HOW TO GUIDE:
FILLING OUT THE CARE-100 PETITION

CONFIDENTIAL

CARE-100

ATTORNEY OR PETITIONER WITHOUT ATTORNEY	STATE BAR NUMBER:	*FOR COURT USE ONLY*
NAME:		
FIRM NAME:		
STREET ADDRESS:		
CITY:	STATE: ZIP CODE:	
TELEPHONE NO.:	FAX NO.:	
EMAIL ADDRESS:		
ATTORNEY FOR (*name*):		

Write your name, address, and phone number.

Write No Attorney or In Pro Per

SUPERIOR COURT OF CALIFORNIA, COUNTY OF

STREET ADDRESS:
MAILING ADDRESS:
CITY AND ZIP CODE:
BRANCH NAME:

CARE ACT PROCEEDINGS FOR *(name)*:

Write the name of the person in need of services

RESPONDENT

Clerk will provide a case number upon filing this Petition.

PETITION TO COMMENCE CARE ACT PROCEEDINGS

CASE NUMBER:

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

Write your name and check all boxes that describe your relationship to the person in need of services.

1. Petitioner *(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 or a private conservator referred by the court under Welfare and Institutions Code section 5978.

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 name in item 1, above.

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

Write the name of the person in need of services

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)*:

For Example: I am his grandmother.
I am her husband, and we live together.
I am a Deputy for Tuolumne County Sheriff's Department and had multiple calls for service for respondent.

Form Adopted for Mandatory Use
Judicial Council of California
CARE-100 [New September 1, 2023]

Welfare & Institutions Code,
§§ 5972–5975, 5977–5977.4, 5978
www.courts.ca.gov

SELF HELP CENTER
SUPERIOR COURT OF CALIFORNIA

CONFIDENTIAL

CARE-100

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

Write the name of the person in need of services.

Case number is provided by clerk upon filing this Petition.

2. c. [x] 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):*

Describe events involving the person needing services as related to their related to their mental health condition.

For Example:
I have known her for her entire life. I most recently saw her last week on _____.

[ ] If you need additional space, please include on a separate piece of paper and label as Attachment 2c.

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):*

For Example:
My granddaughter does not have a home, but was staying at Camp Hope on Stockton Street in Sonora. Her phone number is _____.

[ ] If you need additional space, please include on a separate piece of paper and label as Attachment 3.

4. Respondent *(check all that apply):*

Check all boxes that apply to the person in need of services. "County named above" refers to the county where the petition is being filed.

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. [ ] Is a resident of *(specify county if known and different from the county named above):*

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):*
Age in years *(if exact age not known, give approximate age):*

Write date of birth and approximate 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.
[x] below.

Describe the respondent's diagnosis if known and how you are aware of the diagnosis. Provide any additional information which may be helpful if you are unsure of the diagnosis.

For Example:
My son was diagnosed with schizophrenia in December of 2022. I am aware because we live together, and I took him to some appointments. When he does not take his medications, he is extremely paranoid and hallucinates.

***Only a person with a schizophrenia spectrum or other psychotic disorder is eligible for the CARE Act process. A person with only another serious mental illness, such as bipolar disorder or major depression, is not eligible.

Note: 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.

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

Write the name of the person in need of services

Case number is provided by the clerk upon filing this Petition.

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.

Describe any behaviors such as delusions, hallucinations or ongoing mood changes which substantially interfere with daily life.

Describe how long the respondent has been presenting these behaviors.

Describe how the respondent's mental illness impacts/interferes with his/her ability to perform regular/routine tasks or care for self.

Describe why you believe respondent cannot live independently, function in the community, manage his/her condition, or relationships without additional help.

For Example:
For the past two years, my grandson has been getting worse and is paranoid. He also is verbally and physically aggressive with others. He will argue for no reason. He thinks the water in the house will burn his skin so he won't take a shower, wash his hands, he thinks food and medication are poisonous and won't take anything. He can't control his emotions, loses track of time, has not been sleeping.

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.

Describe why you believe voluntary treatment is not working for respondent.

