(b) Transfer the patient to voluntary status on his or her own authority or at the patient's request, unless the patient is under criminal charge; or

(c) Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.

(2) NOTICE.—Notice of discharge or transfer of status shall be given to the patient, his or her guardian or representative, the referring professional, and, if the patient was involuntarily placed, the court which entered the order.

(3) CONVALESCENT STATUS; INVOLUNTARY PLACEMENT.—An improved patient may be placed on convalescent status for a period of up to 1 year in the care of a less restrictive community setting when such action is in the best interest of the patient. Notice of the patient's placement on convalescent status shall be given to the patient and his or her guardian or representative, to the referring professional, to the community facility, and to the court which entered the order for involuntary placement. Placement on convalescent status shall include provisions for continuing responsibility by a professional or facility in the community, including a plan for treatment as an outpatient. The administrator of the treatment facility from which the patient is given convalescent status may, at any time during the continuance of such convalescent status, readmit the patient to the treatment facility when the condition of the patient requires. An involuntary patient may be readmitted for the remainder of his or her authorized treatment period, and the treatment facility shall have up to 1 additional month during which to apply for continued involuntary placement.

(4) RESTORATION OF COMPETENCY.—When a patient who has been declared incompetent to consent to treatment is discharged or is released from active treatment, such competency shall be restored by operation of law, and any guardian advocate previously appointed shall stand discharged. However, transfer from one inpatient placement to another shall not be considered as a discharge for this purpose. A record of restoration of competency shall be entered on the patient's certificate of discharge, and a copy of the certificate shall be provided to the patient.

History.—s. 10, ch. 71-131; s. 9, ch. 73-133; s. 10, ch. 79-298; s. 13, ch. 82-212; s. 712, ch. 95-148.

394.471 Validity of prior involuntary placement orders.—No involuntary placement of a mentally ill person, lawful before January 1, 1972, shall be deemed unlawful because of the enactment of this part. The department shall establish reasonable rules to require the administrator of each treatment facility to apply for an order authorizing continued involuntary placement of any patient for whom involuntary placement is necessary and who was initially involuntarily placed under an order of a court prior to July 1, 1972. Such prior orders, unless superseded by an order under this part, shall remain valid until July 1, 1973, after which all such orders shall be null and void and of no effect, and every patient retained shall become a voluntary patient unless previously placed on involuntary status pursuant to procedures under this part. Nothing in this part invalidates any order appointing a guardian or determining incompetency.

History.—s. 11, ch. 71-131; s. 11, ch. 79-298.

394.473 Attorney's fee; expert witness fee.—

(1) In case of indigency of any person for whom an attorney is appointed pursuant to the provisions of this part, the attorney shall be entitled to a reasonable fee to be determined by the court and paid from the general fund of the county from which the patient was involuntarily detained. In case of indigency of any such person, the court may appoint a public defender. The public defender shall receive no additional compensation other than that usually paid his or her office.

[1](2) In case of indigency of any person for whom expert testimony is required in a court hearing pursuant to the provisions of this act, the expert, except one who is classified as a full-time employee of the state or who is receiving remuneration from the state for his [2]or her time in attendance at the hearing, shall be entitled to a reasonable fee to be determined by the court and paid from the general fund of the county from which the patient was involuntarily detained.

History.—s. 13, ch. 71-131; s. 10, ch. 73-133; s. 25, ch. 73-334; s. 12, ch. 79-298; s. 3, ch. 82-176; s. 14, ch. 82-212; s. 713, ch. 95-148.

[1]**Note.**—Published as amended by s. 14, ch. 82-212. The amendment of this subsection by s. 3, ch. 82-176, during the special session of March 29–April 7, 1982, failed to incorporate the amendment of the same subsection by s. 14, ch. 82-212, during the regular session. Although the circumstance that separate sessions were

involved takes the transaction out of the operation of s. 1.04, there was no apparent legislative intent to nullify the amendment of the regular session. However, s. 7, ch. 82-176, provides that those provisions of that act "which provide for state assumption of witness fees which are currently paid by the counties shall take effect on a date determined by the appropriation of funds for this purpose." Giving full effect to both amendments, the subsection reads:

(2) In case of indigency of any person for whom expert testimony is required in a court hearing pursuant to the provisions of this act, the expert, except one who is classified as a full-time employee of the state or who is receiving remuneration from the state for his [2]or her time in attendance at the hearing, shall be entitled to a reasonable fee to be determined by the court and paid by the state.

[2]**Note.**—The words "or her" were inserted by the editors to conform to the directive of the Legislature in s. 1, ch. 93-199, to remove gender-specific references applicable to human beings from the Florida Statutes. Inclusion of subsection (2) in a reviser's bill pursuant to ch. 93-199 is not practicable pending clarification of the effect of s. 3, ch. 82-176, and s. 14, ch. 82-212, on the text of the subsection.

394.475 Acceptance, examination, and involuntary placement of Florida residents from out-of-state mental health authorities.—

(1) Upon the request of the state mental health authority of another state, the Department of Health and Rehabilitative Services is authorized to accept as a patient, for a period of not more than 15 days, a person who is and has been a bona fide resident of this state for a period of not less than 1 year.

(2) Any person received pursuant to subsection (1) shall be examined by the staff of the state facility where such patient has been accepted, which examination shall be completed during the 15-day period.

(3) If upon examination such a person requires continued involuntary placement, a petition for a hearing regarding involuntary placement shall be filed with the court of the county wherein the treatment facility receiving the patient is located or the county where the patient is a resident.

(4) During the pendency of the examination period herein provided for and the pendency of the involuntary placement proceedings herein provided for, such person may continue to be detained by the treatment facility unless the court having jurisdiction enters an order to the contrary.

History.—s. 14, ch. 71-131; s. 25, ch. 73-334; s. 206, ch. 77-147; s. 13, ch. 79-298; s. 15, ch. 82-212.

394.477 Residence requirements.—No person shall be involuntarily placed in a facility under the provisions of this part who has not been a bona fide resident of the state continuously for 1 year immediately preceding his or her involuntary placement. However, any person not a bona fide resident of the state may be involuntarily placed in a treatment facility pending transfer of said person back to the state of his or her residence. An indigent nonresident patient shall be transferred to the state of his or her residence at the expense of the county from which he or she was involuntarily placed. The treatment facility, with the approval of the department, shall retain any nonresident who cannot be transferred subject to the provisions of this part.

History.—s. 15, ch. 71-131; s. 14, ch. 79-298; s. 714, ch. 95-148.

394.478 Autopsy of deceased patient.—In every case where a person is committed to and received as a patient in the Florida State Hospital, and shall die while a patient therein, it is lawful for the superintendent of the Florida State Hospital, and he or she may hold and perform, or cause to be held and performed, an autopsy on such deceased patient, when such deceased patient leaves surviving him or her no relative or guardian, or when said superintendent shall be unable to communicate with or contact any relative or guardian of such deceased patient for the purpose of procuring consent to such autopsy, and when in the judgment and discretion of the superintendent of the Florida State Hospital, such autopsy is in the interest of medical science necessary or desirable.

History.—s. 1, ch. 19367, 1939; CGL 1940 Supp. 3653(11); s. 715, ch. 95-148.
Note.—Former s. 394.19.

394.4781 Residential care for psychotic and emotionally disturbed children.—

(1) DEFINITIONS.—As used in this section:

(a) "Psychotic or severely emotionally disturbed child" means a child so diagnosed by a psychiatrist or clinical psychologist who has specialty training and experience with children. Such a severely emotionally disturbed child or psychotic child shall be considered by this diagnosis to benefit by and require residential care as contemplated by this section.

(b) "Department" means the Department of Health and Rehabilitative Services.

(2) FUNDING OF PROGRAM.—The department shall provide for the purposes of this section such amount as shall be set forth in the annual appropriations act as payment for part of the costs of residential care for psychotic or severely emotionally disturbed children.

(3) ADMINISTRATION OF THE PROGRAM.—

(a) The department shall provide the necessary application forms and office personnel to administer the purchase-of-service program.

(b) The department shall review such applications monthly and, in accordance with available funds, the severity of the problems of the child, the availability of the needed residential care, and the financial means of the family involved, approve or disapprove each application. If an application is approved, the department shall contract for or purchase the services of an appropriate residential facility in such amounts as are determined by the annual appropriations act.

(c) The department is authorized to promulgate such rules as are necessary for the full and complete implementation of the provisions of this section.

(d) The department shall purchase services only from those facilities which are in compliance with standards promulgated by the department.

History.—ss. 1, 2, 3, ch. 77-287; s. 156, ch. 79-400; s. 16, ch. 82-212.

394.4784 Minors; access to outpatient crisis intervention services and treatment.—For the purposes of this section, the disability of nonage is removed for any minor age 13 years or older to access services under the following circumstances:

(1) OUTPATIENT DIAGNOSTIC AND EVALUATION SERVICES.—When any minor age 13 years or older experiences an emotional crisis to such degree that he or she perceives the need for professional assistance, he or she shall have the right to request, consent to, and receive mental health diagnostic and evaluative services provided by a licensed mental health professional, as defined by Florida Statutes, or in a mental health facility licensed by the state. The purpose of such services shall be to determine the severity of the problem and the potential for harm to the person or others if further pro-

fessional services are not provided. Outpatient diagnostic and evaluative services shall not include medication and other somatic methods, aversive stimuli, or substantial deprivation. Such services shall not exceed two visits during any 1-week period in response to a crisis situation before parental consent is required for further services, and may include parental participation when determined to be appropriate by the mental health professional or facility.

(2) OUTPATIENT CRISIS INTERVENTION, THERAPY AND COUNSELING SERVICES.—When any minor age 13 years or older experiences an emotional crisis to such degree that he or she perceives the need for professional assistance, he or she shall have the right to request, consent to, and receive outpatient crisis intervention services including individual psychotherapy, group therapy, counseling, or other forms of verbal therapy provided by a licensed mental health professional, as defined by Florida Statutes, or in a mental health facility licensed by the state. Such services shall not include medication and other somatic treatments, aversive stimuli, or substantial deprivation. Such services shall not exceed two visits during any 1-week period in response to a crisis situation before parental consent is required for further services, and may include parental participation when determined to be appropriate by the mental health professional or facility.

(3) LIABILITY FOR PAYMENT.—The parent, parents, or legal guardian of a minor shall not be liable for payment for any such outpatient diagnostic and evaluation services or outpatient therapy and counseling services, as provided in this section, unless such parent, parents, or legal guardian participates in the outpatient diagnostic and evaluation services or outpatient therapy and counseling services and then only for the services rendered with such participation.

(4) PROVISION OF SERVICES.—No licensed mental health professional shall be obligated to provide services to minors accorded the right to receive services under this section. Provision of such services shall be on a voluntary basis.

