

# CARE Act Petition

Do you want to request court-ordered treatment, services, support and/or a housing plan for yourself or someone else?

<b>Step 1</b>	Before completing forms: If you want to file a petition, read attached form CARE-050-INFO – Information for Petitioner about the CARE Act.
<b>Step 2</b>	<b>Complete forms:</b> Complete the following forms in blue or black ink: <ul style="list-style-type: none"><li>➤ CARE-100 Petition to Commence Care Act Proceedings</li><li>➤ CARE-101 Mental Health Declaration completed by Licensed Behavioral Health Professional. As an alternative to this form, you can provide evidence that the respondent was detained for a minimum of two intensive involuntary treatments of 14 days AND that the most recent event occurred within the last 60 days.</li><li>➤ CARE-105 [Proposed] Order for Care Act Report.</li></ul> <p><i>Samples of CARE-100 and CARE-105 are included in this form packet.</i></p>
<b>Step 3</b>	<b>Copies:</b> Make 1 copy of the forms, not including the original
<b>Step 4</b>	<b>File:</b> File the original and copy in the Probate Clerk’s Office of the courthouse located at: <b>191 North First Street, San Jose, CA 95113</b>  The Clerk will file stamp the forms and give you back a filed copy.  The Clerk’s Office is open Monday-Thursday from 8:30 am to 3:00 pm and Friday from 8:30 am to 12 noon (except on court holidays). Closing times are subject to change. Visit <a href="http://www.scscourt.org">www.scscourt.org</a> or call <b>408-882-2654</b> for current clerk hours.  There is no fee to file these forms.
<b>Step 5</b>	<b>Service:</b> Service of the petition is not required.
<b>Step 6</b>	<b>Assessment:</b> Once you file the petition, the court will evaluate your petition to determine if respondent meets the eligibility requirements for services under CARE Act. <ul style="list-style-type: none"><li>➤ If the court finds that respondent is not eligible or if respondent works with the county voluntarily, the petition will be dismissed.</li><li>➤ If the court finds that respondent is eligible for services, the court will order that a county agency contact respondent and provide a report within 14 days. You and respondent will be notified.</li><li>➤ If the agency report supports that respondent is eligible for CARE Act services and if contact with respondent was not effective, the court will set a court hearing. The county agency will give notice of the hearing to you, respondent, respondent’s appointed counsel and the county behavioral health agency</li></ul>
<b>Step 7</b>	<b>Initial Hearing:</b> Attend the hearing. If you do not attend the initial hearing, the court may dismiss your petition. <ul style="list-style-type: none"><li>• At this hearing, the court will order that county behavioral health agency replace you as petitioner in this case.</li><li>• Your right to future notice in this matter will be determined by the court. In addition, Respondent may agree to your participation in future proceedings.</li></ul>



## WHAT IS the CARE ACT?

The Community Assistance, Recovery, and Empowerment (CARE) Act is a California law that provides services to individuals with severe mental health impairments resulting from certain diagnosis. The CARE Act aims to prevent hospitalizations, incarcerations, and conservatorships.

A petitioner requests court ordered services for respondent by filing Petition to Commence CARE Act Proceedings ([CARE-100](#)) in probate court. One must fall under a specific group to qualify as petitioner, see [CARE-050](#). If a hearing is set, the court will replace the initial petitioner with a county agency. The respondent is the person who may qualify for services if eligibility requirements are met. Eligibility requirements can be found on the California Courts website here: <https://www.courts.ca.gov/48654.htm> and also on form [CARE-050](#).

## WHAT SERVICES ARE PROVIDED UNDER THE CARE ACT?

Services that may be provided under the CARE Act include clinical behavioral health care, counseling, specialized psychotherapy programs and treatment, stabilization medications, a housing plan and other supports and services provided directly and indirectly by local government. The goal is to create a court approved CARE agreement and CARE plan to work in conjunction with respondent to deliver services.

## WHAT ELSE SHOULD I KNOW?

Respondent's progress in the CARE plan will be checked at status review hearings set at intervals by the court. A determination will be made on the 11<sup>th</sup> month as to whether respondent is ready to graduate from the program or if services will continue under the program for up to a year.

You can find more information about the CARE Act at <https://care-act.org>, including a process flow chart and other options to help someone with a severe mental illness.

## HOW CAN I GET HELP?

You can contact the Self Help Center/Family Law Facilitator if you have questions or need assistance with completion of forms:

- **Contact us:** Go to <https://santaclara.courts.ca.gov/>, click on the "**Self Help**" tile, and then click on "**Self-Help Center/Family Law Facilitator's Office**" More Info link. Walk-in assistance is limited to emergencies so contact us remotely first.
- **Obtain court forms in PDF fillable format:** Go to <https://www.courts.ca.gov/forms.htm> and then search under form number.
- **Form Review:** Email your forms to Self Help as a PDF file to [SHCDocReview@scscourt.org](mailto:SHCDocReview@scscourt.org).
- **Note:** We **cannot** help people who have attorneys.

Superior Court, County of Santa Clara  
**Self Help Center/Family Law Facilitator's Office**  
201 N. First Street, San Jose, CA 95113  
408-882-2926

This information sheet describes the CARE Act and how to fill out *Petition to Commence CARE Act Proceedings* (form CARE-100). You may also be able to receive assistance at the court self-help center. Go to <https://selfhelp.courts.ca.gov/self-help/find-self-help> to find one for your court.

### 1 What is the CARE Act?

CARE stands for Community Assistance, Recovery, and Empowerment. The CARE Act is a way to allow specific people, called “petitioners,” to request court-ordered treatment, services, support, and a housing plan for certain people, called “respondents,” who have certain untreated severe mental illnesses, specifically schizophrenia or another psychotic disorder. A respondent must be 18 years of age or older.

CARE Act proceedings involve assessments and hearings to determine whether the respondent meets eligibility requirements. A county behavioral health agency will be involved in the process. If the respondent meets the standards for CARE eligibility, a CARE agreement or plan may be created and, if approved, ordered by the court.

### 2 What is a CARE agreement or CARE plan?

A CARE agreement and a CARE plan are written documents that specify services designed to support the recovery and stability of the respondent. They must be approved by court order. They may include clinical behavioral health care; counseling; specialized psychotherapies, programs, and treatments; stabilization medications; a housing plan; and other supports and services directly and indirectly through a local government entity. Stabilization medications must not be forcibly administered.

