JV-220 Application for Psychotropic Medication

Clerk stamps date here when form is filed.

Fill in court name and street address:

Superior Court of California, County of

Fill in child's name and date of birth:

Child's Name:

Date of Birth:

Court fills in case number when form is filed.

Case Number:

A completed and signed *Physician's Statement—Attachment (form JV-220(A)), or Physician's Request to Continue Medication—Attachment* (form JV-220(B)) with all its attachments must be attached to this form before it is filed with the court. Read form JV-217-INFO, *Guide to Psychotropic Medication Forms,* for more information about the required forms and the application process.

1 Information about where the child lives:

a. The child lives ☐ with a relative ☐ in a foster home
☐ with a nonrelative extended family member
☐ in a group home, level ______ ☐ at a juvenile custodial facility
☐ in a short-term residential therapeutic program
☐ other *(specify):* ______________________________

b. If applicable, the name of the facility where the child lives:

____

c. Contact information for a responsible adult where the child lives:
(1) Name:
(2) Phone:

d. The child has lived at the placement in (a) since *(insert date):*

____

2 Information about the child's current location:

a. ☐ The child remains at the location identified in **1**.
b. ☐ The child is currently staying in:
(1) ☐ a psychiatric hospital *(name):*
(2) ☐ a juvenile hall *(name):*
(3) ☐ other *(specify):*

3 Child's ☐ social worker ☐ probation officer

a. Name:
b. Address:
c. Phone: E-mail: Fax:

4 Number of pages attached:

Date:

____
Type or print name of person completing this form

____
Signature

☐ Child welfare services staff *(sign above, complete items* **1**–**13***, and sign on page 4)*
☐ Probation department staff *(sign above, complete items* **1**–**13***, and sign on page 4)*
☐ Medical office staff *(sign above)*
☐ Caregiver *(sign above)*
☐ Prescribing physician *(sign on page 6 of JV-220(A) or page 4 of JV-220(B))*

Child's name: ______________________

Case Number:

If you are the child's social worker or probation officer, you must fill out items 5–13 of this form. If you do not know the answer to a question, write "I do not know." If you are **not** *the child's social worker or probation officer, you do not need to fill out items 5–13 of this form.*

5. Describe if the child has shared feelings about starting to take medication. If this is a request to renew or modify medication, include what the child reports regarding the benefits and side effects of having taken the medication.

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6. The child will provide input on the medication being prescribed (*check all that apply):*

a. ☐ Through the social worker/probation officer.
b. ☐ Through his or her attorney.
c. ☐ Through his or her CASA.
d. ☐ By filling out form JV-218.
e. ☐ By writing a letter to the judge.
f. ☐ By talking to the judge at a hearing.
g. ☐ Other *(specify):* ______________________

7. Describe what the caregiver reports regarding the child being placed on the medication. If this is a request to renew or modify medication, include what the caregiver reports regarding the benefits and side effects of having the child take medication.

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8. The caregiver will provide input on the medication being prescribed (*check all that apply)*:

a. ☐ Through the social worker/probation officer.
b. ☐ By filling out form JV-219.
c. ☐ By writing a letter to the judge.
d. ☐ By talking to the judge at a hearing.
e. ☐ Other *(specify):* ______________________

9. a. Is the information provided by the physician on form JV-220(A) at questions 10 and 11 or on form JV-220(B) at question 8 accurate, to the best of your knowledge?
☐ Yes ☐ No ☐ I do not know

b. Do you have additional information about mental health treatment alternatives to the proposed medications that have been used in the last six months? ☐ Yes ☐ No If yes, explain:

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9 c. Do you have additional information to add about other psychotropic medications that have been tried in the last six months? ☐ Yes ☐ No If yes, explain:

d. List the psychotropic medications that you know were taken by the child in the past and the reason or reasons these were stopped, if the reasons are known to you.

Medication name (generic or brand)	*Reason for stopping*

10 Therapeutic services, other than medication, which the child is enrolled in or is recommended to participate in during the next six months *(check all that apply; include frequency for therapy on blank line):*

a. ☐ Group therapy: ____________ b. ☐ Individual therapy: ____________
c. ☐ Milieu therapy *(explain):* ____________
d. ☐ Therapeutic Behavioral Services (TBS): ____________
e. ☐ Therapy for children on the autism spectrum: ____________
f. ☐ Art therapy: ____________
g. ☐ Cognitive behavioral therapy (CBT): ____________
h. ☐ Wraparound services: ____________
i. ☐ American Indian/Alaska Native healing and cultural traditions: ____________
j. ☐ Speech therapy: ____________
k. ☐ In Home Behavioral Services (IHBS): ____________
l. ☐ Other modality *(explain):* ____________

11 What other services could benefit or enhance the child's well-being *(for example, sports, art, extracurricular activities)?*

Child's name: ______________________

Case Number:

(12) What comments, if any, do you have regarding the application? What else do you want the judge to know?

____

(13) ☐ Check here if you need more space for any of the items. Write the item number and additional information here. If you need more space, attach a sheet or sheets of paper.

____

Date: ______________

____
Type or print name of person completing this form

____
Signature

☐ Child welfare services staff *(sign above)*

☐ Probation department staff *(sign above)*