History.—s. 2, ch. 91-170; s. 716, ch. 95-148.

394.4785 Minors; admission and placement in mental facilities.—

(1)(a) A minor who is admitted to a state mental hospital and placed in the general population or in a specialized unit for children or adolescents shall reside in living quarters separate from adult patients, and a minor who has not attained the age of 14 shall reside in living quarters separate from minors who are 14 years of age or older.

(b) A minor under the age of 14 who is admitted to any hospital licensed pursuant to chapter 395 shall not be admitted to a bed in a room or ward with an adult patient in a mental health unit or share common areas with an adult patient in a mental health unit. However, a minor 14 years of age or older may be admitted to a bed in a room or ward in the mental health unit with an adult if the admitting physician documents in the case record that such placement is medically indicated or for reasons of safety. Such placement shall be reviewed by the attending physician or a designee or on-call physician each day and documented in the case record.

(2) In all cases involving the admission of minors to a state mental hospital, the case record shall document that a good faith effort was made to place the minor in a less restrictive form of treatment. Admission to a state mental hospital shall be regarded as the last and only treatment option available. Notwithstanding the provision of paragraph (1)(a), an individual under the age of 18 may be housed in the general population if the hospital multidisciplinary treatment and rehabilitation team has reviewed the patient and has documented in the case record that such placement is necessary for reasons of safety. Such patients placed in the general population must be reviewed by this team every 30 days and recertified as appropriate for placement in the general population.

History.—ss. 1, 2, ch. 82-212; s. 1, ch. 85-254; s. 1, ch. 87-209.

394.4786 Intent.—

(1) The Legislature intends that all hospitals, excluding hospitals owned and operated by the Department of Health and Rehabilitative Services or the Department of Corrections, be assessed on a continuing basis an amount equal to 1.5 percent of the hospital's annual net operating revenues and that the assessments be deposited into the Public Medical Assistance Trust Fund.

(2) Further, the Legislature intends that a specialty psychiatric hospital which provides health care to specified indigent patients be eligible for reimbursement up to the amount that hospital contributed to the Public Medical Assistance Trust Fund in the previous fiscal year.

History.—s. 1, ch. 89-355.

394.4787 Definitions.—As used in this act:

(1) "Acute mental health services" means mental health services provided through inpatient hospitalization.

(2) "Charity care" means that portion of hospital charges for care provided to a patient whose family income for the 12 months preceding the determination is equal to or below 150 percent of the current federal nonfarm poverty guideline or the amount of hospital charges due from the patient which exceeds 25 percent of the annual family income and for which there is no compensation. Charity care shall not include administrative or courtesy discounts, contractual allowances to third party payors, or failure of a hospital to collect full charges due to partial payment by governmental programs.

(3) "Department" means the Agency for Health Care Administration.

(4) "Indigent" means an individual whose financial status would qualify him or her [1]for charity care.

(5) "Operating expense" means all common and accepted costs appropriate in developing and maintaining the operating of the patient care facility and its activities.

(6) "PMATF" means the Public Medical Assistance Trust Fund.

(7) "Specialty psychiatric hospital" means a hospital licensed by the department pursuant to s. 395.002(27) as a specialty psychiatric hospital.

History.—s. 2, ch. 89-355; s. 1, ch. 90-192; s. 11, ch. 90-295; s. 55, ch. 91-282; s. 90, ch. 92-33; ss. 70, 98, ch. 92-289; s. 717, ch. 95-148.

[1]**Note.**—The word "for" was substituted for the word "as" by the editors.

394.4788 Use of certain PMATF funds for the purchase of acute care mental health services.—

(1) A hospital may be eligible to be reimbursed an amount no greater than the hospital's previous year contribution to the PMATF for acute mental health services provided to indigent mentally ill persons who have been determined by the department or its agent to require such treatment and who:

(a) Do not meet Medicaid eligibility criteria, unless the department makes a referral for a Medicaid eligible patient pursuant to s. 394.4789;

(b) Meet s. 394.455(3) or s. 394.463, criteria for mental illness; and

(c) Meet the definition of charity care.

(2) By October 1, 1989, and annually thereafter, the [1]HCCB shall calculate a per diem reimbursement rate for each specialty psychiatric hospital to be paid to the specialty psychiatric hospitals for the provision of acute mental health services provided to indigent mentally ill patients who meet the criteria in subsection (1). After the first rate period, providers shall be notified of new reimbursement rates for each new state fiscal year by June 1. The new reimbursement rates shall commence July 1.

(3) Reimbursement rates shall be calculated using the most recent audited actual costs received by the [1]Health Care Cost Containment Board. Cost data received as of August 15, 1989, and each April 15 thereafter shall be used in the calculation of the rates. Historic costs shall be inflated from the midpoint of a hospital's fiscal year to the midpoint of the state fiscal year. The inflation adjustment shall be made utilizing the latest available projections as of March 31 for the Data Resources Incorporated National and Regional Hospital Input Price Indices as calculated by the Medicaid program office.

(4) Reimbursement shall be based on compensating a specialty psychiatric hospital at a per diem rate equal to its operating costs per inpatient day.

(5) No hospital shall be entitled to receive more in any one fiscal year than that hospital contributed to the PMATF during the previous fiscal year.

(6) Hospitals that agree to participate in the program set forth in this act shall agree that payment from the PMATF is payment in full for all patients for which reimbursement is received under the provisions of this act, until the funds for this program are no longer available.

(7) The department shall develop a payment system to reimburse specialty psychiatric hospitals quarterly as set forth in this act.

History.—s. 3, ch. 89-355; s. 1, ch. 90-192; s. 98, ch. 92-289.

[1]**Note.**—Section 82, ch. 92-33, abolished the HCCB, defined as the Health Care Cost Containment Board by s. 2, ch. 89-355, and transferred all powers, duties and functions, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the board to the Agency for Health Care Administration.

394.4789 Establishment of referral process and eligibility determination.—

(1) The department shall adopt by rule a referral process which shall provide each participating specialty psychiatric hospital with a system for accepting into the hospital's care indigent mentally ill persons referred by the department. It is the intent of the Legislature that a hospital which seeks payment under s. 394.4788 shall accept referrals from the department. However, a hospital shall have the right to refuse the admission of a patient due to lack of functional bed space or lack of services appropriate to a patient's specific treatment and no hospital shall be required to accept referrals if the costs for treating the referred patient are no longer reimbursable because the hospital has reached the level of contribution made to the PMATF in the previous fiscal year. Furthermore, a hospital that does not seek compensation for indigent mentally ill patients under the provisions of this act shall not be obliged to accept department referrals, notwithstanding any agreements it may have entered into with the department. The right of refusal in this subsection shall not affect a hospital's requirement to provide emergency care pursuant to s. 395.1041 or other statutory requirements related to the provision of emergency care.

(2) The department shall adopt by rule a patient eligibility form and shall be responsible for eligibility determination. However, the department may contract with participating psychiatric hospitals for eligibility determination. The eligibility form shall provide the mechanism for determining a patient's eligibility according to the requirements of s. 394.4788(1).

(a) A specialty psychiatric hospital shall be eligible for reimbursement only when an eligibility form has been completed for each indigent mentally ill person for whom reimbursement is sought.

(b) As part of eligibility determination, every effort shall be made by the hospital to determine if any third party insurance coverage is available.

History.—s. 4, ch. 89-355; s. 71, ch. 92-289.

PART II

INTERSTATE COMPACT ON MENTAL HEALTH

394.479 Interstate Compact on Mental Health.
394.480 Compact administrator.
394.481 Supplemental agreements with other states.
394.482 Payment of financial obligations imposed by compact.
394.483 Authorized actions by administrator.
394.484 Transmission of copies of act adopting compact.

394.479 Interstate Compact on Mental Health.— The Interstate Compact on Mental Health is hereby enacted into law and entered into by this state with all other states legally joining therein in the form substantially as follows:

INTERSTATE COMPACT ON MENTAL HEALTH

The contracting states solemnly agree that:

ARTICLE I

The party states find that the proper and expeditious treatment of the mentally ill and mentally deficient can be facilitated by cooperative action, to the benefit of the patients, their families, and society as a whole. Further,

the party states find that the necessity of and desirability for furnishing such care and treatment bears no primary relation to the residence or citizenship of the patient but that, on the contrary, the controlling factors of community safety and humanitarianism require that facilities and services be made available for all who are in need of them. Consequently, it is the purpose of this compact and of the party states to provide the necessary legal basis for the institutionalization or other appropriate care and treatment of the mentally ill and mentally deficient under a system that recognizes the paramount importance of patient welfare and to establish the responsibilities of the party states in terms of such welfare.

ARTICLE II

As used in this compact:

(a) "Sending state" shall mean a party state from which a patient is transported pursuant to the provisions of the compact or from which it is contemplated that a patient may be so sent.

(b) "Receiving state" shall mean a party state to which a patient is transported pursuant to the provisions of the compact or to which it is contemplated that a patient may be so sent.

(c) "Institution" shall mean any hospital or other facility maintained by a party state or political subdivision thereof for the care and treatment of mental illness or mental deficiency.

(d) "Patient" shall mean any person subject to or eligible as determined by the laws of the sending state, for institutionalization or other care, treatment, or supervision pursuant to the provisions of this compact.

(e) "Aftercare" shall mean care, treatment, and services provided a patient, as defined herein, on convalescent status or conditional release.

(f) "Mental illness" shall mean mental disease to such extent that a person so afflicted requires care and treatment for his or her own welfare, or the welfare of others, or of the community.

(g) "Mental deficiency" shall mean mental deficiency as defined by appropriate clinical authorities to such extent that a person so afflicted is incapable of managing himself or herself and his or her affairs, but shall not include mental illness as defined herein.

(h) "State" shall mean any state, territory or possession of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

ARTICLE III

(a) Whenever a person physically present in any party state shall be in need of institutionalization by reason of mental illness or mental deficiency, he or she shall be eligible for care and treatment in an institution in that state irrespective of his or her residence, settlement or citizenship qualifications.

(b) The provisions of paragraph (a) of this article to the contrary notwithstanding, any patient may be transferred to an institution in another state whenever there are factors based upon clinical determinations indicating that the care and treatment of said patient would be facilitated or improved thereby. Any such institutionalization may be for the entire period of care and treatment or for any portion or portions thereof. The factors referred to in this paragraph shall include the patient's full record with due regard for the location of the patient's family, character of the illness and probable duration thereof, and such other factors as shall be considered appropriate.

(c) No state shall be obliged to receive any patient pursuant to the provisions of paragraph (b) of this article unless the sending state has given advance notice of its intention to send the patient; furnished all available medical and other pertinent records concerning the patient; given the qualified medical or other appropriate clinical authorities of the receiving state an opportunity to examine the patient if said authorities so wish; and unless the receiving state shall agree to accept the patient.

