APPLICATION FOR INVOLUNTARY EVALUATION
(Pursuant to A.R.S. § 36-520)

STATE OF ARIZONA)
) ss.
COUNTY OF YAVAPAI)

To Polara Health 8655 E Eastridge Rd. or 1200 Prescott Lakes Parkway Bldg B or 181 N Whipple St Prescott AZ 86303

1. The undersigned applicant requests that the above agency conduct a pre-petition screening of the person named herein.

2. The undersigned applicant alleges that there is now in the County a person whose name and address are:

_____ _____
(Name) (Address)

and that s/he believes that the person has a mental disorder and as a result of said mental disorder, is:

☐ a danger to self ☐ a danger to others

☐ gravely disabled ☐ persistently or acutely disabled

and is:
unwilling to undergo voluntary evaluation, as evidenced by the following facts:
_____

unable to undergo voluntary evaluation, as demonstrated by the following facts:
_____

and who is believed to be in need of supervision, care, and treatment because of the following facts:_____

3. The conclusion that the person has a mental disorder is based on the following facts:
_____

4. The conclusion that the person is dangerous or disabled is based on the following facts:
_____

PERSONAL DATA OF PROPOSED PATIENT:

Age _____ Date of Birth _____ Sex _____ Race _____

Weight _____ Height _____ Hair Color _____ Eye Color _____

Marital Status _____ Number of Children _____ Social Security No. _____

Religion _____ Distinguishing marks _____

Occupation _____ Present Location _____

Dates and Places of Previous Hospitalization_____

How Long in Arizona _____ State Last From _____

Veteran? _____ C-No. _____

Education _____

NAME, ADDRESS AND TELEPHONE NUMBER OF:

1) Guardian _____

2) Spouse _____

3) Next of Kin _____

4) Significant Other Persons _____

DATE SIGNATURE OF APPLICANT

_____ _____

Printed or Typed Name of Applicant _____

Relationship to Proposed Patient _____

Applicant's Address _____

Applicant's Telephone _____

SUBSCRIBED AND SWORN to before me this _____ day of _____, 2025.

_____

Notary Public

My Commission Expires:

_____