A CARE agreement is a voluntary agreement entered into by a respondent and the county behavioral health agency after a court has found that the respondent is eligible for the CARE program. The agreement is subject to court modification before approval.

A CARE plan is an individualized range of community-based services and supports for the respondent that is ordered by the court.

### 3 Have you considered alternatives to CARE Act proceedings?

There may be other ways to help a person with a severe mental illness. If the person has commercial health insurance, contact the health plan/insurer. If you do not know if the person has commercial health insurance or if they do not have commercial insurance, contact your county’s behavioral health agency or check its website for services. County behavioral health agencies offer an array of services, from counseling, psychiatrists, psychologists, or therapists, to full-service partnerships, rehabilitative mental health services, peer support services, intensive case management, crisis services, residential care, substance disorder treatment, assertive community treatment, and supportive housing. Counties are required to provide services to Medi-Cal beneficiaries who qualify for specialty mental health and substance use disorder services, but may also provide access to their services to a broader population, depending on local funding and eligibility criteria, without a court order.

A *full-service partnership* is designed for a person with a severe mental illness who would benefit from an intensive service program. A full-service partnership can assist a person who is homeless, involved with the justice system, or uses crisis psychiatric care frequently. *Assertive community treatment* is a form of mental health care provided in a community setting to help a person become independent and integrate into the community as they recover.

Find out if the person has made an advance health care directive or psychiatric advance directive, designating someone else to make health care decisions on their behalf when they cannot. Consider looking into local social services and community-based organizations, too.

**4 How do I complete *Petition to Commence CARE Act Proceedings* (form CARE-100)?****Item 1: Who Can Be the Petitioner?**

The petitioner is the person who is requesting to start CARE Act proceedings for a person with a severe mental illness who needs help.

To be a petitioner, you must be 18 years of age or older and you must fall within one of the following categories to be able to request CARE Act proceedings for a respondent:

- A person who lives with the respondent.
- A spouse or registered domestic partner, parent, sibling, child, or grandparent of the respondent.
- A person who stands in the place of a parent to the respondent.
- The director of a hospital, or their designee, in which the respondent is or was recently hospitalized.
- The director of a public or charitable agency, or their designee, who has within the last 30 days provided or who is currently providing behavioral health services to the respondent or in whose institution the respondent resides.
- A licensed behavioral health professional, or their designee, who is or has been supervising the treatment of or treating the respondent for mental illness within the last 30 days.
- The director of a county behavioral health agency, or their designee, of the county where the respondent resides or is found.
- A judge of a tribal court located in California, or their designee.
- The director of adult protective services, or their designee, of the county where the respondent resides or is found.
- The director of a California Indian health services program or a California tribal behavioral health department, or their designee.
- A first responder—including a peace officer, firefighter, paramedic, emergency medical technician, mobile crisis response worker, or homeless outreach worker—who has had repeated interactions with the respondent in the form of multiple arrests, detentions, and transportation under Welfare and Institutions Code section 5150, multiple attempts to engage the respondent in voluntary treatment, or other repeated efforts to aid the respondent in obtaining professional assistance.
- The public guardian or public conservator, or their designee, of the county where the respondent is present or reasonably believed to be present, or a private court-appointed conservator under the Lanterman-Petris-Short (LPS) Act, if referred from the LPS court.
- The respondent.

In item 1, enter your name and check the box next to the eligible petitioner type or types that apply to you.

**Item 2: Relationship to the Respondent**

Enter the respondent's name in item 2a and describe the nature of your relationship with the respondent in item 2b. If you are a petitioner from a hospital, a public or charitable agency, a first responder, or a licensed behavioral health professional who has been treating or supervising the respondent, you must include the number of interactions, the date of the most recent interaction, and the nature and outcome of each interaction in 2c.

**Item 3: Respondent's Address or Last Known Location**

If you know where the respondent lives, include the address in item 3. If you do not know the respondent's address, or if they do not have one, specify that the address is unknown and provide the last known location and any additional contact information that may be useful to locate the respondent, such as a phone number or email address.

**Item 4: County of Filing**

In item 4, explain why it is appropriate to file the petition in the county where you are filing. The respondent must either live in the county, currently be in the county, or be facing a legal case in the county. Check all that apply. If the person does not live in the county, it is also helpful to include where they live, if you know

**Item 5: Respondent Eligibility**

You must provide facts and supporting information to show that the respondent is eligible for CARE Act proceedings. **All** of the following requirements, listed in item 5 of form CARE-100, must be met for the respondent to be eligible. Please note that the examples below are only examples of circumstances that **may** qualify. All determinations of eligibility are case-specific.

Requirements	Explanations	Examples
<b>The respondent must be 18 years old or older (item 5a) and must:</b>		
<p>Have a diagnosis of a schizophrenia spectrum disorder or another psychotic disorder in the same class, as defined in the current <i>Diagnostic and Statistical Manual of Mental Disorders (item 5b)</i>.</p>	<p>Only a person with a schizophrenia spectrum or other psychotic disorder is eligible for the CARE Act process. A person only with another serious mental illness, such as bipolar disorder or major depression, is not eligible.</p> <p><b>Note:</b> The psychotic disorder must not be based on a medical condition, including a physical health condition such as a traumatic brain injury, autism, dementia, or a neurological condition. A person with a current diagnosis of substance use disorder must also have a psychotic disorder and meet all the other criteria in item 5 to be eligible.</p>	<p>Schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, schizotypal personality disorder, and other psychotic disorders.</p>
<p>Be currently experiencing a mental illness that (item 5c):</p> <ul style="list-style-type: none"> <li>• Is severe in degree and persistent in duration (item 5c(1))</li> <li>• May cause behavior that interferes substantially with activities of daily living (item 5c(2)), <b>and</b></li> <li>• May lead to an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period (item 5c(3)).</li> </ul>	<p>Indicate any behaviors, such as delusions, hallucinations, or unusual and ongoing mood changes, that substantially interfere with the respondent’s ability to perform essential and routine tasks needed for work or self-care.</p> <p>Describe why you believe the respondent is unable to live independently, function in the community, and take care of their condition and social relationships, without additional help.</p>	<p>If caused by a chronic, prolonged, or recurrent mental illness:</p> <ul style="list-style-type: none"> <li>• Difficulty with self-care (e.g., bathing, grooming, obtaining and eating food, dressing appropriate to weather, securing health care, or following medical advice).</li> <li>• Difficulty maintaining a residence, using transportation, or managing money day to day.</li> <li>• Difficulty concentrating or completing tasks as scheduled.</li> <li>• Difficulty functioning socially, creating and maintaining relationships.</li> <li>• Recent history of inability to care for themselves (bathe, groom, get food and eat, use the restroom) daily without additional help.</li> </ul>