(d) In the event that the laws of the receiving state establish a system of priorities for the admission of patients, an interstate patient under this compact shall receive the same priority as a local patient and shall be taken in the same order and at the same time that he or she would be taken if he or she were a local patient.

(e) Pursuant to this compact, the determination as to the suitable place of institutionalization for a patient may be reviewed at any time and such further transfer of the patient may be made as seems likely to be in the best interest of the patient.

ARTICLE IV

(a) Whenever, pursuant to the laws of the state in which a patient is physically present, it shall be determined that the patient should receive aftercare or supervision, such care or supervision may be provided in a receiving state. If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state shall have reason to believe that aftercare in another state would be in the best interest of the patient and would not jeopardize the public safety, they shall request the appropriate authorities in the receiving state to investigate the desirability of affording the patient such aftercare in said receiving state, and such investigation shall be made with all reasonable speed. The request for investigation shall be accompanied by complete information concerning the patient's intended place of residence and the identity of the person in whose charge it is proposed to place the patient, the complete medical history of the patient, and such other documents as may be pertinent.

(b) If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state and the appropriate authorities in the receiving state find that the best interest of the patient would be served thereby, and if the public safety would not be jeopardized thereby, the patient may receive aftercare or supervision in the receiving state.

(c) In supervising, treating, or caring for a patient on aftercare pursuant to the terms of this article, a receiving state shall employ the same standards of visitation, examination, care, and treatment that it employs for similar local patients.

ARTICLE V

Whenever a dangerous or potentially dangerous patient escapes from an institution in any party state, that state shall promptly notify all appropriate authorities within and without the jurisdiction of the escape in a manner reasonably calculated to facilitate the speedy apprehension of the escapee. Immediately upon the apprehension and identification of any such dangerous or potentially dangerous patient, he or she shall be detained in the state where found pending disposition in accordance with law.

ARTICLE VI

The duly accredited officers of any state party to this compact, upon the establishment of their authority and the identity of the patient, shall be permitted to transport any patient being moved pursuant to this compact through any and all states party to this compact, without interference.

ARTICLE VII

(a) No person shall be deemed a patient of more than one institution at any given time. Completion of transfer of any patient to an institution in a receiving state shall have the effect of making the person a patient of the institution in the receiving state.

(b) The sending state shall pay all costs of, and incidental to, the transportation of any patient pursuant to this compact, but any two or more party states may, by making a specific agreement for that purpose, arrange for a different allocation of costs as among themselves.

(c) No provision of this compact shall be construed to alter or affect any internal relationships among the departments, agencies and officers of and in the government of a party state, or between a party state and its subdivisions, as to the payment of costs, or responsibilities therefor.

(d) Nothing in this compact shall be construed to prevent any party state or subdivision thereof from asserting any right against any person, agency or other entity in regard to costs for which such party state or subdivision thereof may be responsible pursuant to any provision of this compact.

(e) Nothing in this compact shall be construed to invalidate any reciprocal agreement between a party state and a nonparty state relating to institutionalization, care or treatment of the mentally ill or mentally deficient, or any statutory authority pursuant to which such agreements may be made.

ARTICLE VIII

(a) Nothing in this compact shall be construed to abridge, diminish, or in any way impair the rights, duties, and responsibilities of any patient's guardian on his or her own behalf or in respect of any patient for whom he or she may serve, except that where the transfer of any patient to another jurisdiction makes advisable the appointment of a supplemental or substitute guardian, any court of competent jurisdiction in the receiving state may make such supplemental or substitute appointment and the court which appointed the previous guardian shall upon being duly advised of the new appointment, and upon the satisfactory completion of such accounting and other acts as such court may by law require, relieve the previous guardian of power and responsibility to whatever extent shall be appropriate in the circumstances; provided, however, that in the case of any patient having settlement in the sending state, the court of competent jurisdiction in the sending state shall have the sole discretion to relieve a guardian appointed by it or continue his or her power and responsibility, whichever it shall deem advisable. The court in the receiving state may, in its discretion, confirm or reappoint the person or persons previously serving as guardian in the sending state in lieu of making a supplemental or substitute appointment.

(b) The term "guardian" as used in paragraph (a) of this article shall include any guardian, trustee, legal committee, conservator, or other person or agency however denominated who is charged by law with power to act for or responsibility for the person or property of a patient.

ARTICLE IX

(a) No provision of this compact except Article V shall apply to any person institutionalized while under sentence in a penal or correctional institution or while subject to trial on a criminal charge, or whose institutionalization is due to the commission of an offense for which, in the absence of mental illness or mental deficiency, said person would be subject to incarceration in a penal or correctional institution.

(b) To every extent possible, it shall be the policy of states party to this compact that no patient shall be placed or detained in any prison, jail or lockup, but such patient shall, with all expedition, be taken to a suitable institutional facility for mental illness or mental deficiency.

ARTICLE X

(a) Each party state shall appoint a "compact administrator" who, on behalf of his or her state, shall act as general coordinator of activities under the compact in his or her state and who shall receive copies of all reports, correspondence, and other documents relating to any patient processed under the compact by his or her state either in the capacity of sending or receiving state. The compact administrator or his or her duly designated representative shall be the official with whom other party states shall deal in any matter relating to the compact or any patient processed thereunder.

(b) The compact administrators of the respective party states shall have power to promulgate reasonable rules and regulations to carry out more effectively the terms and provisions of this compact.

ARTICLE XI

The duly constituted administrative authorities of any two or more party states may enter into supplementary agreements for the provision of any service or facility or for the maintenance of any institution on a joint or coop-

erative basis whenever the states concerned shall find that such agreements will improve services, facilities, or institutional care and treatment in the fields of mental illness or mental deficiency. No such supplementary agreement shall be construed so as to relieve any party state of any obligation which it otherwise would have under other provisions of this compact.

ARTICLE XII

This compact shall enter into full force and effect as to any state when enacted by it into law and such state shall thereafter be a party thereto with any and all states legally joining therein.

ARTICLE XIII

(a) A state party to this compact may withdraw therefrom by enacting a statute repealing the same. Such withdrawal shall take effect one year after notice thereof has been communicated officially and in writing to the governors and compact administrators of all other party states. However, the withdrawal of any state shall not change the status of any patient who has been sent to said state or sent out of said state pursuant to the provisions of the compact.

(b) Withdrawal from any agreement permitted by Article VII(b) as to costs or from any supplementary agreement made pursuant to Article XI shall be in accordance with the terms of such agreement.

ARTICLE XIV

This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters.

History.—s. 1, ch. 71-219; s. 718, ch. 95-148.

394.480 Compact administrator.—Pursuant to said compact, the Secretary of Health and Rehabilitative Services shall be the compact administrator who, acting jointly with like officers of other party states, shall have power to promulgate rules and regulations to carry out more effectively the terms of the compact. The compact administrator is hereby authorized, empowered, and directed to cooperate with all departments, agencies, and officers of and in the government of this state and its subdivisions in facilitating the proper administration of the compact of any supplementary agreement or agreements entered into by this state thereunder.

History.—s. 2, ch. 71-219.

394.481 Supplemental agreements with other states.—The compact administrator is hereby authorized and empowered to enter into supplementary agreements with appropriate officials of other states pursuant to Articles VII and XI of the compact. In the event that such supplementary agreements shall require or contemplate the use of any institution or facility of this state or require or contemplate the provision of any service by this state, no such agreement shall have force or effect until approved by the head of the department or agency under whose jurisdiction said institution or facility is operated or whose department or agency will be charged with the rendering of such service.

History.—s. 3, ch. 71-219.

394.482 Payment of financial obligations imposed by compact.—The compact administrator, subject to the approval of the Comptroller, may make or arrange for any payments necessary to discharge any financial obligations imposed upon this state by the compact or by any supplementary agreement entered into thereunder.

History.—s. 4, ch. 71-219.

394.483 Authorized actions by administrator.—The compact administrator is hereby directed to consult with the immediate family representatives or guardian of any proposed transferee and, in the case of a proposed transferee from an institution in this state to an institution in another party state, to take no final action without approval of the committing court, if any.

History.—s. 5, ch. 71-219.

394.484 Transmission of copies of act adopting compact.—Copies of this act shall upon its approval be transmitted by the Department of State to the governor of each state, the Attorney General and the Administrator of General Services of the United States, and the Council of State Governments.

History.—s. 6, ch. 71-219.

PART III

CHILDREN'S RESIDENTIAL AND DAY TREATMENT CENTERS

394.50 Children's residential and day treatment centers.
394.56 Voluntary admission to a center; procedure.
394.57 Involuntary admission to a center; procedure.
394.58 Records.
394.59 Payment for care and treatment of patients.
394.60 Transfer of patients.
394.61 Discharge of voluntary patients.
394.62 Age limit.

394.50 Children's residential and day treatment centers.—There are established in this state children's residential and day treatment centers which shall be under the supervision and control of the Department of Health and Rehabilitative Services. The purpose of the centers shall be to provide for evaluation, care, treatment, and education of emotionally, mentally, or behaviorally disturbed children. The department is authorized to develop children's residential and day treatment cen-

ters and children's programs in such locations as it deems appropriate and within the limits of funds appropriated by the Legislature.

History.—s. 1, ch. 59-383; ss. 19, 35, ch. 69-106; s. 207, ch. 77-147; s. 2, ch. 78-434.

394.56 Voluntary admission to a center; procedure.

(1) Application for admission to a residential or day treatment program shall be made to the center on forms provided by the department. Applications should be signed by the parent or legal guardian of the applicant or, in absence of such, the person or agency having legal custody of the applicant. A child 12 years or older has the same right to volunteer for treatment without parental consent as specified in s. 394.465(1)(b). An application for admission to a residential or day treatment program shall be accompanied by a certificate signed by a physician licensed or authorized to practice in Florida under chapter 458 and by any comprehensive community mental health center director or mental health clinic director, designated receiving facility, licensed clinical psychologist, or social or child care agency director. The certificate shall be based on an examination conducted not more than 15 days prior to the date of application. The application shall contain the history of and the results of any examinations of the applicant and a diagnosis of the applicant's condition, and it shall state that admission to the center, including related evaluation, treatment, and educational programs, would, in the physician's opinion, be beneficial to the child.

(2) Upon receipt of the application, the director of a center shall, on the basis of the certificate and any other evaluation methods he or she determines, accept or reject the applicant as a patient in the center. The director of the center shall determine the order of admission of applicants. The ability to pay shall never be a prerequisite to admission, evaluation, treatment, and education in a center.

