SUPERIOR COURT OF CALIFORNIA
COUNTY OF ORANGE

Self-Help Services
www.occourts.org/self-help

CARE ACT - BECOME A LINK TO CARE

SELF-HELP FORM PACKET

SHC-CC-01 (Rev. 07/01/2026)

Self-Help Services can review your completed forms before you file them with the Court. To request a review of your completed forms, visit your nearest Self-Help Center location:

- **Central Justice Center:** 700 Civic Center Drive West, Santa Ana, 92701
- **Costa Mesa Justice Complex:** 3390 Harbor Blvd., Costa Mesa, 92626
- **Harbor Justice Center:** 4601 Jamboree Road, Newport Beach, 92660
- **Lamoreaux Justice Center:** 341 The City Drive South, Orange 92868
- **North Justice Center:** 1275 N. Berkeley Ave., Fullerton, 92832
- **Stephen K. Tamura-West Justice Center:** 8141 13th St., Westminster, 92683

CARE Act

Become a Link to Care

COMMON WORDS

CARE Act: The Community Assistance, Recovery, and Empowerment Act created a legal process to assist individuals living with Bipolar I Disorder with Psychotic Features, Psychotic Disorders, or Schizophrenia Spectrum Disorders.

Orange County Health Care Agency (HCA): Agency whose findings and resources are relied on by the CARE Act.

Petition: Form CARE-100.

Petitioner: Person or entity that files Form CARE-100.

Prima Facie: The first time a Judge reviews filed Form CARE-100 to decide if Respondent qualifies under the CARE Act.

Probate Court: A division of the court that oversees cases that involve individual rights outside of civil and criminal law.

Respondent: A person listed on Form CARE-100 as someone who qualifies under CARE Act.

Bipolar I Disorder with Psychotic Features, Psychotic Disorders, or Schizophrenia Spectrum Disorders: Severe mental health disorders that interfere with someone's daily activities and their ability to be independent.

Volunteer Supporter: Respondent's chosen support person to help navigate the CARE Act.

OVERVIEW

The Community Assistance, Recovery, and Empowerment Act (**CARE Act**), may help someone link an individual living with untreated **Bipolar I Disorder with Psychotic Features, Psychotic Disorders,** or **Schizophrenia Spectrum Disorders,** to community care resources.

The person that wants to help is called the **Petitioner**. While the person that needs the help is called the **Respondent**.

The **CARE Act** does not force a **Respondent** to receive care. The **Respondent** may decline to receive care or stop participating at any time. There are no civil or criminal penalties for the **Respondent**.

If you are unsure if the **CARE Act** is the right link to resources for the **Respondent**, please reach out to Self-Help Services before completing this packet.

PARTICIPANTS

Petitioner

A **Petitioner** can link a **Respondent** to care through the **CARE Act** by filing a **Petition** with the **Probate Court**. However, not everyone that wants to help a **Respondent** can be a **Petitioner**. The following persons may serve as **Petitioners**:

The **Respondent's**:

- ☐ Parent or Legal Guardian
- ☐ Spouse
- ☐ Sibling
- ☐ Child
- ☐ Grandparent
- ☐ Roommate
- ☐ Homeless outreach worker
- ☐ Service provider who is treating or has recently treated **Respondent**.
- ☐ Director of a hospital in which the **Respondent** was recently or is hospitalized in.
- ☐ Directors of Public Service Agencies and their designees.
- ☐ A first responder who has had repeated contact with the **Respondent**.

Respondent

Under the **CARE Act**, a person in need of care can only be a **Respondent** if:

- They are at least 18 years old;
- Have a diagnosis of **Bipolar I Disorder with Psychotic Features, Psychotic Disorder,** or **Schizophrenia Spectrum Disorder;**
- A statement signed by a licensed behavioral health professional, nurse practitioner, or physician assistant confirming the diagnosis can be obtained;
- There are other eligibility criteria that will be fully assessed by the court to determine if the **Respondent** qualifies under the **CARE Act**.