Requirements	Explanations	Examples
<p>Not be clinically stabilized in ongoing voluntary treatment (<b>item 5d</b>).</p>	<p>Describe why you believe the respondent is not being adequately supported in a voluntary treatment program such that their condition and symptoms are stable.</p>	<ul style="list-style-type: none"> <li>● Repeated and ongoing refusal to accept voluntary treatment without reason.</li> <li>● Temporary acceptance of voluntary treatment that is interrupted by failure or refusal to continue the treatment without reason.</li> <li>● Voluntary treatment is accepted, but that treatment is not effective to stabilize the respondent.</li> </ul>
<p><b>At least <i>one</i> of the following must be true (item 5e):</b></p>		
<p>The respondent is unlikely to survive safely in the community without supervision <b>and</b> the respondent's condition is substantially deteriorating (<b>item 5e(1)</b>).</p> <p><b>OR</b></p>	<p>Indicate recent instances where the respondent has needed supervision to survive in the community due to lack of reality orientation, confusion, or impaired insight.</p> <p>Describe how the respondent's ability to think clearly, communicate, or participate in regular activities has worsened quickly.</p>	<ul style="list-style-type: none"> <li>● Recent or frequent hospitalizations due to symptoms such as delusions, hallucinations, disorganization, impaired insight, impaired judgment.</li> <li>● Recent or frequent arrests due to mental illness.</li> </ul>
<p>The respondent needs services and supports to prevent a relapse or deterioration that would likely result in grave disability or serious harm to the respondent or others (<b>item 5e(2)</b>).</p>	<p>Describe how the respondent would be unable to survive safely, would be gravely disabled, or would cause serious harm to others or themselves unless they received services and supports.</p> <ul style="list-style-type: none"> <li>● <i>Grave disability</i> means a person's inability, due to mental illness, to provide for their basic personal needs for food, clothing, or shelter.</li> <li>● <i>Serious harm</i> includes injury causing extreme pain, high risk of death, or loss of physical or mental functions.</li> </ul>	<ul style="list-style-type: none"> <li>● A person who has access to immediate, safe housing but chooses to live in conditions that could lead to a danger to their health, as a result of mental illness.</li> <li>● A person who has recently attempted suicide because of their mental illness and continues to express a desire to self-harm.</li> <li>● Self-injurious behavior, such as walking into traffic or harming oneself unknowingly through behavior that puts them at risk for serious injury or loss of life.</li> </ul>

Requirements	Explanations	Examples
<b>The respondent’s participation in a CARE plan or CARE agreement must:</b>		
<p>Be the least restrictive alternative necessary to ensure the respondent's recovery and stability (<b>item 5f</b>), and</p>	<p>Explain how participation in a CARE plan or CARE agreement would:</p> <ul style="list-style-type: none"> <li>• Be necessary because other less restrictive alternatives would not sufficiently ensure the respondent's recovery and stability, potentially because other less restrictive alternatives have not been successful.</li> <li>• Effectively meet the respondent's treatment needs while placing as few limits as possible on the respondent's rights and personal freedoms.</li> </ul>	<p>Less-restrictive alternatives might include:</p> <ul style="list-style-type: none"> <li>• <b>Voluntary full-service partnerships</b>, which are collaborative relationships between the county and the individual, and when appropriate the individual's family, through which the county plans for and provides the full spectrum of community services.</li> <li>• <b>Supported decisionmaking</b>, which is an individualized process of supporting and accommodating an adult with a disability to enable them to make life decisions without impeding their self-determination.</li> <li>• <b>Assertive community treatment</b>, which is a person-centered, recovery-based treatment option that employs low client-to-staff ratios.</li> </ul>
<p>Be likely to benefit the respondent (<b>item 5g</b>).</p>	<p>Explain how participating in a CARE plan could help the respondent stabilize and improve their current state and situation.</p>	<ul style="list-style-type: none"> <li>• The respondent's prior improvement when participating in similar treatment programs.</li> <li>• Medical opinion that the patient would benefit from treatment.</li> </ul>

**Note:** Include in the petition as much information as possible for each item listed above. You may also attach any documents you have that you think support one or more of the items.

**Item 6: Required Documentation**

You must attach supporting documentation to the petition. That documentation must include one of two things:

- a. A declaration by a licensed behavioral health professional on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101); **OR**
- b. Evidence that the respondent was detained for a minimum of two intensive treatments, the most recent one within the last 60 days. Evidence can include copies of certification for intensive treatment, a declaration from a witness to the intensive treatment, or other documents showing that the respondent was detained twice for up to 14 days of intensive treatment. Evidence should include the dates of the last treatment period. **Note:** For purposes of the CARE Act, “intensive treatment” only includes involuntary treatment authorized by Welfare and Institutions Code section 5250. It does *not* refer to treatment authorized by any other statute, including but not limited to 72-hour holds under Welfare and Institutions Code section 5150 or treatments under Welfare and Institutions Code sections 5260 and 5270.15.



**Item 7: Tribal Enrollment or Services From an American Indian Health Care Provider (Optional)**

If you know or believe that the respondent is a member of a federally recognized Indian tribe, or is receiving services from an Indian health care provider, tribal court, or tribal organization, include that information in item 7.

**Note:** The petition will be processed even if you do not complete item 7.

**Item 8: Referral From Another Court (Optional)**

If you are filing a petition based on a referral from a court proceeding, check this box. Indicate which court made the referral and include the case number and department, if known. If you know which of the types of proceedings listed on the petition it was referred from, check the appropriate box in item 8c. Otherwise, leave item 8 blank and do not check the box. If you have a copy of the court order making the referral, label it as “Item 8” and attach it to the petition.

**Note:** The petition will be processed even if you do not complete item 8.

**Item 9: Helpful Information**

In item 9, check any of the boxes that apply to the respondent, if you know.

**Note:** The petition will be processed even if you do not complete item 9.

**Item 10: Attachments**

In item 10, list the total number of pages attached to the petition.