History.—s. 7, ch. 59-383; ss. 19, 35, ch. 69-106; s. 4, ch. 70-432; s. 1, ch. 70-439; s. 25, ch. 73-334; s. 213, ch. 77-147; s. 3, ch. 78-434; s. 719, ch. 95-148.

394.57 Involuntary admission to a center; procedure.—Whenever any child in the state is believed to be severely emotionally, mentally, or behaviorally disturbed and voluntary admission is not possible, the involuntary admission criteria and procedures established in s. 394.467 shall be followed. In the event a child has been a patient in a children's residential or day treatment center on a voluntary basis and it becomes necessary to initiate involuntary proceedings, the criteria and procedures established in s. 394.467 shall be followed by the director of the center.

History.—s. 8, ch. 59-383; s. 5, ch. 70-432; s. 25, ch. 73-334; s. 23, ch. 78-414; s. 4, ch. 78-434.

394.58 Records.—The order of involuntary hospitalization shall be forwarded to the center. This shall be accompanied by a copy of the medical and psychiatric examination and a social history of the child.

History.—s. 9, ch. 59-383; ss. 19, 35, ch. 69-106; s. 214, ch. 77-147; s. 5, ch. 78-434.

394.59 Payment for care and treatment of patients. Fees and fee collections for patients at a residential or day treatment center shall be based on the provisions of s. 402.33.

History.—s. 10, ch. 59-383; ss. 19, 35, ch. 69-106; s. 215, ch. 77-147; s. 4, ch. 78-332; s. 6, ch. 78-434.

394.60 Transfer of patients.—If the director of a center upon advice of his or her clinical staff determines that any child at the center is not responding to or benefiting from the treatment and education programs at the center and that such child is in need of further care, rehabilitation, special training, education, and treatment and would be more suitably cared for, rehabilitated, trained, educated, and treated at another of the state facilities under the Department of Health and Rehabilitative Services, the center shall request the child's transfer to the proper facility. Transfers of such child to a mental health facility or retardation facility shall follow the procedures as set forth in part I of chapter 394 and chapter 393, respectively.

History.—s. 11, ch. 59-383; ss. 19, 35, ch. 69-106; s. 131, ch. 77-104; s. 216, ch. 77-147; s. 24, ch. 78-414; s. 7, ch. 78-434; s. 720, ch. 95-148.

394.61 Discharge of voluntary patients.—

(1) When a child has been a patient at a center and subject to care, treatment, and education, and the director, upon advice of his or her professional staff, is of the opinion that the child has sufficiently improved or will no longer benefit from care, treatment, and education at the center, the director may issue a certificate of discharge and discharge the child from the center.

(2) The director of the center shall discharge a child within 5 days of receipt of written request from the parent or legal guardian for discharge, unless the discharge is, in the opinion of the center staff, unsafe for the patient or others; in which case, the director of the center shall initiate proceedings for involuntary hospitalization within 3 days of the delivery of the written request. A center is authorized to retain a child after proceedings for involuntary admission have been initiated pending the outcome of the judicial decision. Upon discharge of a child who was involuntarily admitted, a copy of the certificate of discharge shall be mailed to the circuit judge who ordered the child's involuntary admission. A copy of the discharge certificate shall also be sent by registered or certified mail to the parent or guardian of the child. Upon the filing and docketing of the certificate, the case shall be terminated. In the event the parent or legal guardian cannot be found or refuses to accept custody of the discharged child, the child shall be placed in the care and custody of an appropriate community agency. If no community agency is willing or able to accept care and custody of the child, the circuit court of the judicial district from which the child was originally admitted shall place the child in the care and custody of the department. The circuit court may make such other order as it deems in the best interest of the child.

History.—s. 12, ch. 59-383; ss. 19, 35, ch. 69-106; s. 25, ch. 73-334; s. 217, ch. 77-147; s. 8, ch. 78-434; s. 721, ch. 95-148.

394.62 Age limit.—Any child 5 to 14 years of age is eligible for admission to a children's residential or day treatment center.

History.—s. 13, ch. 59-383; s. 9, ch. 78-434.

PART IV

COMMUNITY ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH SERVICES

394.65 Short title.
394.66 Legislative intent with respect to alcohol, drug abuse, and mental health services.
394.67 Definitions.
394.675 Alcohol, drug abuse, and mental health service system.
394.73 Joint alcohol, drug abuse, and mental health service programs in two or more counties.
394.74 Contracts for provision of local alcohol, drug abuse, and mental health programs.
394.75 District alcohol, drug abuse, and mental health plans.
394.76 Financing of district programs and services.
394.77 Uniform management information, accounting, and reporting systems for providers.
394.78 Operation and administration; personnel standards; procedures for audit and monitoring of service providers; resolution of disputes.
394.79 State alcohol, drug abuse, and mental health plan.
394.80 Authorization to appropriate funds.
394.875 Crisis stabilization units and residential treatment facilities; authorized services; license required; penalties.
394.876 Applications.
394.877 Fees.
394.878 Issuance and renewal of licenses.
394.879 Rules; enforcement.
394.90 Inspection; right of entry; records.
394.902 Denial, suspension, and revocation; other remedies.
394.903 Receivership proceedings.
394.904 Mental Health Facility Licensing Trust Fund.
394.907 Community mental health centers; quality assurance programs.

394.65 Short title.—This part shall be known as "The Community Alcohol, Drug Abuse, and Mental Health Services Act."

History.—s. 1, ch. 70-109; s. 10, ch. 84-285.

394.66 Legislative intent with respect to alcohol, drug abuse, and mental health services.—It is the intent of the Legislature to:

(1) Promote and improve the mental health of the citizens of the state through a system of comprehensive, coordinated alcohol, drug abuse, and mental health services.

(2) Involve local citizens in the planning of alcohol, drug abuse, and mental health services in their communities.

(3) Ensure that all activities of the Department of Health and Rehabilitative Services and its contractors are directed toward the coordination of planning efforts in alcohol, drug abuse, and mental health treatment services.

(4) Provide access to services to all residents of the state with priority of attention being given to individuals exhibiting symptoms of acute or chronic mental illness, alcohol abuse, or drug abuse.

(5) Ensure continuity of care, consistent with minimum standards, for persons who are released from a state treatment facility into the community.

(6) Provide accountability for service provision through statewide standards for management, monitoring, and reporting of information.

(7) Include alcohol, drug abuse, and mental health services as a component of the integrated service delivery system of the Department of Health and Rehabilitative Services.

(8) Ensure that the districts of the department are the focal point of all alcohol, drug abuse, and mental health planning activities, including budget submissions, grant applications, contracts, and other arrangements that can be effected at the district level.

(9) Organize and finance community alcohol, drug abuse, and mental health services in local communities throughout the state through locally administered service delivery programs that maximize the involvement of local citizens.

History.—s. 2, ch. 70-109; s. 30, ch. 75-48; s. 1, ch. 76-221; s. 11, ch. 84-285.

394.67 Definitions.—When used in this part, unless the context clearly requires otherwise, the term:

(1) "Advisory council" means a district advisory council.

(2) "Alcohol, drug abuse, and mental health planning council" or "council" means the council within a Department of Health and Rehabilitative Services district or subdistrict established in accordance with the provisions of this part for the purpose of assessing the alcohol, drug abuse, and mental health needs of the community and developing a plan to address those needs.

(3) "Department" means the Department of Health and Rehabilitative Services.

(4) "District administrator" means the person appointed by the Secretary of Health and Rehabilitative Services for the purpose of administering a department service district as set forth in s. 20.19.

(5) "District plan" or "plan" means the combined district alcohol, drug abuse, and mental health plan prepared by the alcohol, drug abuse, and mental health planning council and approved by the district administrator and governing bodies in accordance with this part.

(6) "Federal funds" means funds from federal sources for alcohol, drug abuse, or mental health facilities and programs, exclusive of federal funds that are deemed eligible by the Federal Government, and are eligible through state regulation, for matching purposes.

(7) "Governing body" means the chief legislative body of a county, a board of county commissioners, or boards of county commissioners in counties acting jointly, or their counterparts in a charter government.

(8) "Local matching funds" means funds received from governing bodies of local government, including city commissions, county commissions, district school boards, special tax districts, private hospital funds, private gifts, both individual and corporate, and bequests

and funds received from community drives or any other sources.

(9) "Patient fees" means compensation received by a community alcohol, drug abuse, or mental health facility for services rendered to clients from any source of funds, including city, county, state, federal, and private sources.

(10) "Program office" means the Alcohol, Drug Abuse, and Mental Health Program Office of the Department of Health and Rehabilitative Services.

(11) "Service district" means a community service district as established by the department under s. 20.19 for the purpose of providing community alcohol, drug abuse, and mental health services.

(12) "Service provider" means any agency in which all or any portion of the programs or services set forth in s. 394.675 are carried out.

(13) "Crisis stabilization unit" means a program providing an alternative to inpatient hospitalization and which provides brief, intensive services 24 hours a day, 7 days a week, for mentally ill individuals who are in an acutely disturbed state.

(14) "Residential treatment facility" means a facility providing residential care and treatment to individuals exhibiting symptoms of mental illness who are in need of a 24-hour, 7-day-a-week structured living environment, respite care, or long-term community placement. Residential treatment facility shall also include short-term residential treatment facilities for treatment of mental illness.

(15) "Licensed facility" means a facility licensed in accordance with this chapter.

(16) "Premises" means those buildings, beds, and facilities located at the main address of the licensee and all other buildings, beds, and facilities for the provision of acute or residential care located in such reasonable proximity to the main address of the licensee as to appear to the public to be under the dominion and control of the licensee.

(17) "Client" means any individual receiving services in any alcohol, drug abuse, or mental health facility, program, or service, which facility, program, or service is operated, funded, or regulated by the Department of Health and Rehabilitative Services.

History.—s. 3, ch. 70-109; s. 2, ch. 76-221; s. 132, ch. 77-104; s. 7, ch. 81-290; s. 2, ch. 82-223; s. 12, ch. 84-285; s. 1, ch. 85-167; s. 12, ch. 86-220; s. 11, ch. 92-58; s. 12, ch. 93-200.

394.675 Alcohol, drug abuse, and mental health service system.—

(1) A system of comprehensive alcohol, drug abuse, and mental health services shall be established as follows:

(a) "Primary care services" are those services which, at a minimum, must be made available in each service district to persons who have acute or chronic mental illnesses, who are acute or chronic drug dependents, and who are acute or chronic alcohol abusers to provide them with immediate care and treatment in crisis situations and to prevent further deterioration or exacerbation of their conditions. These services include, but are not limited to, emergency-stabilization services, detoxification services, inpatient services, residential services, and case management services.

