



## BAKER ACT DATA COLLECTION FORM

This form must be completed in its entirety and attached to the forms listed below. The Provider must submit the forms within **five** working days of the individual's arrival at the facility or upon the facility's receipt of a court order for involuntary inpatient placement or involuntary outpatient placement. All receiving facilities must submit forms to the Department's Baker Act Data Collection portal at: <https://dcfapps.myflfamilies.com/BakerAct>.

### Check the box(es) to indicate the type of form(s) attached

- |   |  |
|---|--|
| <input type="checkbox"/> Ex-Parte Order for Involuntary Examination                           | <input type="checkbox"/> Involuntary Inpatient Placement Order                 |
| <input type="checkbox"/> Report of Law Enforcement Officer Initiating Involuntary Examination | <input type="checkbox"/> Involuntary Outpatient Placement Order                |
| <input type="checkbox"/> Certificate of Professional Initiating Involuntary Examination       | <input type="checkbox"/> Continued Involuntary Outpatient Placement Order      |
| <input type="checkbox"/> Continued Involuntary Inpatient Placement or for Release Order       | <input type="checkbox"/> Evaluation for Involuntary Outpatient Placement Order |
| <input type="checkbox"/> Transportation to a Receiving Facility                               |  |

### Identifying Information about the person (if known)

Person's Name (please print):																			
Florida County of Residence:						OR		State (if not FL):											
Florida Zip Code of Residence:						OR		<input type="checkbox"/> Homeless (no zip code)											
Social Security Number (Last Four Digits):						Date of Birth				-				-					
The Social Security information requested on this form is being collected for the purpose of compliance with Section 394.463(2)(e), Florida Statutes. The collection of this information is imperative for the performance of the Department's duties and responsibilities, as prescribed by law, and is authorized under Section 119.071(5), Florida Statutes.								M	M			D	D			Y	Y	Y	Y

<b>Gender</b> <input type="checkbox"/> Female <input type="checkbox"/> Male  <b>Hispanic Origin?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Race</b> <input type="checkbox"/> Caucasian/White <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other: _____	<b>Immediately prior to this exam and/or placement, was the person in:</b>										
	<b>Yes</b>		<b>No</b>		<b>Answer for Children Only (under age 18)</b>						
	<input type="checkbox"/>	<input type="checkbox"/>	Was this child in Department of Juvenile Justice custody prior to this exam or placement?								
	<input type="checkbox"/>	<input type="checkbox"/>	Was this child in Department of Children and Family custody (such as sheltered with a relative or caregiver, or foster care) prior to this exam or placement?								
	<input type="checkbox"/>	<input type="checkbox"/>	Was this child in school prior to this exam or placement?								
	<b>Yes</b> <b>No</b> <b>Answer for Adults Only (age 18 and over)</b>										
<input type="checkbox"/>		<input type="checkbox"/>		Was this adult in a nursing home prior to this exam or placement?							
<input type="checkbox"/>		<input type="checkbox"/>		Was this adult in an Assisted Living Facility (ALF) prior to this exam or placement?							
<input type="checkbox"/>		<input type="checkbox"/>		Was this adult in jail prior to this exam or placement?							
<input type="checkbox"/>		<input type="checkbox"/>		Was this adult homeless prior to this exam or placement?							

Information about school, DJJ Facility, jail, nursing home, group home, ALF or homeless shelter, if box for any of these locations checked "Yes":

Name of School or Facility: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/Town: \_\_\_\_\_ Zip: \_\_\_\_\_

License # (for nursing homes and ALFs only): \_\_\_\_\_

Find nursing home and ALF information at <http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx>

Was the individual admitted to the Baker Act receiving facility? ☐ Yes ☐ No

If Yes, date of discharge (if applicable): \_\_\_\_\_

Name of Provider:		OR	FMHI Assigned Provider #:
Address:			
Provider Phone Number:	ext:		
Name of Person Completing Form (please print):			
Date Completed:		Date Person Arrived at Facility:	