**Signature:** You must write the date, print your name, and *sign the petition under penalty of perjury*, which means that if anything you have said you know to be untrue, you may be criminally liable. If you have an attorney helping you, they will sign as well.

**5 Is service of process required?**

No. To begin CARE Act proceedings, you do not need to provide anyone except the court with a copy of the petition.

**6 What will happen after I file the petition?**

After a CARE Act petition is filed, the court will promptly review the petition and supporting documents to determine if they show that the respondent meets or might meet the requirements described above. Then it will do one of the following:

- a. **Dismiss the petition.** The court will do this if it finds (1) that the petition does not show that the respondent meets or may meet the CARE Act eligibility requirements or (2) that the respondent is voluntarily working with the county agency, their engagement is effective, and the respondent has enrolled or is likely to enroll in voluntary treatment through the county or another provider.
  - b. **Order a report.** If the court finds that the petition does show that the respondent meets or may meet the criteria for the CARE Act process, the court will order a county agency to engage the respondent and file a written report with the court within 14 business days. You and the respondent will be notified that the report has been ordered.
  - c. **Set an initial appearance.** The court will set an initial appearance if it finds that the county agency’s report supports the petition’s showing that the respondent meets or may meet the CARE Act eligibility requirements and the county’s engagement with the respondent was not effective. The court will also order the county to give notice of the hearing to you, the respondent, the respondent’s appointed counsel, and the county behavioral health agency.
- Note:** The procedures are somewhat different if the county behavioral health agency is the petitioner.

**7 What happens at the initial appearance?**

You, the petitioner, must be present at the initial hearing, or the court may dismiss the petition. You will receive a notice in the mail of the date, time, and place of the hearing.

**Note:** At the initial appearance, the director of the county behavioral health agency, or their designee, will replace you as the petitioner



**8 What rights do petitioners have?**

If you live with the respondent, are a spouse or registered domestic partner, parent, sibling, child, or grandparent of the respondent, or someone who stands in the place of a parent to the respondent, you have the right to participate during the hearing to determine the merits of the petition. The court may, in its discretion, assign you ongoing rights of notice. If the respondent agrees, the court may allow you to participate in the rest of the CARE Act proceedings.

If the matter is dismissed and later there is a change in circumstances, you may file a new petition with the court.

If you are a petitioner other than those listed above, you have the right to make a statement at the hearing on the merits of the petition, but you will not be assigned ongoing rights.

**9 What is a vexatious litigant?**

The court may determine a person is a vexatious litigant if that person files more than one petition under the CARE Act that has no basis in truth or reality or is intended to harass or annoy the respondent. A person who is deemed a vexatious litigant may be placed on a vexatious litigants list prepared and maintained by the Judicial Council. The court may enter an order that prevents a vexatious litigant from filing any new litigation, including potentially other types of cases (not just CARE Act petitions), without first obtaining permission from the presiding judge. If such an order is issued, a vexatious litigant who does not follow the order may be punished for contempt of court, which could result in fines or imprisonment.

**10 What if I don't speak English?**

When you file your papers, ask the clerk if a court interpreter is available. You can also use *Request for Interpreter (Civil)* (form INT-300), or a local court form or website to request an interpreter. For more information about court interpreters, go to <https://selfhelp.courts.ca.gov/request-interpreter>.

**11 What if I have a disability?**

If you have a disability and need an accommodation while you are at court, you can use *Disability Accommodation Request* (form MC-410) to make your request. You can also ask the ADA Coordinator in your court for help. For more information, see *How to Request a Disability Accommodation for Court* (form MC-410-INFO) or go to <https://selfhelp.courts.ca.gov/jcc-form/MC-410>.



# **BLANK FORMS**

**THESE ARE THE DOCUMENTS YOU  
COMPLETE AND FILE.**



ATTORNEY OR PARTY WITHOUT ATTORNEY STATE BAR NUMBER: NAME: FIRM NAME: STREET ADDRESS: CITY: STATE: ZIP CODE: TELEPHONE NO.: FAX NO.: EMAIL ADDRESS: ATTORNEY FOR (name):	<b>FOR COURT USE ONLY</b>
<b>SUPERIOR COURT OF CALIFORNIA, COUNTY OF</b> Santa Clara STREET ADDRESS: 191 N. First Street MAILING ADDRESS: 191 N. First Street CITY AND ZIP CODE: San Jose, CA 95113 BRANCH NAME: Probate Division	
CARE ACT PROCEEDINGS FOR (name):	
RESPONDENT	
<b>PETITION TO COMMENCE CARE ACT PROCEEDINGS</b>	
CASE NUMBER:	

For information on completing this form, see *Information for Petitioners—About the CARE Act* (form CARE-050-INFO).

1. Petitioner (name):

is 18 years of age or older and (check all that apply):

- |  |  |
|--|--|
| a. <input type="checkbox"/> A person who lives with respondent.<br>b. <input type="checkbox"/> A spouse or registered domestic partner, parent, sibling, child, or grandparent of respondent.<br>c. <input type="checkbox"/> A person who stands in the place of a parent to respondent.<br>d. <input type="checkbox"/> The director* of a hospital in which respondent is hospitalized.<br>e. <input type="checkbox"/> The director* of a public or charitable organization, agency, or home<br>(1) <input type="checkbox"/> who is or has been, within the past 30 days, providing behavioral health services to respondent; or<br>(2) <input type="checkbox"/> in whose institution respondent resides.<br>f. <input type="checkbox"/> A licensed behavioral health professional* who is or has been, within the past 30 days, treating or supervising the treatment of respondent. | g. <input type="checkbox"/> A first responder, including a peace officer, firefighter, paramedic, emergency medical technician, mobile crisis response worker, or homeless outreach worker who has had repeated interactions with respondent.<br>h. <input type="checkbox"/> The public guardian* or public conservator* of the county named above or a private conservator referred by the court under Welfare and Institutions Code section 5978.<br>i. <input type="checkbox"/> The director* of the county behavioral health agency of the county named above.<br>j. <input type="checkbox"/> The director* of adult protective services of the county named above.<br>k. <input type="checkbox"/> The director* of a California Indian health services program or a California tribal behavioral health department.<br>l. <input type="checkbox"/> A California tribal court judge.*<br>m. <input type="checkbox"/> Respondent. |
|--|--|

\* This person may designate someone else to file the petition on their behalf. If the petitioner is a designee, check this category and put designee's name in item 1, above.