Orange County Health Care Agency

The **Orange County Health Care Agency (HCA)** is responsible for protecting and promoting Orange County community health. As a centralized resource hub, **HCA** is a key part of the **CARE Act**.

HCA can be a **CARE Act Petitioner**. If **HCA** did not file the **Petition**, **HCA** will be responsible for contacting, investigating, and submitting a report to the Court about whether the **Respondent** is eligible.

If you believe that someone that needs assistance may not be eligible for **CARE Act** help, reach out to **HCA** to learn about other resources here:

1-855-OC-Links (625-4657)
Monday – Friday: 8:00am – 6:00pm

You can also visit **HCA's** OC Navigator. This online tool helps find and connect with supportive resources 24/7.

www.ocnavigator.org

Orange County Public Defender

Once the **CARE Act Petition** is filed, an Orange County Public Defender (PD) will be appointed to represent **Respondent**, free of charge, to ensure the **Respondent's** interests are recognized and **CARE Act** requirements met.

Volunteer Supporter

A **Respondent** may choose a **Volunteer Supporter**. This person helps the **Respondent** understand available care options, consider potential consequences, and feel heard during the process.

ROADMAP

Participants

Complete Forms

Affidavit

Review

File

Prima Facie

Judge

The Judge will be a neutral facilitator ensuring the **CARE Act** is followed. The Judge is responsible for determining:

- ☐ The **Respondent** qualifies under the **CARE Act**.
- ☐ The **Respondent** is willing to participate.
- ☐ The **Respondent** understands and agrees to the plan of care and the plan continues to meet the **Respondent's** needs.
- ☐ The **Respondent** has received available benefits.

PROCEDURE

[If you are reading this packet on an internet enabled device, forms in **BOLD** are attached and can be clicked on to open and view electronically.]

If you are ready to serve as **Petitioner** and believe that a potential **Respondent** meets all **CARE Act** requirements, you must complete:

- ☐ **CARE-100 – Petition to Commence Care Act Proceedings**
- ☐ **CARE-101: Mental Health Declaration**
  - Complete the top of Pg. 1— **Petitioner's** name and contact information, case name, and case number.
  - The rest of the form must be completed by a licensed behavioral health professional, nurse practitioner, or physician assistant, and must be attached to **CARE-100** at the time of filing.
- ☐ **CARE-105: Order for CARE Act Report**
  - Complete the top of Pg. 1—**Petitioner's** name and contact information, case name, and case number and Item 1.
    - The rest of **CARE-105** is completed by the Court.

Document Review

Self-Help Services offers a free optional document review service for self-represented litigants. As part of this service, an attorney or paralegal will review your documents for completion before filing. **Our staff cannot provide you with legal advice or strategy.** To have your documents reviewed, you may choose:

- ☐ Electronic Submission
  - Visit: https://www.occourts.org/self-help/self-help-services
  - Scroll down to the teal "Contact Self-Help Services" button and click.
  - Complete the request for assistance form in full and submit.

ROADMAP

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Prima Facie

- In Person
  - Central Justice Center
    Self-Help Services, 1st Floor, Room G-100
    700 Civic Center Drive West, Santa Ana, CA 92701
  - Costa Mesa Justice Complex
    3390 Harbor Boulevard, Costa Mesa, CA 92626
  - Harbor Justice Center
    Criminal Operations, 1st Floor, Suite 111
    4601 Jamboree Road, Newport Beach, CA 92660
  - Lamoreaux Justice Center
    Self-Help Services, 1st Floor
    341 The City Drive South
    Orange, CA 92868
  - North Justice Center
    Criminal/Traffic Operations, 3rd Floor
    1275 North Berkeley Avenue, Fullerton, CA 92832
  - West Justice Center
    Criminal/Traffic Operations, 1st Floor
    8141 13th Street, Westminster, CA 92683

Filing

CARE Act Petitioner's must file in the county where:

- The **Respondent** lives, or
- The **Respondent** is found, or
- The **Respondent** is facing criminal or civil proceedings.