For Example:
My grandson stops taking his medication after a short period of time and will not go to behavioral health.

My brother is "ok" for a little bit but that changes quickly, and he believes the doctor is poisoning him. He will self-medicate with whatever he can find.

My wife quit taking medications because she believes big pharma is in a conspiracy with the US Government and Facebook to make us take vaccines.

Note:
Repeated and ongoing refusal to accept voluntary treatment without reason.

Temporary acceptance of voluntary treatment that is interrupted by failure or refusal to continue the treatment without reason.

Voluntary treatment is accepted, but that treatment is not effective to stabilize the respondent.

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

Write the name of the person in need of services.

Case number is provided by the clerk upon filing this Petition.

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

(1) [x] 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).
- [x] below.

Describe why the respondent is unable to survive in the community, what type of supervision is needed, and how the respondent's condition has gotten worse.

For Example:
My son will not be able to survive because he now refuses to stay in the house. He thinks the air is toxic and will only sleep outside.

He screams at neighbors and has tried to break into their houses because he thinks people are getting hurt inside. The police have been called 4 times in the last week.

My brother has been on a 5150 hold twice in the last week, but he lies to the hospital staff and they let him go.

People are calling the police all the time because he walks in the middle of the road and is nearly hit by cars.

Note:
Indicate recent instances where the respondent needed supervision to survive in the community due to lack of reality orientation, confusion, or impaired insight.

Describe how the respondent's ability to think clearly, communicate,or participate in regular activities has worsened quickly.

(2) [x] 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).
- [x] below.

Describe how the respondent would be injured, unable to survive or would cause harm to others or themselves if they do not receive services.
For Example:
If my wife does not receive services to keep her on her medications, then she becomes depressed and self-harms by cutting herself.

My roommate becomes highly agitated for no logical reason which leads to him making threats and being violent. It scares the neighbors and they call the police. He becomes threatening to police and they may use force.

Note:
Grave disability means a person's inability, due to mental illness, to provide for their basic personal needs for food, clothing, or shelter. Serious harm includes injury causing extreme pain, high risk of death, or loss of physical or mental functions.

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. A person who has recently attempted suicide because of their mental illness and continues to express a desire to self-harm. 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.

CARE ACT PROCEEDINGS FOR *(name)*:	CASE NUMBER:
Write the name of the person in need of services. RESPONDENT	Case number provided by the clerk upon filing this Petition.

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.

Describe how CARE services are necessary because other less restrictive alternatives would not help ensure Respondent's recovery and stability.

For Example:
My son was involved with Full Service Partnership at Behavioral Health and he was not consistent.

My sister always makes "Safety Plans" with the crisis mental health workers and never follows through. She makes appointments and does not keep them, won't follow-up with her doctor.

Note:
The respondent's participation in a CARE plan/agreement MUST be the least restrictive option and be likely to benefit the respondent.

Effectively meet the respondent's treatment needs while placing as few limits as possible on the respondent's rights and personal freedoms.

Explain how participation in a CARE plan or CARE agreement would 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.

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.

Explain how participating in a CARE plan could help the respondent stabilize and improve their current state and situation.

For Example:
My spouse's symptoms improved while in therapy and on medication about a year ago, but then she stopped going to therapy and is no longer interested in taking medication.

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.

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

Write the name of the person in need of services.

Case number is provided by the clerk upon filing this Petition.

6. b. [x] 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.

For Example:
Copy of DHCS Form 1808
Declaration from someone with personal knowledge
Hospital Discharge documents
Other information including dates of treatment

Optional information

Complete (a) and (b), if applicable.

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.

Complete, if applicable.

   a. Court, department, and judicial officer:
   b. Case number:
   c. Type of proceeding from which respondent was referred:
      (1) [ ] Misdemeanor competence to stand trial (Penal 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:

Complete, if applicable.

   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: _____

Write number of pages attached to this document.

Date:

For Attorney signature only.

(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:

Write the date.

Print your name.

Sign your name.

(TYPE OR PRINT NAME OF PETITIONER) (SIGNATURE OF PETITIONER)