2. a. Petitioner asks the court to find that respondent (name):

is eligible to participate in the CARE Act process and to commence CARE Act proceedings for respondent.

b. Petitioner's relationship to respondent (specify and describe relationship):





CARE ACT PROCEEDINGS FOR <i>(name)</i> :	CASE NUMBER:
RESPONDENT	

5. e. At least one of these is true (*complete (1) or (2) or both*):

(1)  Respondent is unlikely to survive safely in the community without supervision **and** respondent's condition is substantially deteriorating. Reasons that respondent is unlikely to survive safely in the community, the type of supervision respondent would need to survive safely, and the extent to which respondent's physical or mental condition has recently grown worse are described

on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.

on separate documents, attached and labeled Attachment 5e(1).

below.

(2)  Respondent needs services and supports to prevent a relapse or deterioration that would be likely to lead to grave disability or serious harm to respondent or others. The services and supports needed by respondent and the reasons respondent would become gravely disabled or present a risk of harm to self or others are described

on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.

on separate documents, attached and labeled Attachment 5e(2).

below.



CARE ACT PROCEEDINGS FOR (name):	CASE NUMBER:
RESPONDENT	

5. f. Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure respondent's recovery and stability. A description of available alternative treatment plans and an explanation why no alternative treatment plan that would be less restrictive of respondent's liberty could ensure respondent's recovery and stability are provided

- on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
- on separate documents, attached and labeled Attachment 5f.
- below.

g. Respondent is likely to benefit from participation in a CARE plan or CARE agreement. Reasons in support of this assertion are provided

- on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
- on separate documents, attached and labeled Attachment 5g.
- below.

**6. Required Documentation**

The evidence described below is attached in support of this petition. (*Attach the documents listed in a or b, or both, and check the box next to the description of each document or set of documents attached*).

- a.  A completed *Mental Health Declaration—CARE Act Proceeding* (form CARE-101), the declaration of a licensed behavioral health professional stating that, no more than 60 days before this petition was filed, the professional or a person designated by them
  - (1)  examined respondent and determined that respondent met the diagnostic criteria for eligibility to participate in the CARE Act proceedings; or
  - (2)  made multiple attempts to examine respondent but was not successful in obtaining respondent's cooperation and has reasons, explained with specificity, to believe that respondent meets the diagnostic criteria for eligibility to participate in CARE Act proceedings.

Attach *Mental Health Declaration—CARE Act Proceedings* (form CARE-101) and label it Attachment 6a.

CARE ACT PROCEEDINGS FOR <i>(name)</i> :	CASE NUMBER:
RESPONDENT	

6. b.  Evidence that respondent was detained for at least two periods of intensive treatment, the most recent period within the past 60 days. Examples of evidence: a copy of the certification of intensive treatment, a declaration from a witness to the intensive treatment, or other documentation indicating involuntary detention and certification for up to 14 days of intensive treatment. *(Attach all supporting documents and label each, in order, Attachment 6b1, 6b2, 6b3, etc.)*

**Note:** For purposes of the CARE Act, "intensive treatment" refers to involuntary treatment authorized by Welfare and Institutions Code section 5250. It does **not** refer to treatment authorized by any other statutes, including but not limited to Welfare and Institutions Code sections 5150, 5260, and 5270.15.

**Optional information**

7. Tribal affiliation

a.  Respondent is an enrolled member of a federally recognized Indian tribe.  
Tribe's name and mailing address:

b.  Respondent is receiving services from a California Indian health services program, a California tribal behavioral health department, or a California tribal court.  
Name and mailing address of program, department, or court:

8.  This petition is based on a referral from another court proceeding.

a. Court, department, and judicial officer:

b. Case number:

c. Type of proceeding from which respondent was referred:

- (1)  Misdemeanor competence to stand trial (Pen. Code, § 1370.01)
- (2)  Assisted outpatient treatment (Welf. & Inst. Code, §§ 5346–5348)
- (3)  Lanterman-Petris-Short Act conservatorship (Welf. & Inst. Code, §§ 5350–5372)
- Court order attached and labeled as Attachment 8 (optional).

9. Check any of the following statements that is true:

- a.  Respondent needs interpreter services or an accommodation *(specify)*:
- b.  Respondent is under juvenile court jurisdiction *(specify which court)*:
- c.  Respondent is currently under conservatorship *(specify which court)*:
- d.  Respondent is served by a Regional Center *(specify which)*:
- e.  Respondent is a current or former member of the state or federal armed services or reserves *(specify which branch)*:

10. Number of pages attached:

Date:

\_\_\_\_\_  
(TYPE OR PRINT NAME OF ATTORNEY)

▶ \_\_\_\_\_  
(SIGNATURE OF ATTORNEY)

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

\_\_\_\_\_  
(TYPE OR PRINT NAME OF PETITIONER)

▶ \_\_\_\_\_  
(SIGNATURE OF PETITIONER)

# CONFIDENTIAL

CARE-101

ATTORNEY OR PARTY WITHOUT ATTORNEY NAME: FIRM NAME: STREET ADDRESS: CITY: TELEPHONE NO.: EMAIL ADDRESS: ATTORNEY FOR (name):	STATE BAR NUMBER:  STATE: ZIP CODE:  FAX NO.:	<b>FOR COURT USE ONLY</b>
<b>SUPERIOR COURT OF CALIFORNIA, COUNTY OF Santa Clara</b> STREET ADDRESS: 191 N. First Street MAILING ADDRESS: 191 N. First Street CITY AND ZIP CODE: San Jose, CA 95113 BRANCH NAME: Probate Division		
CARE ACT PROCEEDINGS FOR (name):  RESPONDENT		
<b>MENTAL HEALTH DECLARATION—CARE ACT PROCEEDINGS</b>		CASE NUMBER:

## TO LICENSED BEHAVIORAL HEALTH PROFESSIONAL

This form will be used to help the court determine whether respondent meets the diagnostic criteria for CARE Act proceedings.