In Orange County, a **CARE Act Petition** may be filed:

- In Person:
  - Central Justice Center
    Self-Help Services, 1st Floor, Room G-100
    700 Civic Center Drive West, Santa Ana, CA 92701
  - Costa Mesa Justice Complex
    3390 Harbor Boulevard, Costa Mesa, CA 92626
  - Harbor Justice Center
    Criminal Operations, 1st Floor, Suite 111
    4601 Jamboree Road, Newport Beach, CA 92660
  - Lamoreaux Justice Center
    Self-Help Services, 1st Floor
    341 The City Drive South
    Orange, CA 92868

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Prima Facie

- North Justice Center
  Criminal/Traffic Operations, 3rd Floor
  1275 North Berkeley Avenue, Fullerton, CA 92832
- West Justice Center
  Criminal/Traffic Operations, 1st Floor
  8141 13th Street, Westminster, CA 92683

- 24/7 DropBox located outside of the Costa Mesa Justice Complex
- Mail:
  - Costa Mesa Justice Complex
    ATTN: Probate Filing Clerk
    3390 Harbor Boulevard, Costa Mesa, CA 92626
- E-filing:
  - Visit: **https://www.occourts.org/online-services/efiling/efiling-probate-mental-health**

Filing Fee

There is no fee for filing.

What is Next?

The Judge will review the **CARE Act Petition** and determine if the **Respondent's** needs meet the basic requirements of the **CARE Act**. This is called a **Prima Facie** review.

If the **Respondent** does not, the Judge will dismiss the case.

If the **Respondent** does, the Judge will assign **HCA** to complete a report and will appoint a Public Defender to represent the **Respondent**.

Once the report is completed, the Judge must decide whether to move forward to develop a care plan to meet the **Respondent's** needs.

ROADMAP

Participants

Complete Forms

Affidavit

Review

File

Prima Facie

CARE-050-INFO Information for Petitioners—About the CARE Act

This information sheet describes the CARE Act and how to fill out *Petition to Begin CARE Act Proceedings* (form CARE-100). A court self-help center may also be able to help you. Go to selfhelp.courts.ca.gov/self-help/find-self-help to find your court's self-help center. **Note:** There is no cost to file a CARE Act petition.

1 What is the CARE Act?

CARE stands for Community Assistance, Recovery, and Empowerment. The CARE Act allows a person in one or more of 14 categories (see page 2) to file a petition asking a court to start proceedings intended to get help for an adult who has a schizophrenia spectrum disorder or another psychotic disorder and meets several other requirements. The person who asks the court to start the proceedings is called the *petitioner*. This form assumes that you are thinking about whether to file a petition and become a petitioner. The person who you think needs help is called the *respondent*.

If the court decides that the respondent is eligible for the CARE Act, the county behavioral health agency will work with them to try to reach a CARE agreement, as described in item 2.

2 What is a CARE agreement or CARE plan?

A CARE agreement and a CARE plan are written documents that describe services to support the recovery and stability of the respondent. They must be approved by court order. Services may include clinical behavioral health care; counseling; specialized psychotherapy, programs, and treatments; stabilization medications; a housing plan; and other supports and services provided directly and indirectly by local government. The agreement or plan cannot give anyone the right to use force to medicate the respondent.

A CARE agreement is a voluntary agreement for services and treatment between the respondent and the county behavioral health agency after a court has found that the respondent is eligible for the CARE program. For the agreement to be valid, the court must approve it. The court can change the agreement before approving it.

A CARE plan is a set of community-based services and supports for the respondent that is ordered by the court if the respondent and the county cannot reach a CARE agreement.

A CARE plan or CARE agreement may be amended if the respondent and the county agree to amend the plan or agreement. The court may also approve amendments to a CARE plan without the parties' agreement if the court holds a hearing and finds that the amendments are needed to support the respondent in getting the help they need.

3 Have you thought about ways to help other than CARE Act proceedings?

There may be other ways to help a person with a serious mental illness. If the person has private health insurance, contact their health plan/insurer. If you do not know if the person has private health insurance or if they do not have private insurance, contact your county's behavioral health agency or check its website.