(b) "Rehabilitative services" are those services which are made available to the general population at risk of serious mental health problems or substance abuse problems or which are provided as part of a rehabilitative program. These services are designed to prepare or train persons to function within the limits of their disabilities, to restore previous levels of functioning, or to improve current levels of inadequate functioning. Rehabilitative services include, but are not limited to, outpatient services, day treatment services, and partial hospitalization services.

(c) "Preventive services" are those services which are made available to the general population for the purpose of preventing or ameliorating the effects of alcohol abuse, drug abuse, or mental illness. These services emphasize the reduction of the occurrence of emotional disorders, mental disorders, and substance abuse through public education, early detection, and timely intervention. Preventive services include consultation, public education, and prevention services which have been determined through the district planning process to be necessary to complete a continuum of services as required by this part and which are included in the district plan.

(2) Notwithstanding the provisions of this part, funds which are provided through state and federal sources for specific services shall be used for those purposes.

History.—s. 13, ch. 84-285.

394.73 Joint alcohol, drug abuse, and mental health service programs in two or more counties.—

(1) Subject to rules established by the department, any county within a service district shall have the same power to contract for alcohol, drug abuse, and mental health services as the department has under existing statutes.

(2) In order to carry out the intent of this part and to provide alcohol, drug abuse, and mental health services in accordance with the district plan, the counties within a service district may enter into agreements with each other for the establishment of joint service programs. The agreements may provide for the joint provision or operation of services and facilities or for the provision or operation of services and facilities by one participating county under contract with other participating counties.

(3) When a service district comprises two or more counties or portions thereof, it is the obligation of the planning council to submit to the governing bodies, prior to the budget submission date of each governing body, an estimate of the proportionate share of costs of alcohol, drug abuse, and mental health services proposed to be borne by each such governing body.

(4) Any county desiring to withdraw from a joint program may submit to the district administrator a resolution requesting withdrawal therefrom together with a plan for the equitable adjustment and division of the assets, property, debts, and obligations, if any, of the joint program.

History.—s. 9, ch. 70-109; s. 1, ch. 70-439; s. 8, ch. 76-221; s. 15, ch. 84-285.

394.74 Contracts for provision of local alcohol, drug abuse, and mental health programs.—

(1) The department, when funds are available for such purposes, is authorized to contract for the establishment and operation of local alcohol, drug abuse, and mental health programs with any hospital, clinic, laboratory, institution, or other appropriate service provider.

(2) Contracts for service shall be consistent with the approved district plan and the service priorities established in s. 394.75(4).

(3) Contracts shall include, but are not limited to:

(a) A provision that, within the limits of available resources, primary care alcohol, drug abuse, and mental health services shall be available to any individual residing or employed within the service area, regardless of ability to pay for such services, current or past health condition, or any other factor;

(b) A provision that such services be available with priority of attention being given to individuals who exhibit symptoms of chronic or acute alcoholism, drug abuse, or mental illness and who are unable to pay the cost of receiving such services;

(c) A provision that every reasonable effort to collect appropriate reimbursement for the cost of providing alcohol, drug abuse, and mental health services to persons able to pay for services, including first-party payments and third-party payments, shall be made by facilities providing services pursuant to this act;

(d) A program description and line-item operating budget by program service component for alcohol, drug abuse, and mental health services, provided the entire proposed operating budget for the service provider will be displayed; and

(e) A requirement that the contractor must conform to department rules and the priorities established thereunder.

(4) The department shall develop standard contract forms for use between the district administrator and community alcohol, drug abuse, and mental health service providers.

(5) Nothing in this part prevents any city or county, or combination of cities and counties, from owning, financing, and operating an alcohol, drug abuse, or mental health program by entering into an arrangement with the district to provide, and be reimbursed for, services provided as part of the district plan.

History.—s. 10, ch. 70-109; s. 9, ch. 76-221; s. 3, ch. 82-223; s. 32, ch. 83-216; s. 16, ch. 84-285.

394.75 District alcohol, drug abuse, and mental health plans.—

(1)(a) The district planning council shall prepare a combined district alcohol, drug abuse, and mental health plan. The plan shall be prepared on a [1]biennial basis and shall be reviewed annually and shall reflect both the program priorities established by the department and the needs of the district. The plan shall include a program description and line-item budget by program service component for alcohol, drug abuse, and mental health service providers that will receive state funds. The entire proposed operating budget for each service provider shall be displayed. A schedule, format, and procedure for development and review of the plan shall be promulgated by the department.

(b) The plan shall be submitted by the district planning council to the district administrator and to the governing bodies for review, comment, and approval, as provided in subsection (9).

(2) The plan shall:

(a) Provide a projection of district program and fiscal needs for the next [1]biennium, provide for the orderly and economical development of needed services, and indicate priorities and anticipated expenditures and revenues.

(b) Include a summary budget request for the total district alcohol, drug abuse, and mental health program which shall include the funding priorities established by the district planning process.

(c) Provide a basis for the district legislative budget request.

(d) Include a policy and procedure for allocation of funds.

(e) Include a procedure for securing local matching funds. Such a procedure shall be developed in consultation with governing bodies and service providers.

(f) Provide for the integration of alcohol, drug abuse, and mental health services with the other departmental programs and with the criminal justice system within the district.

(g) Provide a plan for the coordination of services in such manner as to ensure effectiveness and avoid duplication, fragmentation of services, and unnecessary expenditures.

(h) Provide for continuity of client care between state treatment facilities and community programs.

(i) Provide for the most appropriate and economical use of all existing public and private agencies and personnel.

(j) Provide for the fullest possible and most appropriate participation by existing programs; state hospitals and other hospitals; city, county, and state health and family service agencies; drug abuse and alcoholism programs; probation departments; physicians; psychologists; social workers; public health nurses; school systems; and all other public and private agencies and personnel which are required to, or may agree to, participate in the plan.

(k) Include an inventory of all public and private alcohol, drug abuse, and mental health resources within the district, including consumer advocacy groups registered with the department.

(3) The plan shall address how primary care services will be provided and how a continuum of services will be provided given the resources available in the service district.

(4) The plan shall provide the means by which the needs of the following population groups having priority will be addressed in the district:

(a) Chronic public inebriates;

(b) Marginally functional alcoholics;

(c) Chronic opiate abusers;

(d) Poly-drug abusers;

(e) Chronically mentally ill individuals;

(f) Acutely mentally ill individuals;

(g) Severely emotionally disturbed children and adolescents;

(h) Elderly persons at high risk of institutionalization; and

(i) Individuals returned to the community from a state mental health treatment facility.

(5) In developing the plan, optimum use shall be made of any federal, state, and local funds that may be available for alcohol, drug abuse, and mental health service planning.

(6) The planning council shall establish a subcommittee to prepare the portion of the district plan relating to children and adolescents. The subcommittee shall include representative membership of any committee organized or established by the district to review placement of children and adolescents in residential treatment programs.

(7) All departments of state government and all local public agencies shall cooperate with officials to assist them in service planning. Each district administrator shall, upon request and the availability of staff, provide consultative services to the local agency directors and governing bodies.

(8) The district administrator shall ensure that the district plan:

(a) Conforms to the priorities in the state plan, the requirements of this part, and the standards adopted under this part;

(b) Ensures that the most effective and economical use will be made of available public and private alcohol, drug abuse, and mental health resources in the service district; and

(c) Has adequate provisions made for review and evaluation of the services provided in the service district.

(9) The district administrator shall require such modifications in the district plan as he or she deems necessary to bring the plan into conformance with the provisions of this part. If the district planning council and the district administrator cannot agree on the plan, including the projected budget, the issues under dispute shall be submitted directly to the secretary of the department for immediate resolution.

(10) Each governing body that provides local funds has the authority to require necessary modification to only that portion of the district plan which affects alcohol, drug abuse, and mental health programs and services within the jurisdiction of that governing body.

(11) The district administrator shall report annually to the district planning council the status of funding for priorities established in the district plan. Each report must include:

(a) A description of the district plan priorities that were included in the district legislative budget request;

(b) A description of the district plan priorities that were included in the departmental budget request prepared under s. 20.19;

(c) A description of the programs and services included in the district plan priorities that were appropriated funds by the Legislature in the legislative session that preceded the report.

History.—s. 11, ch. 70-109; s. 1, ch. 70-439; s. 10, ch. 76-221; s. 2, ch. 77-372; s. 4, ch. 82-223; s. 17, ch. 84-285; s. 18, ch. 88-398; s. 60, ch. 91-221; s. 6, ch. 92-174; s. 13, ch. 93-200; s. 7, ch. 93-267; s. 722, ch. 95-148.

[1]**Note.**—Chapter 91-109 provides for a change from biennial to annual budgeting.

394.76 Financing of district programs and services.—If the local match funding level is not provided in the General Appropriations Act or the substantive bill implementing the General Appropriations Act, such funding level shall be provided as follows:

(1) The district administrator shall ensure that, to the extent possible within available resources, a continuum of integrated and comprehensive services will be available within the district.

(2) If in any fiscal year the approved state appropriation is insufficient to finance the programs and services specified by this part, the department shall have the authority to determine the amount of state funds available to each service district for such purposes in accordance with the priorities in both the state and district plans. The district administrator shall consult with the planning council to ensure that the summary operating budget conforms to the approved plan.

(3) The state share of financial participation shall be determined by the following formula:

(a) The state share of approved program costs shall be a percentage of the net balance determined by deducting from the total operating cost of services and programs, as specified in s. 394.675(1), those expenditures which are ineligible for state participation as provided in subsection (7) and those ineligible expenditures established by rule of the department pursuant to s. 394.78.

(b) Residential and case management services which are funded as part of a deinstitutionalization project shall not require local matching funds and shall not be used as local matching funds. The state and federal financial participation portions of Medicaid earnings pursuant to Title XIX of the Social Security Act, except for the amount of general revenue equal to the amount appropriated in 1985-1986 plus all other general revenue that is shifted from any other alcohol, drug abuse, and mental health appropriation category after fiscal year 1986-1987, shall not require local matching funds and shall not be used as local matching funds. Local matching funds are not required for general revenue transferred by the department into alcohol, drug abuse, and mental health appropriations categories during a fiscal year to match federal funds earned from Medicaid services provided for mental health clients in excess of the amounts initially appropriated. Funds for children's services which were provided through the Children, Youth, and Families Services budget which did not require local match prior to being transferred to the Alcohol, Drug Abuse, and Mental Health Services budget shall be exempt from local matching requirements. All other contracted community alcohol and mental health services and programs, except as identified in s. 394.457(3), shall require local participation on a 75-to-25 state-to-local ratio.

(c) The expenditure of 100 percent of all third-party payments and fees shall be considered as eligible for state financial participation if such expenditures are in accordance with subsection (7) and the approved district plan.

