MHRT USE ONLY – BOOKING DETAILS		
DAY:____________ DATE:____/____/____ TIME:____________	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ OVP ☐ BOARD	☐ LIVE ☐ VIDEO ☐ PEXIP ☐ PAPERS ☐ PHONE

APPLICATION TO REVOKE FINANCIAL MANAGEMENT ORDER

Civil Jurisdiction – Mental Health Act 2007

PO Box 247 Gladesville NSW 1675 | Tel. 1800 815 511
Email: MHRT-Civil@health.nsw.gov.au
Website: www.mhrt.nsw.gov.au

CLIENT DETAILS **MHRT NO:**____________________

Surname:______________________________ Given name(s):______________________________

Date of birth:____________________ ☐ Male ☐ Female ☐ Aboriginal/Torres Strait Islander

Disability: ☐ None ☐ Vision ☐ Hearing ☐ Mobility ☐ Other:____________________

Country of birth:____________________ Interpreter: ☐ No ☐ Yes – language:____________________

Address:____

Phone:______________________________ Email:______________________________

Community Mental Health Facility:____

Date original order made:____________________ Number of reports included with application:__________

Please state why you believe that you are now capable of managing your financial affairs, and/or why it is in your best interest to have the financial management order revoked.

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REPORTS AND SUPPORTING DOCUMENTS

Your application must be accompanied by information in support of your case. This may be from a professional person involved in your care as well as other persons involved in your life. For example - family, friends, carers, psychiatrist, case worker, social worker or psychologist.

Reports should include the reasons that person believes you can manage your affairs and why they consider it to be in your best interest to have the order revoked. The report must also include the person's qualifications, experience and their connection to you.

REPORTS PROVIDED BY:

Name: ____ ☐ Report attached

Relationship: ____

Mobile Telephone: ______________________ Email: ______________________

Postal Address: ____

Name: ____ ☐ Report attached

Relationship: ____

Mobile Telephone: ______________________ Email: ______________________

Postal Address: ____

REPORTS PROVIDED BY:

Name: ______________________ ☐ Report attached

Relationship: ______________________

Mobile Telephone: ______________ Email: ______________

Postal Address: ______________________

OTHER REFEREES AND SUPPORT

Name: ______________________ ☐ Document attached

Relationship: ______________________

Mobile Telephone: ______________ Email: ______________

Postal Address: ______________________

Name: ______________________ ☐ Document attached

Relationship: ______________________

Mobile Telephone: ______________ Email: ______________

Postal Address: ______________________

Name: ______________________ ☐ Document attached

Relationship: ______________________

Mobile Telephone: ______________ Email: ______________

Postal Address: ______________________

DECLARATION

I confirm that to the best of my knowledge, the information provided in this form is complete and accurate.

Signature – applicant	*Signature – witness*
Name – applicant	*Name – witness*
	Address - witness
Date: ______________	Date: ______________

Please return the completed application and the required reports and documentation to

MHRT-Civil@health.nsw.gov.au

or by post to:

Mental Health Review Tribunal - Civil Division
PO Box 247 Gladesville NSW 1675

For further information or assistance please call 1800 815 511.