County behavioral health agencies offer many services. These include services like counseling, therapy, and medication and can also include programs like full-service partnerships, rehabilitative mental health services, peer support services, intensive case management, crisis services, residential care, substance use 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. They are also allowed to provide their services to people who do not receive Medi-Cal, depending on local funding and eligibility standards. These services do not require a court order. Also, you can refer someone to your local behavioral health agency. The agency can investigate and may decide to file a petition itself, but it is not required to do so.

Find out if the person has made an advance health care directive or psychiatric advance directive. These written documents name someone else to make health care decisions for a person when that person cannot. If the person has a directive, you can contact the person named in it to ask for their help. Think about looking into local social services and community-based programs too.

4 How do I complete *Petition to Begin CARE Act Proceedings* (form CARE-100)?

This section walks you through the petition, form CARE-100, item by item.

Item 1: Names and Age

As noted on page 1, you are the *petitioner*, the person asking the court to start CARE Act proceedings for the *respondent*, a person who needs help because of a serious mental disorder. In item 1 of form CARE-100, enter your name, the respondent's name, and the respondent's date of birth (or, if you don't know it, give the respondent's approximate age).

Item 2: What Type of Petitioner Are You?

In item 2, confirm that you are an adult, and check the box next to each petitioner type that applies to you:

- A person who lives with the respondent.
- The respondent's spouse or registered domestic partner, parent, sibling, child, or grandparent.
- A person who has authority to act as the respondent's parent.
- The director of a county behavioral health agency of the county where the respondent lives or is present, or the director's designee.
- A licensed behavioral health professional who is or has been supervising the treatment of or treating the respondent for a mental disorder within the last 30 days, or the professional's designee.
- The director of a public or charitable agency who is or has, within the last 30 days, been providing behavioral health services to the respondent or in whose institution the respondent resides, or the director's designee.
- The director of a hospital in which the respondent is or was recently hospitalized, or the director's designee.
- A California tribal court judge in whose court the respondent has appeared within the previous 30 days, or the judge's designee.
- The director of adult protective services of the county where the respondent lives or is present, or the director's designee.
- The director of a California Indian health services program or tribal behavioral health department that is or has, within the previous 30 days, been providing behavioral health services to the respondent, or the director's designee.
- A first responder who has encountered the respondent multiple times to arrest or involuntarily detain the respondent, engage the respondent in voluntary treatment, or make other efforts to get the respondent professional help.
- The public guardian or public conservator of the county where the respondent lives or is present, or the public officer's designee.
- A conservator or proposed conservator referred from a proceeding under the Lanterman-Petris-Short (LPS) Act.
- The respondent.

Item 3: Your Interaction With the Respondent

Describe your interactions and relationship with the respondent in item 3. For example, describe how you know the respondent, how often you see or talk with them, when (give the date) you last saw them, and what happened when you interacted with the respondent.

Item 4: The Respondent's Contact information

If you know where the respondent lives, enter that address in item 4a. If you do not know the respondent's address or if they do not have one, give the respondent's last known location and any other information, such as a post office box where they get mail or locations where they are frequently found, that might help to locate the respondent. In item 4b, provide the respondent's phone number—including whether they respond to text messages—and their email address, if any. If you are in contact with the respondent, check the box or boxes in item 4c that show all ways you have been able to contact them. Then, if respondent needs any language assistance, check the box in item 4d and identify the respondent's preferred language.

Item 5: The Right Court and County

You can file a petition *only* in a county where the respondent lives, where the respondent is currently located, or where the respondent is involved in a court case. In item 5, check the box or boxes that show why the county where you are filing the petition is the right place to file. If the respondent does not live in the county, state what county they live in, if you know it.

Item 6: Required Supporting Evidence

You must include supporting evidence in or with the petition. That evidence must be one of the following:

a. A completed declaration by a licensed behavioral health professional on *Mental Health Declaration—CARE Act Proceedings* (form CARE-101); **OR**

b. A statement or documentation that the respondent has been hospitalized at least twice for involuntary treatment, and that the most recent hospitalization ended no more than 60 days before you file the petition.