(d) Fees generated by residential and case management services which are funded as part of a deinstitutionalization program and do not require local matching funds shall be used to support program costs approved in the district plan.

(e) Any earnings pursuant to Title XIX of the Social Security Act in excess of the amount appropriated shall be used to support program costs approved in the district plan.

(4) Notwithstanding the provisions of subsection (3), the department is authorized to develop and demonstrate alternative financing systems for alcohol, drug abuse, and mental health services. Proposals for demonstration projects conducted pursuant to this subsection shall be reviewed by the substantive and appropriations committees of the Senate and the House of Representatives prior to implementation of the projects.

(5) The department is authorized to make investigations and to require audits of expenditures. The department may authorize the use of private certified public accountants for such audits. Audits shall follow department guidelines.

(6) Claims for state payment shall be made in such form and in such manner as the department determines.

(7) The expenditures which are subject to state payment include expenditures that are approved in the district plan for: salaries of personnel; approved facilities and services provided through contract; operation, maintenance, and service cost; depreciation of facilities; and such other expenditures as may be approved by the district administrator. Such expenditures do not include expenditures for compensation to members of a community agency board, except the actual and necessary expenses incurred in the performance of official duties, or expenditures for a purpose for which state payment is claimed under any other provision of law.

(8) Expenditures for capital improvements relating to construction of, addition to, purchase of, or renovation of a community alcohol, drug abuse, or mental health facility may be made by the state, provided such expenditures or capital improvements are part and parcel of an approved district plan. Nothing shall prohibit the use of such expenditures for the construction of, addition to, renovation of, or purchase of facilities owned by a county, city, or other governmental agency of the state or a nonprofit entity. Such expenditures are subject to the provisions of subsection (6).

(9)(a) State funds for community alcohol and mental health services shall be matched by local matching funds as provided in paragraph (3)(b). The governing bodies within a district or subdistrict shall be required to participate in the funding of alcohol and mental health services under the jurisdiction of such governing bodies. The amount of the participation shall be at least that amount which, when added to other available local matching funds, is necessary to match state funds.

(b) The provisions of paragraph (a) to the contrary notwithstanding, no additional matching funds may be required solely due to the addition in the General Appropriations Act of Alcohol, Drug Abuse, and Mental Health Block Grant Funds for local community mental health centers and alcohol project grants.

(10) A local governing body is authorized to appropriate moneys, in lump sum or otherwise, from its public funds for the purpose of carrying out the provisions of this part. In addition to the payment of claims upon submission of proper vouchers, such moneys may also, at the option of the governing body, be disbursed in the form of a lump-sum or advance payment for services for expenditure, in turn, by the recipient of the disbursement without prior audit by the auditor of the governing body. Such funds shall be expended only for alcohol, drug abuse, or mental health purposes as provided in the approved district plan. Each governing body appropriating and disbursing moneys pursuant to this subsection shall require the expenditure of such moneys by the recipient of the disbursement to be audited annually either in conjunction with an audit of other expenditures or by a separate audit. Such annual audits shall be furnished to the governing bodies of each participating county and municipality for their examination.

(11) No additional local matching funds shall be required solely due to the addition in the General Appropriations Act of alcohol, drug abuse, and mental health block grant funds for local community mental health centers, drug abuse programs, and alcohol project grants.

History.—s. 12, ch. 70-109; s. 1, ch. 70-439; s. 111, ch. 71-355; ss. 1, 2, ch. 72-386; s. 1, ch. 74-291; s. 11, ch. 76-221; s. 33, ch. 77-312; ss. 3, 5, ch. 77-372; s. 5, ch. 82-223; s. 18, ch. 84-285; s. 1, ch, 87-244; s. 26, ch. 87-247; s. 19, ch. 88-398; s. 27, ch. 88-557.

394.77 Uniform management information, accounting, and reporting systems for providers.—The department shall establish, for the purposes of control of costs:

(1) A uniform management information system and fiscal accounting system for use by providers of community alcohol, drug abuse, and mental health services.

(2) A uniform reporting system with uniform definitions and reporting categories.

History.—s. 13, ch. 70-109; s. 1, ch. 70-439; s. 12, ch. 76-221; s. 6, ch. 82-223; s. 19, ch. 84-285.

394.78 Operation and administration; personnel standards; procedures for audit and monitoring of service providers; resolution of disputes.—

(1)(a) The Department of Health and Rehabilitative Services shall administer this part and shall adopt rules necessary for its administration.

(b) Rules of the department shall be adopted in accordance with the Administrative Procedure Act under chapter 120.

(2) The department shall, by rule, establish standards of education and experience for professional and technical personnel employed in alcohol, drug abuse, and mental health programs.

(3) The department shall establish, to the extent possible, a standardized auditing procedure for alcohol, drug abuse, and mental health service providers; and audits of service providers shall be conducted pursuant to such procedure and the applicable department rules. Such procedure shall be supplied to all current and prospective contractors and subcontractors prior to the signing of any contracts.

(4) The department shall monitor service providers for compliance with contracts and applicable state and federal regulations. A representative of the district planning council shall be represented on the monitoring team.

(5) In unresolved disputes regarding this part or rules established pursuant to this part, providers and district planning councils shall adhere to formal proce-

dures as provided by the rules established by the department.

History.—s. 14, ch. 70-109; s. 1, ch. 70-439; s. 13, ch. 76-221; s. 4, ch. 77-372; s. 20, ch. 84-285.

394.79 State alcohol, drug abuse, and mental health plan.—

(1) The department shall prepare a [1]biennial plan for the delivery and financing of a system of alcohol, drug abuse, and mental health services. The plan shall include:

(a) The current and projected need for alcohol, drug abuse, and mental health services, displayed statewide and by district, and the extent to which the need is being addressed by existing services.

(b) A proposal for the development of a data system that will evaluate the effectiveness of programs and services provided to clients of the alcohol, drug abuse, and mental health service system.

(c) A proposal to resolve the funding discrepancies between districts.

(d) A methodology for the allocation of resources available from federal, state, and local sources and a description of the current level of funding available from each source.

(e) A description of the statewide priorities for clients and services and each district's priorities for clients and services.

(f) Recommendations for methods of enhancing local participation in the planning, organization, and financing of alcohol, drug abuse, and mental health services.

(g) A description of the current methods of contracting for services, an assessment of the efficiency of these methods in providing accountability for contracted funds, and recommendations for improvements to the system of contracting.

(h) Recommendations for improving access to services by clients and their families.

(i) Guidelines and formats for the development of district plans.

(j) Recommendations for future directions for the alcohol, drug abuse, and mental health service delivery system.

(2) The department shall prepare the state plan in consultation with district administrators, state treatment facility administrators, and district planning councils.

(3) A copy of the state plan shall be submitted to the Legislature and each district planning council. A summary budget request and a summary statement of priorities from each service district shall be attached to the plan.

History.—s. 15, ch. 70-109; s. 1, ch. 70-439; s. 14, ch. 76-221; s. 21, ch. 84-285; s. 20, ch. 88-398.

[1]Note.—Chapter 91-109 provides for a change from biennial to annual budgeting.

394.80 Authorization to appropriate funds.—The several cities and counties of this state are authorized to appropriate funds to support all or any portion of the cost of services and construction not met through support by the state or federal governments.

History.—s. 16, ch. 70-109.

394.875 Crisis stabilization units and residential treatment facilities; authorized services; license required; penalties.—

(1)(a) The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Crisis stabilization units may screen, assess, and admit for stabilization persons who present themselves to the unit and persons who are brought to the unit under s. 394.463. Clients may be provided 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services. Crisis stabilization units shall provide services regardless of the client's ability to pay and shall be limited in size to a maximum of 30 beds.

(b) The purpose of a residential treatment facility is to be a part of a comprehensive treatment program for mentally ill individuals in a community-based residential setting.

(2) After July 1, 1986, it is unlawful for any entity to hold itself out as a crisis stabilization unit or a residential treatment facility, or to act as a crisis stabilization unit or a residential treatment facility, unless it is licensed by the department pursuant to this chapter.

(3) Any person who violates subsection (2) is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(4) The department may maintain an action in circuit court to enjoin the unlawful operation of a crisis stabilization unit or a residential treatment facility if the department first gives the violator 14 days' notice of its intention to maintain such action and if the violator fails to apply for licensure within such 14-day period.

(5) Subsection (2) does not apply to:

(a) Homes for special services licensed under chapter 400;

(b) Nursing homes licensed under chapter 400; or

(c) Residential child caring facilities licensed under s. 409.175.

(6) The department may establish multiple license classifications for residential treatment facilities.

(7) The department shall not issue a license to a crisis stabilization unit unless the unit receives state mental health funds and is affiliated with a designated public receiving facility.

(8) The department may issue a license for a crisis stabilization unit or short-term residential treatment facility, certifying the number of authorized beds for such facility as indicated by existing need and available appropriations. The department may disapprove an application for such a license if it determines that a facility should not be licensed pursuant to the provisions of this chapter. Any facility operating beds in excess of those authorized by the department shall, upon demand of the department, reduce the number of beds to the authorized number, forfeit its license, or provide evidence of a license issued pursuant to chapter 395 for the excess beds.

(9) A children's crisis stabilization unit which does not exceed 20 licensed beds and which provides separate facilities or a distinct part of a facility, separate staffing, and treatment exclusively for minors may be located on the same premises as a crisis stabilization unit serving adults. The department shall promulgate rules governing facility construction, staffing and licensure requirements, and the operation of such units for minors.

(10) Notwithstanding the provisions of subsection (8), crisis stabilization units may not exceed their licensed capacity by more than 10 percent, nor may they exceed their licensed capacity for more than 3 consecutive working days or for more than 7 days in 1 month.

(11) Notwithstanding the other provisions of this section, any facility licensed under chapters [1]396 and 397 for detoxification, residential level I care, and outpatient treatment may elect to license concurrently all of the beds at such facility both for that purpose and as a long-term residential treatment facility pursuant to this section, if all of the following conditions are met:

(a) The licensure application is received by the department prior to January 1, 1993.

(b) On January 1, 1993, the facility was licensed under chapters [1]396 and 397 as a facility for detoxification, residential level I care, and outpatient treatment of substance abuse.

(c) The facility restricted its practice to the treatment of law enforcement personnel for a period of at least 12 months beginning after January 1, 1992.

(d) The number of beds to be licensed under chapter 394 is equal to or less than the number of beds licensed under chapters [1]396 and 397 as of January 1, 1993.

(e) The licensee agrees in writing to a condition placed upon the license that the facility will limit its treatment exclusively to law enforcement personnel and their immediate families who are seeking admission on a voluntary basis and who are exhibiting symptoms of posttraumatic stress disorder or other mental health problems, including drug or alcohol abuse, which are directly related to law enforcement work and which are amenable to verbal treatment therapies; the licensee agrees to coordinate the provision of appropriate postresidential care for discharged individuals; and the licensee further agrees in writing that a failure to meet any condition specified in this paragraph shall constitute grounds for a revocation of the facility's license as a residential treatment facility.