### GENERAL INFORMATION

1. Declarant's name:
2. Office address, telephone number, and email address:
3. **License status (complete either a or b):**
  - a.  I am a licensed behavioral health professional and conducting the examination described on this form is within the scope of my license. I have a valid California license as a (check one):
    - (1)  physician.
    - (2)  psychologist.
    - (3)  clinical social worker.
    - (4)  marriage and family therapist.
    - (5)  professional clinical counselor.
  - b.  I have been granted a waiver of licensure by the State Department of Health Care Services under Welfare and Institutions Code section 5751.2 because (check one):
    - (1)  I am employed as a  psychologist  clinical social worker continuing my employment in the same class as of January 1, 1979, in the same program or facility.
    - (2)  I am registered with the licensing board of the State Department of Health Care Services for the purpose of acquiring the experience required for licensure and employed or under contract to provide mental health services as a (check one):
      - (a)  clinical social worker.
      - (b)  marriage and family therapist.
      - (c)  professional clinical counselor.
    - (3)  I am employed or under contract to provide mental health services as a psychologist who is gaining experience required for licensure.

Page 1 of 4

CARE ACT PROCEEDINGS FOR <i>(name)</i> :  <div style="text-align: right; padding-right: 20px;">RESPONDENT</div>	CASE NUMBER:
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3. b. (4)  I have been recruited for employment from outside this state, and my experience is sufficient to gain admission to a California licensing examination. I am employed or under contract to provide mental health services as a *(check one)*:
- (a)  psychologist.
  - (b)  clinical social worker.
  - (c)  marriage and family therapist.
  - (d)  professional clinical counselor.

4. Respondent *(name)*:  
 is  is not a patient under my continuing care and treatment.

**EXAMINATION OR ATTEMPTS MADE AT EXAMINATION OF RESPONDENT**

5. Complete one of the following: *(both a and b must be within 60 days of the filling of the CARE Act petition)*
- a.  I examined the respondent on *(date)*: *(proceed to item 7).*
  - b.  On the following dates: I attempted to examine respondent but was unsuccessful due to respondent's lack of cooperation in submitting to an examination.
6. *(Answer only if 5b is checked.)* Explain in detail when, how many attempts, and the types of attempts that were made to examine respondent. Also explain respondent's response to those attempts and the outcome of each attempt.

7. Based on the following information, I have reason to believe respondent meets the diagnostic criteria for CARE Act proceedings *(each of the following requirements **must** be met for respondent to qualify for CARE Act proceedings)*:
- a. Respondent has a diagnosis of a schizophrenia spectrum disorder or another psychotic disorder in the same class *(indicate the specific disorder)*:

**Note:** Under Welfare and Institutions Code section 5972, a qualifying psychotic disorder must be primarily psychiatric in nature and not due to a medical condition such as a traumatic brain injury, autism, dementia, or a neurological condition. A person who has a current diagnosis of substance use disorder without also meeting the other statutory criteria, including a diagnosis of schizophrenia spectrum or other psychotic disorder, does not qualify.

- b. Respondent is experiencing a severe mental illness that *(all of the following must be completed)*:
  - (1) Is severe in degree and persistent in duration *(explain in detail)*:

CARE ACT PROCEEDINGS FOR <i>(name)</i> :	CASE NUMBER:
RESPONDENT	

7. b. (2) May cause behavior that interferes substantially with the primary activities of daily living *(explain in detail)*:

(3) May result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period *(explain in detail)*:

c. Respondent is not clinically stabilized in ongoing voluntary treatment *(explain in detail)*:

d. At least one of these is true *(complete one or both of the following)*:

(1)  Respondent is unlikely to survive safely in the community without supervision **and** respondent's condition is substantially deteriorating *(explain in detail)*:

(2)  Respondent needs services and supports to prevent a relapse or deterioration that would likely result in grave disability or serious harm to respondent or others *(explain in detail)*:

CARE ACT PROCEEDINGS FOR <i>(name)</i> :  RESPONDENT	CASE NUMBER:
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7. e. Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure respondent's recovery and stability (*explain in detail*):

f. Respondent is likely to benefit from participation in a CARE plan or CARE agreement (*explain in detail*):

8.  Additional information regarding my examination of respondent is  as follows  on Attachment 8.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

\_\_\_\_\_

(TYPE OR PRINT DECLARANT'S NAME)



\_\_\_\_\_

(SIGNATURE OF DECLARANT)







# **SAMPLE**

**Use these sample forms to help you  
complete the blank forms in packet.**



ATTORNEY OR PARTY WITHOUT ATTORNEY STATE BAR NUMBER:		FOR COURT USE ONLY
NAME:	<b>YOUR FIRST / LAST NAME</b>	
FIRM NAME:	<b>YOUR STREET ADDRESS, APT# IF ANY</b>	
STREET ADDRESS:	<b>YOUR CITY, STATE AND ZIP CODE</b>	
CITY:	<b>YOUR PHONE NUMBER</b>	
TELEPHONE NO.:	<b>YOUR EMAIL ADDRESS</b>	
EMAIL ADDRESS:		
ATTORNEY FOR (name):		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF <b>Santa Clara</b>		
STREET ADDRESS:	<b>191 N. First Street</b>	
MAILING ADDRESS:	<b>191 N. First Street</b>	
CITY AND ZIP CODE:	<b>San Jose, CA 95113</b>	
BRANCH NAME:	<b>Probate Division</b>	
CARE ACT P	<b>NAME OF PERSON IN NEED OF SERVICES</b>	RESPONDENT
<b>PETITION TO COMMENCE CARE ACT PROCEEDINGS</b>		CASE NUMBER:
For information on completing this form, see <i>Information for Petitioners—About the CARE Act</i> (form CARE-050-INFO).		

1. Petitioner (name): **YOUR LEGAL NAME**

is 18 years of age or older and (check all that apply):

- a.  A person who lives with respondent.
- b.  A spouse or registered domestic partner, parent, sibling, child, or grandparent of respondent.
- c.  A person who is the conservator of the respondent.
- d.  The director of the county behavioral health agency that hospitalized respondent.
- e.  The director of the county behavioral health agency, or home
  - (1)  who is or has been, within the past 30 days, providing behavioral health services to respondent; or
  - (2)  in whose institution respondent resides.
- f.  A licensed behavioral health professional\* who is or has been, within the past 30 days, treating or supervising the treatment of respondent.
- g.  A first responder, including a peace officer, firefighter, paramedic, emergency medical technician, mobile crisis response worker, or homeless outreach worker who has had repeated contact with respondent.
- h.  The state conservator of the respondent.
- i.  The director\* of the county behavioral health agency of the county named above.
- j.  The director\* of adult protective services of the county named above.
- k.  The director\* of a California Indian health services program or a California tribal behavioral health department.
- l.  A California tribal court judge.\*
- m.  Respondent.