   If you know personally about the respondent's hospitalizations for involuntary treatment, you can describe them in the space provided in item 6a. You can also check item 6b and attach documentation, such as copies of certifications for intensive treatment, declarations from one or more witnesses to the involuntary treatment, or other documents showing that the respondent was hospitalized at least twice for involuntary treatment. At least one piece of evidence in or with the petition should show the beginning and ending (discharge) dates of the most recent treatment period.

   Note: For purposes of the CARE Act, "involuntary treatment" includes only a 14-day hold for intensive 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 a 72-hour hold under Welfare and Institutions Code section 5150 or treatment under Welfare and Institutions Code sections 5260, 5270.15, and 5270.70.

Item 7: The Respondent's Eligibility for the CARE Process

Your petition must state facts and provide information to support your claim that, to the best of your knowledge, the respondent is eligible for the CARE Act process. **All** of the following requirements, which are listed in items 7a–7f on form CARE-100, must be met for a respondent to be eligible. If you are attaching a declaration on form CARE-101 (see item 6a above) containing the information required by this item, then you may check the box at the beginning of item 7 and not fill out the rest of that item. Please note that the situations discussed below are only *examples* of circumstances that **may** qualify. The court decides whether a respondent is eligible based on facts about that respondent.

Requirements	Explanations	Examples
The respondent must be 18 years old or older and must meet each requirement identified below:		
Have a diagnosis as defined in the current *Diagnostic and Statistical Manual of Mental Disorders* of a schizophrenia spectrum disorder or another psychotic disorder in the same class, or bipolar I disorder with psychotic features, except psychosis related to current intoxication (**item 7a**).	Only a person with a schizophrenia spectrum or other psychotic disorder, or bipolar I disorder with psychotic features, is eligible for the CARE Act. A person who does not have one of these diagnoses is not eligible even if they have a different serious mental disorder, such as major depression. **Note:** The person's diagnosis 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 7 to be eligible.	Eligible diagnoses include: schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, schizotypal personality disorder, bipolar I disorder with psychotic features, except psychosis related to current intoxication, and other psychotic disorders.

Requirements	Explanations	Examples
Be currently experiencing a serious mental disorder that (**item 7b**): • Is severe in degree and persistent in duration, • May cause behavior that interferes substantially with the person's activities of daily living, **and** • May lead to an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period.	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. 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.	If caused by a chronic, prolonged, or recurrent mental disorder: • Difficulty with self-care (e.g., bathing, grooming, obtaining and eating food, using the restroom, dressing appropriately for the weather, securing health care, or following medical advice). Poor hygiene or being unhoused alone is not sufficient. • Difficulty maintaining a residence, using transportation, or managing money day to day. • Difficulty concentrating or completing tasks as scheduled. • Difficulty functioning socially, creating and maintaining relationships.
Not be clinically stabilized in ongoing voluntary treatment (**item 7c**). A person is clinically stabilized in ongoing treatment if their condition is stable and not deteriorating, and they are currently engaged in treatment and managing symptoms through medication or other therapeutic interventions.	Describe why you believe the respondent is not being adequately supported in a voluntary treatment program such that their condition and symptoms are stable. Enrollment in treatment alone is not enough to be considered clinically stabilized in ongoing voluntary treatment.	• 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.
At least *one* of the following must be true (item 7d):		
The respondent is unlikely to survive safely in the community without supervision ***and*** the respondent's condition is substantially deteriorating (**item 7d(1)**). **OR** *(see next page)*	Indicate recent instances where the respondent has needed supervision to survive in the community due to confusion or impaired insight. Describe how the respondent's ability to think clearly, communicate, or participate in regular activities has been getting worse recently.	• Recent or frequent hospitalizations due to symptoms such as delusions, hallucinations, disorganization, impaired insight, impaired judgment. • Recent or frequent arrests due to a mental disorder.

