Community Assistance, Recovery, and Empowerment Act

The Community Assistance, Recovery, and Empowerment (CARE) Act authorizes specified adult persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan that can include treatment, housing support, and other services for persons with untreated schizophrenia or other psychotic disorders.

How to File the CARE-100 Form to Begin CARE Act Proceedings

KEY

This is a guide for people who wish to fill out a **CARE-100 petition form** to begin CARE Act proceedings. Each item in this guide corresponds to an item in the CARE-100 form and is color-coded according to this key.

- Information about the **petitioner** (person filling out the CARE-100 form)
- Information about the **respondent** (person you believe is eligible for the CARE Act process)
- Instructions on how to fill out each item of the CARE-100 form

Fill out the information at the top of the form. This is called the caption. In the first box, provide your name, address, and contact information. In the second box, provide the information of the court you are filing in. In the third box, write the name of the respondent.

ITEM 1

Petitioner Eligibility

1. Petitioner *(name)*: YOUR 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 stands in the place of a parent to respondent.
d. The director* of a hospital in which respondent is hospitalized.
e. The director* of a public or charitable organization, 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 interactions with respondent.
h. The public guardian* or public conservator* of the county named above.
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.

* 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 own name in item 1, above.

*Write your name in ITEM 1. You must be **at least 18 years old or older** to submit this petition. Check all the boxes next to the eligible petitioner types in **1a-1m** that apply to you.*

ITEM 2

Relationship to the Respondent

2. a. Petitioner asks the court to find that respondent *(name)*: RESPONDENT'S 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)*:
YOUR RELATIONSHIP WITH THE RESPONDENT
c. Petitioner's interactions with respondent *(if petitioner is specified in 1d, 1e, 1f, or 1g, specify the number of interactions with respondent and the date of the most recent interaction, and describe the nature and outcome of each interaction)*:
YOUR INTERACTIONS WITH THE RESPONDENT (IF APPLICABLE)
If you need additional space, please include on a separate piece of paper and label as Attachment 2c.

*If you are one of the petitioner types described in **1d, 1e, 1f or 1g** from ITEM 1, check the box in **2c** and write in the empty space the number of times you interacted with the respondent, the date of your most recent interaction, and the nature and outcomes of each interaction. If you need more space, check the box and attach a separate piece of paper labeled "**Attachment 2c**."*

ITEM 3

Respondent's Address or Last Known Location

3. Respondent lives or was last found at *(give respondent's residential address, if known and one exists; otherwise, state that the address is unknown and provide the last known location and any additional contact information, such as a phone number, including whether the number can receive texts, or an email address)*:
RESPONDENT'S ADDRESS OR LOCATION WHERE LAST SEEN
If you need additional space, please include on a separate piece of paper and label as Attachment 3.

*Provide respondent's specific address or last known location (examples: a park, hotel, or intersection). If unknown, indicate "unknown" and include phone number or email address if known. If you need more space, check the box and attach a separate piece of paper labeled "**Attachment 3**."*

ITEM 4

County of Filing

4. Respondent *(check all that apply)*:
a. Is a resident of the county named above.
b. Is currently located in the county named above.
c. Is a defendant or respondent in a criminal or civil proceeding pending in the superior court of the county named above.
d. Respondent's county of residence is *(if known and different from the county named above)*: COUNTY NAME

*Check all the boxes that apply to the respondent. The "county named above" refers to the county in which the petition is being filed. If you know the respondent's county of residence and it differs from the county in which the petition is being filed, check the box in **4d** and write the county name.*

Rev. 08/31/23

ITEM 5

Respondent's Eligibility

*In **5a,** write the respondent's birthday and age in years (approximate respondent's age if unknown).*

*In **5b-5g,** check the box next to the type of supporting document you intend on attaching to the petition to meet each of the CARE Act criteria items. If you check "below" write the information in the space provided.*

*If you are attaching a CARE-101 form signed by a licensed behavioral health professional, label the document as "**Attachment 6a.**"*

*If you are attaching other documents, label each document to match the criteria item it applies to, for example, "**Attachment 5c**" or "**Attachment 5e(1).**"*

5. Respondent meets each of the following requirements and is eligible to participate in the CARE Act process and receive services and support under a CARE agreement or CARE plan *(provide information below to support each requirement):*

a. Respondent is 18 years of age or older. Date of birth *(if known):* RESPONDENT'S BIRTHDAY
Age in years *(if exact age not known, give approximate age):* AGE

b. Respondent has a diagnosis of a schizophrenia spectrum disorder or another psychotic disorder in the same class, as defined in the current *Diagnostic and Statistical Manual of Mental Disorders*. Diagnosis and additional information are provided
☐ on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101), attached as Attachment 6a.
☐ on separate documents, attached and labeled as Attachment 5b.
☐ below.

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.

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.

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.

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.

ITEM 6

Required Documentation

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.

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.)*

*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.*

ITEM 7

Tribal Enrollment/Services From an American Indian Health Care Provider (Optional)

7. Tribal affiliation

a. ☐ Respondent is an enrolled member of a federally recognized Indian tribe.
Tribe's name and mailing address: TRIBE NAME AND 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: PROGRAM/COURT NAME AND 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.*

ITEM 8

Referral From Another Court (Optional)

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

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

b. Case number: CASE #

c. Type of proceeding from which respondent was referred:
(1) ☐ Misdemeanor competence to stand trial (Penal Code, § 1370.01)
(2) ☐ Assisted outpatient treatment (Welfare and Institutions Code, §§ 5346–5348)
(3) ☐ Lanterman-Petris-Short Act conservatorship (Welfare and Institutions Code, §§ 5350–5372)
☐ 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.**"*

ITEM 9

Helpful Information (Optional)

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

a. ☐ Respondent needs interpreter services or an accommodation *(specify):* LANGUAGE OR ACCOMMODATION

b. ☐ Respondent is under juvenile court jurisdiction *(specify which court):* COURT/DEPARTMENT

c. ☐ Respondent is currently under conservatorship (*specify which court):* COURT/DEPARTMENT

d. ☐ Respondent is served by a Regional Center *(specify which):* REGIONAL CENTER

e. ☐ Respondent is a current or former member of the state or federal armed services or reserves
(specify which branch): 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.*

ITEM 10

Attachments & Signature

10. Number of pages attached: # OF PAGES

Date: DATE

ATTORNEY NAME
(TYPE OR PRINT NAME OF ATTORNEY)

ATTORNEY SIGNATURE
(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

YOUR NAME
(TYPE OR PRINT NAME OF PETITIONER)

YOUR SIGNATURE
(SIGNATURE OF PETITIONER)

Write the total number of pages attached to the petition.

If you have an attorney, they must date, print their name, and sign.

You must also date, print your name, and sign to verify that everything in the form and the attachments is true.

Have questions?

Visit this page for more CARE Act information.