**CHECK ALL THE BOXES THAT APPLY TO YOU**

\* This person may designate someone else to file the petition on their behalf. If the petitioner is a designee, check this category and put designee's name in item 1, above.

2. a. Petitioner asks the court to find that respondent (name) **NAME OF PERSON IN NEED OF SERVICES / RESPONDENT** is eligible to participate in the CARE Act process and to commence CARE Act proceedings for respondent.

b. Petitioner's relationship to respondent (specify and describe relationship):  
**YOUR RELATIONSHIP WITH RESPONDENT**



CARE ACT PROCEEDINGS	<b>NAME OF RESPONDENT</b>	RESPONDENT CASE NUMBER:
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5. c. Respondent is currently experiencing a severe mental illness, as defined in Welfare and Institutions Code section 5600.3(b)(2), in that the illness:
- (1) Is severe in degree and persistent in duration;
  - (2) May cause behavior that interferes substantially with respondent's primary activities of daily living; **and**
  - (3) May result in respondent's inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period.

Supporting information regarding the severity, duration, and risks of respondent's disorder is provided

- on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
- on separate documents, attached and labeled as Attachment 5c.
- below.

**#5B TO #5D : COMPLETE SECTION(S) THAT APPLY.**

**YOU MUST ATTACH FORM CARE-101, SEPARATE SUPPORTING DOCUMENTS, OR A STATEMENT IN SUPPORT OF EACH APPLICABLE STATEMENT.**

**LABEL ALL ATTACHMENTS PER QUERY.**

- d. Respondent is not currently stabilized in ongoing voluntary treatment. Respondent's current stability and treatment are described
- on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
  - on separate documents, attached and labeled as Attachment 5d.
  - below.

CARE ACT PROCEEDING	<b>NAME OF RESPONDENT</b>	RESPONDENT	CASE NUMBER:
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5. e. At least one of these is true (*complete (1) or (2) or both*):

- (1)  Respondent is unlikely to survive safely in the community without supervision **and** respondent's condition is substantially deteriorating. Reasons that respondent is unlikely to survive safely in the community, the type of supervision respondent would need to survive safely, and the extent to which respondent's physical or mental condition has recently grown worse are described
- on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
  - on separate documents, attached and labeled Attachment 5e(1).
  - below.

**COMPLETE SECTION(S) #5E(1) OR #5E(2), OR BOTH.**

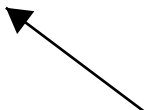
**LABEL SUPPORTING DOCUMENTS AS STATED IN EACH QUERY.**

- (2)  Respondent needs services and supports to prevent a relapse or deterioration that would be likely to lead to grave disability or serious harm to respondent or others. The services and supports needed by respondent and the reasons respondent would become gravely disabled or present a risk of harm to self or others are described
- on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
  - on separate documents, attached and labeled Attachment 5e(2).
  - below.

CARE ACT PROCEEDING	<b>NAME OF RESPONDENT</b>	CASE NUMBER:
	RESPONDENT	

5. f. Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure respondent's recovery and stability. A description of available alternative treatment plans and an explanation why no alternative treatment plan that would be less restrictive of respondent's liberty could ensure respondent's recovery and stability are provided

- on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
- on separate documents, attached and labeled Attachment 5f.
- below.



**CHECK AT LEAST 1 BOX. IF 2ND BOX IS CHECKED, ATTACH SUPPORTING DOCUMENTS, LABELED AS "ATTACHMENT 5F".**

g. Respondent is likely to benefit from participation in a CARE plan or CARE agreement. Reasons in support of this assertion are provided

- on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
- on separate documents, attached and labeled Attachment 5g.
- below.



**CHECK AT LEAST 1 BOX. IF 2ND BOX IS CHECKED, ATTACH SUPPORTING DOCUMENTS, LABELED AS "ATTACHMENT 5G".**

**6. Required Documentation**

The evidence described below is to be provided in the box next to the description of each item.

- a.  A completed *Mental Health Declaration—CARE Act Proceedings* (form CARE-101) signed by a licensed behavioral health professional stat[redacted] designated by them
  - (1)  examined respondent
  - (2)  made multiple att[redacted] reasons, explained in CARE Act proceedings.

**EITHER CHECK THE BOX NEXT TO 6A IF YOU ARE ATTACHING A CARE-101 FORM SIGNED BY A LICENSED BEHAVIORAL HEALTH PROFESSIONAL AND 6A(1) OR 6A(2) DEPENDING ON WHETHER AN EXAMINATION OF THE RESPONDENT WAS CONDUCTED. LABEL DOCUMENT AS "ATTACHMENT 6A."**

**OR**

**CHECK THE BOX NEXT TO 6B IF YOU ARE ATTACHING OTHER TYPES OF EVIDENCE (SUCH AS A CERTIFICATION COPY, A DECLARATION, ETC.). LABEL EACH "ATTACHMENT 6B1", "ATTACHMENT 6B2", ETC (SEE NEXT PAGE)**

or b, or both, and check the box next to the description of a licensed behavioral health professional or a person's ability to participate in the respondent's cooperation and has a for eligibility to participate

Attach *Mental Health Declaration—CARE Act Proceedings* (form CARE-101) and label it Attachment 6a.

CARE ACT PROCEEDING <b>NAME OF RESPONDENT</b>	CASE NUMBER:  RESPONDENT
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6. b.  Evidence that respondent was detained for at least two periods of intensive treatment, the most recent period within the past 60 days. Examples of evidence: a copy of the certification of intensive treatment, a declaration from a witness to the intensive treatment, or other documentation indicating involuntary detention and certification for up to 14 days of intensive treatment. *(Attach all supporting documents and label each, in order, Attachment 6b1, 6b2, 6b3, etc.)*

**Note:** For purposes of the CARE Act, "intensive treatment" refers to involuntary treatment authorized by Welfare and Institutions Code section 5250. It does **not** refer to treatment authorized by any other statutes, including but not limited to Welfare and Institutions Code sections 5150, 5260, and 5270.15.