(f) The licensee agrees that the facility will meet all licensure requirements for a residential treatment facility, including minimum standards for compliance with lifesafety requirements, except those licensure requirements which are in express conflict with the conditions and other provisions specified in this subsection.

(g) The licensee agrees that the conditions stated in this subsection must be agreed to in writing by any person acquiring the facility by any means.

Any facility licensed under this subsection is not required to provide any services to any persons except those included in the specified conditions of licensure, and is exempt from any requirements related to the 60-day or greater average length of stay imposed on community-based residential treatment facilities otherwise licensed under this chapter.

History.—ss. 2, 11, ch. 85-167; s. 1, ch. 90-251; s. 249, ch. 91-224; s. 4, ch. 91-429; s. 9, ch. 93-247.

[1]**Note.**—Repealed by s. 48, ch. 93-39.

394.876 Applications.—

(1) Any person desiring to be licensed under this chapter shall apply to the department on forms provided by the department. The application shall contain the following:

(a) The name and address of the applicant, the name of the unit or facility, and the address of the unit or facility.

(b)1. If the applicant is a partnership, association, or other form of entity other than an individual or a corporation, the name and address of each member or owner of the entity.

2. If the applicant is a corporation, the name and address of each director or officer and the name and address of each person holding at least 10 percent ownership interest in the corporation.

(c) Such information as the department determines to be necessary to establish the character and competency of the applicant and of the person who is or will be administrator of the unit or facility.

(d) Such information as the department determines necessary to determine the ability of the applicant to carry out its responsibilities under this chapter.

(2) The applicant shall furnish proof satisfactory to the department of its financial ability to operate the unit or facility in accordance with this chapter. An applicant for an original license shall submit a balance sheet and a statement projecting revenues, expenses, taxes, extraordinary items, and other credits and charges for the first 6 months of operation.

(3) The applicant shall provide proof of liability insurance coverage in amounts set by the department by rule.

(4) The department shall accept proof of accreditation by the Joint Commission on Accreditation of Hospitals in lieu of the information required by subsection (1).

History.—ss. 3, 11, ch. 85-167; s. 4, ch. 91-429.

394.877 Fees.—

(1) Each application for licensure or renewal shall be accompanied by a fee set by the department by rule. Such fees shall be reasonably calculated to cover only the cost of regulation under this chapter.

(2) All fees collected under this section shall be deposited in the Mental Health Facility Licensing Trust Fund.

History.—ss. 4, 11, ch. 85-167; s. 4, ch. 91-429.

394.878 Issuance and renewal of licenses.—

(1) Upon review of the application for licensure and receipt of appropriate fees, the department shall issue an original or renewal license to any applicant that meets the requirements of this chapter.

(2) A license is valid for a period of 1 year. An applicant for renewal of a license shall apply to the department no later than 90 days before expiration of the current license.

(3) A license may not be transferred from one entity to another and is valid only for the premises for which it was originally issued. For the purposes of this subsection, "transfer" includes, but is not limited to, transfer of a majority of the ownership interests in a licensee or transfer of responsibilities under the license to another entity by contractual arrangement.

(4) Each license shall state the services which the licensee is required or authorized to perform and the maximum residential capacity of the licensed premises.

(5) The department may issue a probationary license to an applicant that has completed the application requirements of this chapter but has not, at the time of the application, developed an operational crisis stabilization unit or residential treatment facility. The probationary license shall expire 90 days after issuance and may once be renewed for an additional 90-day period. The department may cancel a probationary license at any time.

(6) The department may issue an interim license to an applicant that has substantially completed all application requirements and has initiated action to fully meet such requirements. The interim license shall expire 90 days after issuance and, in cases of extreme hardship, may once be renewed for an additional 90-day period.

(7) Any applicant which fails to file an application for license renewal during the 90-day relicensure period shall be considered unlicensed and subject to penalties pursuant to s. 394.875.

History.—ss. 5, 11, ch. 85-167; s. 4, ch. 91-429.

394.879 Rules; enforcement.—

(1) The department shall adopt reasonable rules to implement this chapter, including, at a minimum, rules providing standards to ensure that:

(a) Sufficient numbers and types of qualified personnel are on duty and available at all times to provide necessary and adequate client safety and care.

(b) Adequate space is provided each client of a licensed facility.

(c) Licensed facilities are limited to an appropriate number of beds.

(d) Each licensee establishes and implements adequate infection control, housekeeping, sanitation, disaster planning, and medical recordkeeping.

(e) Licensed facilities are established, organized, and operated in accordance with programmatic standards of the department.

(2) Minimum firesafety standards shall be established and enforced by the State Fire Marshal in cooperation with the department. Such standards shall be included in the rule adopted by the department after consultation with the State Fire Marshal.

(3) The department shall allow any licensed facility in operation at the time of adoption of any rule a reasonable period, not to exceed 1 year, to bring itself into compliance with such rule.

(4) The department may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend or revoke the license or deny the renewal application of such licensee. In imposing such penalty, the department shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. Fines collected under this subsection shall be deposited in the Mental Health Facility Licensing Trust Fund.

History.—ss. 6, 11, ch. 85-167; s. 4, ch. 91-429.

394.90 Inspection; right of entry; records.—

(1)(a) The department may enter and inspect at any time a licensed facility to determine whether the facility is in compliance with this chapter and the rules of the department.

(b) The department may enter and inspect any premises that it has probable cause to suspect may be operating as an unlicensed crisis stabilization unit or residential treatment facility; however, such entry and inspection shall be made only with the permission of the person in charge of such premises or pursuant to warrant.

(c) Any application for licensure under this chapter constitutes full permission for the department to enter and inspect the premises of the applicant or licensee at any time.

(2) For purposes of monitoring and investigation, the department shall have access to the clinical records of any client of a licensee, the provisions of s. 394.459(9) to the contrary notwithstanding.

(3) The department shall schedule periodic inspections of licensees so as to minimize the cost to the licensees and the disruption of the licensees' programs. This subsection shall not be construed to limit the authority of the department to inspect the facilities of a licensee at any time.

(4) Each licensee shall maintain as public information, available to any person upon request, copies of all reports of inspections of the licensee filed with or issued by any governmental agency during the preceding 5-year period. The licensee shall furnish a copy of the most recent inspection report of the department to any person upon payment of a reasonable charge for copying.

(5)(a) The department may accept, in lieu of its own inspections for licensure, the survey or inspection of an accrediting organization, if the provider is accredited and the department receives the report of the accrediting organization. The department shall develop, and adopt by rule, specific criteria for assuring that the accrediting organization has specific standards and experience related to the program area being licensed, specific criteria for accepting the standards and survey methodologies of an accrediting organization, delineations of the obligations of accrediting organizations to assure adherence to those standards, criteria for receiving, accepting and maintaining the confidentiality of the survey and corrective action reports, and allowance for the department's participation in surveys.

(b) The department shall conduct [1]compliance investigations and sample validation inspections to evaluate the inspection process of accrediting organizations to ensure minimum standards are maintained as provided in Florida Statute and rule. The department may conduct a lifesafety inspection in calendar years in which an accrediting organization survey is not conducted and shall conduct a full state inspection, including a lifesafety inspection, if an accrediting organization survey has not been conducted within the previous 36 months. The department, by accepting the survey or inspection of an accrediting organization, does not forfeit its right to perform inspections.

History.—ss. 7, 11, ch. 85-167; s. 4, ch. 91-429; s. 47, ch. 93-39.

[1]**Note.**—The word "compliance" was substituted by the editors for the word "compliant."

394.902 Denial, suspension, and revocation; other remedies.—

(1) The department may issue an emergency order suspending or revoking a license if the department determines that the continued operation of the licensed facility presents a clear and present danger to the public health or safety.

(2) The department may impose a moratorium on elective admissions to a licensee or any program or portion of a licensed facility if the department determines that any condition in the facility presents a threat to the public health or safety.

(3) If the department determines that an applicant or licensee is not in compliance with this chapter or the rules adopted under this chapter, the department may deny, suspend, or revoke the license or application or may suspend, revoke, or impose reasonable restrictions on any portion of the license. If a license is revoked, the licensee is barred from submitting any application for licensure to the department for a period of 6 months following revocation.

(4) The department may maintain an action in circuit court to enjoin the operation of any licensed or unlicensed facility in violation of this chapter or the rules adopted under this chapter.

(5) License denial, suspension, or revocation procedures shall be in accordance with chapter 120.

History.—ss. 8, 11, ch. 85-167; s. 4, ch. 91-429.

394.903 Receivership proceedings.—

(1) The department may petition a court of competent jurisdiction for the appointment of a receiver for a crisis stabilization unit or a residential treatment facility when any of the following conditions exist:

(a) Any person is operating a unit or facility without a license and refuses to make application for a license as required by this part.

(b) The licensee is closing the unit or facility or has informed the department that it intends to close and adequate arrangements have not been made for relocation of the residents within 7 days, exclusive of weekends and holidays, of the closing of the unit or facility.

(c) The department determines that conditions exist in the unit or facility which present an imminent danger to the health, safety, or welfare of the residents of the unit or facility or a substantial probability that death or serious physical harm would result therefrom. The department shall, whenever possible, facilitate the continued operation of the program.

(d) The licensee cannot meet its financial obligations for providing food, shelter, care, and utilities. Issuance of bad checks or accumulation of delinquent bills for such items as personnel salaries, food, drugs, or utilities shall constitute prima facie evidence that the ownership of the unit or facility lacks the financial ability to operate the unit or facility in accordance with the requirements of this chapter and all rules adopted hereunder.