**Optional information**

7. Tribal affiliation **TRIBE NAME AND ADDRESS**

a.  Respondent is an enrolled member of a federally recognized Indian Tribe. Enter the name and mailing address of the Tribe's name and mailing address:

**IF APPLICABLE, CHECK THE BOX NEXT TO 7A IF YOU KNOW OR BELIEVE THE RESPONDENT TO BE A MEMBER OF A FEDERALLY RECOGNIZED INDIAN TRIBE. CHECK THE BOX NEXT TO 7B IF YOU KNOW OR BELIEVE THE RESPONDENT TO BE RECEIVING SERVICES FROM AN INDIAN HEALTH CARE PROVIDER, TRIBAL COURT OR ORGANIZATION.**

b.  Respondent is receiving services from a California Indian health services program, a California tribal behavioral health department, or a California tribal court.

Name and mailing address of program, department, or court:

**PROGRAM/COURT NAME AND ADDRESS  
(IF APPLICABLE)**

8.  This petition is based on a referral from another court proceeding.

a. Court, department, and judicial officer: **COURT/DEPARTMENT THAT MADE REFERRAL**

b. Case number: **PROVIDE CASE #**

c. Type of proceeding from which respondent was referred:

(1)  Misdemeanor competence to stand trial (Pen. Code, § 13680)

(2)  Assisted outpatient treatment (Welf. & Inst. Code, §§ 5340-5346)

(3)  Lanterman-Petris-Short Act conservatorship (Welf. & Inst. Code, §§ 5350-5356)

Court order attached and labeled as Attachment 8 (optional).

**IF APPLICABLE, CHECK THE BOX IN ITEM 8 IF YOU ARE FILING A PETITION BASED ON A REFERRAL FROM A COURT PROCEEDING. ENTER THE CONTACT INFO IN 8A AND THE CASE NUMBER IN 8B IF KNOWN. CHECK THE APPROPRIATE BOX IN 8C NEXT TO THE TYPE OF PROCEEDING FROM WHICH THE RESPONDENT WAS REFERRED FROM. IF UNKNOWN, LEAVE BLANK. CHECK THE LAST BOX IN 8C IF YOU ARE ATTACHING THE COURT ORDER AND LABEL IT "ATTACHMENT 8."**

9. Check any of the following statements that is true:

a.  Respondent needs an interpreter or other language accommodation (specify): **LANGUAGE OR ACCOMODATION**

b.  Respondent needs a disability accommodation (specify which court): **COURT/DEPARTMENT**

c.  Respondent needs a disability accommodation (specify which court): **COURT/DEPARTMENT**

d.  Respondent needs a disability accommodation (specify which): **REGIONAL CENTER**

e.  Respondent is a current or former member of the state or federal armed services or reserves (specify): **STATE/FEDERAL ARMED SERVICES BRANCH**

**IF APPLICABLE, CHECK THE BOX NEXT TO 9A IF YOU KNOW OR BELIEVE THE RESPONDENT NEEDS INTERPRETER SERVICES OR A DISABILITY ACCOMMODATION. CHECK THE BOXES NEXT TO 9B, 9C, 9D, OR 9E IF YOU KNOW OR BELIEVE THOSE STATEMENTS APPLY TO THE RESPONDENT.**

10. Number of pages attached: **TOTAL NUMBER OF PAGES ATTACHED TO PETITION**

Date: **LEAVE BLANK UNLESS YOU HAVE AN ATTORNEY**

(TYPE OR PRINT NAME OF ATTORNEY)

(SIGNATURE OF ATTORNEY)

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: **DATE**  
**PRINT YOUR NAME**

(TYPE OR PRINT NAME OF PETITIONER)

**YOUR SIGNATURE**

(SIGNATURE OF PETITIONER)



# CONFIDENTIAL

CARE-105

ATTORNEY OR PARTY WITHOUT ATTORNEY NAME: FIRM NAME: STREET ADDRESS: CITY: TELEPHONE NO.: EMAIL ADDRESS: ATTORNEY FOR (name):	<b>YOUR LEGAL NAME</b> <b>YOUR STREET ADDRESS, APT# IF ANY</b> <b>YOUR CITY, STATE AND ZIP CODE</b> <b>YOUR PHONE NUMBER</b> <b>YOUR EMAIL ADDRESS</b>	<b>FOR COURT USE ONLY</b>
<b>SUPERIOR COURT OF CALIFORNIA, COUNTY OF Santa Clara</b> STREET ADDRESS: <b>191 N. First Street</b> MAILING ADDRESS: <b>191 N. First Street</b> CITY AND ZIP CODE: <b>San Jose, CA 95113</b> BRANCH NAME: <b>Probate Division</b>		
CARE ACT NAME OF PERSON IN NEED OF SERVICES / RESPONDENT'S NAME RESPONDENT		
<b>ORDER FOR CARE ACT REPORT</b>		CASE NUMBER:

1. The court has read and reviewed *Petition to Commence CARE Act Proceedings* (form CARE-100) filed by petitioner (name): **YOUR LEGAL NAME** (address): **YOUR ADDRESS** on (date) \_\_\_\_\_, petitioning the court to begin CARE Act proceedings for respondent (name): **RESPONDENT'S NAME** (address, if known): **RESPONDENT'S ADDRESS**

2. The court has found that *Petition to Commence CARE Act Proceedings* has made a prima facie showing that the respondent is or may be eligible to participate in the CARE Act process. A copy of the petition and all attachments are included with this order.

**The court orders as follows:**

3. The following county agency (name): \_\_\_\_\_ or its designee must contact and engage the respondent and, no later than (date): \_\_\_\_\_ file with the court a written report that includes the following information:

- a. Respondent's county of residence;
- b. A determination whether respondent meets or is likely to meet the CARE Act eligibility requirements;
- c. The outcome of the county's efforts to engage respondent during the period before the report deadline above;
- d. Conclusions and recommendations about respondent's ability to voluntarily engage in services; and
- e. Other \_\_\_\_\_

**LEAVE BLANK, THE JUDGE WILL FILL THIS SECTION OUT LETTING YOU KNOW THE ORDERS OF THE COURT.**

4. Before \_\_\_\_\_  
Order for \_\_\_\_\_  
provided \_\_\_\_\_

5. The court has, by separate order, appointed the following attorney to represent the respondent at all stages of these CARE Act proceedings.

- a. Name:
- b. Firm name:
- c. Street address:
- d. Mailing address (if different):
- e. Email address:
- f. Telephone number:
- g. Fax number:

Date: \_\_\_\_\_

\_\_\_\_\_  
JUDICIAL OFFICER

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