(2) Petitions for receivership shall take precedence over other court business unless the court determines that some other pending proceeding, having similar statutory precedence, shall have priority. A hearing shall be conducted within 5 days of the filing of the petition, at which time all interested parties shall have the opportunity to present evidence pertaining to the petition. The department shall notify the owner or operator of the unit or facility named in the petition of its filing and the dates for the hearing. The court shall grant the petition only upon finding that the health, safety, and welfare of residents of the unit or facility would be threatened if a condition existing at the time the petition was filed is permitted to continue. A receiver shall not be appointed ex parte unless the court determines that one or more of the conditions of subsection (1) exist and that the owner or operator cannot be found, that all reasonable means of locating the owner or operator and notifying him or her of the petition and hearing have been exhausted, or that the owner or operator after notification of the hearing chooses not to attend. After such findings, the court may appoint any person qualified by education, training, or experience to carry out the responsibilities of receiver pursuant to this section, except that it shall not appoint any owner or affiliate of the unit or facility which is in receivership. Prior to the appointment as receiver of a person who is the operator, manager, or supervisor of another unit or facility, the court shall determine that the person can reasonably operate, manage, or supervise more than one unit or facility. The receiver may be appointed for up to 90 days with the option of petitioning the court for 30-day extensions. The receiver may be selected from a list of persons qualified to act as receivers developed by the department and presented to the court with each petition for receivership. Under no circumstances shall the department or a designated departmental employee be appointed as a receiver for more than 60 days; however, the departmental receiver may petition the court for 30-day extensions. The department may petition the court to appoint a substitute receiver. The court shall grant the extension upon a showing of good cause. During the first 60 days of the receivership, the department shall not take action to decertify or revoke the license of a unit or facility unless conditions causing imminent danger to the health and welfare of the residents exist and a receiver has been unable to remove those conditions. After the first 60 days of receivership, and every 60 days thereafter until the receivership is terminated, the department shall submit to the court the results of an assessment of the unit's or facility's ability to assure the safety and care of the residents. If the conditions at the unit or facility or the intentions of the owner indicate that the purpose of the receivership is to close the unit or facility rather than to facilitate its continued operations, the department shall place the residents in appropriate alternative residential settings as quickly as possible. If, in the opinion of the court, the department has not been diligent in its efforts to make adequate placement arrangements, the court may find the department to be in contempt and shall order the department to submit its plans for moving the residents.

(3) The receiver shall make provisions for the continued health, safety, and welfare of all residents of the unit or facility and:

(a) Shall exercise those powers and perform those duties set out by the court.

(b) Shall operate the unit or facility in such a manner as to assure safety and adequate health care for the residents.

(c) Shall take such action as is reasonably necessary to protect or conserve the assets or property of the unit or facility for which the receiver is appointed, or the proceeds from any transfer thereof, and he or she may use them only in the performance of the powers and duties set forth in this section or by order of the court.

(d) May use the buildings, fixtures, furnishings, and any accompanying consumable goods in the provision of care and services to residents and to any other persons receiving services from the unit or facility at the time the petition for receivership is filed. The receiver shall collect payments for all goods and services provided to residents or others during the period of the receivership at the same rate of payment charged by the owners at the time the petition for receivership was filed or at a fair and reasonable rate otherwise approved by the court for private-pay residents.

(e) May correct or eliminate any deficiency in the structure, furnishings, or staffing of the unit or facility which endangers the safety or health of residents while they remain in the unit or facility; however, the total cost of correction shall not exceed $3,000. The court may order expenditures for this purpose in excess of $3,000 on application from the receiver after notice to the owner. A hearing may be requested by the owner within 72 hours.

(f) May let contracts and hire agents and employees to carry out the powers and duties of the receiver under this section.

(g) Shall honor all leases, mortgages, and secured transactions governing the building in which the unit or facility is located and all goods and fixtures in the building of which the receiver has taken possession, but only to the extent of payments which, in the case of rental agreement, are for the use of the property during the period of the receivership or which, in the case of a purchase agreement, become due during the period of the receivership.

(h) Shall have full power to direct, manage, hire, and discharge employees of the unit or facility subject to any contract rights they may have. The receiver shall hire and pay employees at the rate of compensation, including benefits, approved by the court. Receivership does not relieve the owner of any obligation to employees made prior to the appointment of a receiver and not carried out by the receiver.

(i) Shall be entitled to take possession of all property or assets of residents which are in the possession of a unit or facility or its owner. The receiver shall preserve all property or assets and all resident records of which the receiver takes possession and shall provide for the prompt transfer of the property, assets, and records to the new placement of any transferred resident. An inventory list certified by the owner and by the receiver shall be made at the time the receiver takes possession of the facility.

(4)(a) A person who is served with notice of an order of the court appointing a receiver and of the receiver's name and address shall be liable to pay the receiver for any goods or services provided by the receiver after the date of the order if the person would have been liable for the goods or services as supplied by the owner. The receiver shall give a receipt for each payment and shall keep a copy of each receipt on file. The receiver shall deposit accounts received in a separate account and shall use this account for all disbursements.

(b) The receiver may bring an action to enforce the liability created by paragraph (a).

(c) A payment to the receiver of any sum owing to the facility or its owner shall discharge any obligation to the facility to the extent of the payment.

(5)(a) A receiver may petition the court that he or she not be required to honor any lease, mortgage, secured transaction, or other wholly or partially executory contract entered into by the owner of the facility if the rent, price, or rate of interest required to be paid under the agreement was substantially in excess of a reasonable rent, price, or rate of interest at the time the contract was entered into, or if any material provision of the agreement was unreasonable, when compared to contracts negotiated under similar conditions. Any relief in this form provided by the court shall be limited to the life of the receivership, unless otherwise determined by the court.

(b) If the receiver is in possession of real estate or goods subject to a lease, mortgage, or security interest which the receiver has obtained a court order to avoid under paragraph (a), and if the real estate or goods are necessary for the continued operation of the unit or facility under this section, the receiver may apply to the court to set a reasonable rental, price, or rate of interest to be paid by the receiver during the duration of the receivership. The court shall hold a hearing on the application within 15 days. The receiver shall send notice of the application to any known persons who own the property involved or to mortgage holders at least 10 days prior to the hearing. Payment by the receiver of the amount determined by the court to be reasonable is a defense to any action against the receiver for payment or for possession of the goods or real estate subject to the lease, security interest, or mortgage involved by any person who received such notice, but the payment does not relieve the owner of the facility of any liability for the difference between the amount paid by the receiver and the amount due under the original lease, security interest, or mortgage involved.

(6) The court shall set the compensation of the receiver, which shall be considered a necessary expense of a receivership.

(7) A receiver may be held liable in a personal capacity only for the receiver's own gross negligence, intentional acts, or breaches of fiduciary duty.

(8) The court may require a receiver to post a bond.

(9) The court may terminate a receivership when:

(a) The court determines that the receivership is no longer necessary because the conditions which gave rise to the receivership no longer exist; or

(b) All of the residents in the unit or facility have been transferred or discharged.

(10) Within 30 days after termination, unless this time period is extended by the court, the receiver shall give the court a complete accounting of all property of which the receiver has taken possession, of all funds collected and disbursed, and of the expenses of the receivership.

(11) Nothing in this section shall be construed to relieve any owner, operator, or employee of a unit or

facility placed in receivership of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or omissions of the owner, operator, or employee prior to the appointment of a receiver; nor shall anything contained in this section be construed to suspend during the receivership any obligation of the owner, operator, or employee for payment of taxes or other operating and maintenance expenses of the unit or facility or of the owner, operator, or employee or any other person for the payment of mortgages or liens. The owner shall retain the right to sell or mortgage any unit or facility under receivership, subject to approval of the court which ordered the receivership. Receivership imposed under the provisions of this chapter shall be subject to the Mental Health Facility Licensing Trust Fund pursuant to s. 394.904. The owner of a facility placed in receivership by the court shall be liable for all expenses and costs incurred by the Mental Health Facility Licensing Trust Fund which occur as a result of the receivership.

History.—ss. 9, 11, ch. 85-167; s. 4, ch. 91-429; s. 723, ch. 95-148.

394.904 Mental Health Facility Licensing Trust Fund.—There is created in the State Treasury the Mental Health Facility Licensing Trust Fund. All moneys collected by the department pursuant to this chapter shall be deposited in the trust fund. Moneys in the trust fund shall be appropriated to the department for the purpose of covering the cost of regulation of facilities licensed under this chapter and any other purpose related to enforcement of this chapter.

History.—ss. 10, 11, ch. 85-167; s. 4, ch. 91-429.

394.907 Community mental health centers; quality assurance programs.—

(1) As used in this section, "community mental health center" means a publicly funded, not-for-profit center which contracts with the department for the provision of inpatient, outpatient, day treatment, or emergency services.

(2) Effective April 1, 1989, any community mental health center and any facility licensed pursuant to s. 394.875 shall have an ongoing quality assurance program. The purpose of the quality assurance program shall be to objectively and systematically monitor and evaluate the appropriateness and quality of client care, to ensure that services are rendered consistent with reasonable, prevailing professional standards and to resolve identified problems.

(3) Each facility shall develop a written plan which addresses the minimum guidelines for the quality assurance program. Such guidelines shall include, but are not limited to:

(a) Standards for the provision of client care and treatment practices;

(b) Procedures for the maintenance of client records;

(c) Policies and procedures for staff development;

(d) Standards for facility safety and maintenance;

(e) Procedures for peer review and resource utilization;

(f) Policies and procedures for adverse incident reporting to include verification of corrective action to remediate or minimize incidents and for reporting such incidents to the department by a timeframe as prescribed by rule.

Such plan shall be submitted to the governing board for approval and a copy provided to the department.

(4) The quality assurance program shall be directly responsible to the executive director of the facility and shall be subject to review by the governing board of the agency.

(5) Each facility shall designate a quality assurance manager who is an employee of the agency or under contract with the agency.

(6) Incident reporting shall be the affirmative duty of all staff. Any person filing an incident report shall not be subject to any civil action by virtue of such incident report.

(7) The department shall have access to all records necessary to determine agency compliance with the provisions of this section. The records of quality assurance programs which relate solely to actions taken in carrying out the provisions of this section, and records obtained by the department to determine agency compliance with the provisions of this section, are confidential and exempt from the provisions of s. 119.07(1). Such records are not admissible in any civil or administrative action, except in disciplinary proceedings by the Department of Business and Professional Regulation and the appropriate regulatory board, nor shall such records be available to the public as part of the record of investigation for, and prosecution in disciplinary proceedings made available to the public by the Department of Business and Professional Regulation or the appropriate regulatory board. Meetings or portions of meetings of quality assurance program committees that relate solely to actions taken pursuant to this section are exempt from the provisions of s. 286.011. These exemptions are subject to the Open Government Sunset Review Act in accordance with [1]s. 119.14.

(8) The department shall promulgate rules to carry out the provisions of this section.

(9) The provisions of this section shall not apply to hospitals licensed pursuant to chapter 395 or programs operated within such hospitals.

History.—ss. 22, 26, ch. 88-398; s. 22, ch. 90-347; s. 4, ch. 91-429; s. 43, ch. 94-218.

[1]**Note.**—

A. Repealed by s. 1, ch. 95-217.

B. Section 4, ch. 95-217, provides that "[n]otwithstanding any provision of law to the contrary, exemptions from chapter 119, Florida Statutes, or chapter 286, Florida Statutes, which are prescribed by law and are specifically made subject to the Open Government Sunset Review Act in accordance with section 119.14, Florida Statutes, are not subject to review under that act, and are not abrogated by the operation of that act, after October 1, 1995."