Requirements	Explanations	Examples
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 (**item 7d(2)**).	Describe how the respondent would become gravely disabled or likely to cause serious harm to themselves or others without services and supports. • *Grave disability* includes a person's inability, due to a mental disorder, to provide for their basic personal needs for food, clothing, shelter, safety, or medical care. • *Serious harm* includes injury causing extreme pain, high risk of death, or loss of physical or mental functions.	• A person who has immediate access to safe housing but chooses, because of a mental disorder, to live in conditions that could lead to a serious danger to their health. • A person who recently attempted suicide because of their mental disorder and continues to express a desire to harm themselves. • Self-injuring behavior, such as walking into traffic or harming oneself unknowingly through behavior that puts them at risk for serious injury or death.
The respondent's participation in a CARE plan or CARE agreement must:		
Be the least restrictive alternative necessary to ensure the respondent's recovery and stability (**item 7e**), **and**	Explain how participation in a CARE plan or CARE agreement: • Would effectively meet the respondent's treatment needs while placing as few limits as possible on the respondent's rights and personal freedoms. • Is necessary because other less restrictive alternatives would not ensure the respondent's recovery and stability; for example, because other less restrictive alternatives have not been successful.	Examples of less restrictive alternatives might include: • **Voluntary full-service partnerships**, 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. • **Supported decisionmaking**, 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. • **Assertive community treatment**, which is a person-centered, recovery-based treatment option that employs low client-to-staff ratios.
Be likely to benefit the respondent (**item 7f**).	Explain how participating in a CARE plan could help the respondent stabilize and improve their current state and situation.	• The respondent's prior improvement when participating in similar treatment programs. • Medical opinion that the patient would benefit from treatment.

Note: Include in the petition as much information as you have about each item listed above. If you notice you're repeating yourself, you can say that you already gave the information and say where you said it before. You may also attach any documents you have that support one or more of those items.

Item 8: Other Optional Information

In item 8, check any of the boxes that apply to the respondent and provide any requested information that you know. Please find information about specific sections of item 8 below.

Note: If you don't know the information requested in any part of item 8, leave that part blank. The petition will be processed even if you do not complete item 8.

- *Regional Center*: If you know that respondent is served by a regional center, please check item 8b, provide the name and location of the center, and list any services the center provides to the respondent. A list of service centers can be found at dds.ca.gov/rc/listings/.
- *Tribal Enrollment or Services From an American Indian Health Care Provider*: If you know that the respondent is a member of a federally recognized Indian tribe or is receiving services from a California Indian health care provider, tribal court, or tribal organization, include that information in item 8d or item 8e.
- *Juvenile Court Information*: If the respondent is within a juvenile court's jurisdiction as a dependent, ward, or nonminor dependent, fill out item 8f. Give the court name, the case number, and contact information for the respondent's juvenile court attorney.
- *Conservator Information*: If the respondent has a conservator, fill out item 8g. Give the court name, the case number, and contact information for the respondent's conservatorship attorney.

Item 9: Court Referral

If you are filing a petition in response to a referral from another court proceeding, fill out item 9. Give the name of the referring court and the case number, department, and type of case, if you know it. If you have a copy of the referral order, label it "Attachment 9" and attach it to the petition.

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.* That means that if you have stated anything that you know is not true on the form, you may be criminally liable. If you have an attorney helping you, they will sign as well.

5 Am I required to give or send the petition to the respondent or anyone else?

No. To begin CARE Act proceedings, you must file the petition with the court. You do not need to give or send a copy of the petition to the respondent or anyone else.

6 What will happen after I file the petition?

After you file the petition, the court will review it and the supporting documents filed with it. The court will decide if the documents show that the respondent meets or may meet the CARE Act eligibility requirements. Then the court will either:

a. **Dismiss the petition** 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. **OR**

b. **Order a report** if it finds that the petition shows that the respondent meets or may meet the CARE Act eligibility requirements. The court order will require a county agency to engage the respondent and file a written report with the court as soon as practicable, but within 30 court days. If the court orders a report, the county agency will notify you and the respondent.

   Note: The procedures are different if the county behavioral health agency is the petitioner.

7 The initial appearance

If the court 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 set an *initial appearance.* The court will also order the county to give notice of the initial appearance to you, as well as to the respondent, the respondent's appointed counsel, and the county behavioral health agency.

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

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

8 Do petitioners have any rights?

You have the right to go to the hearing on the merits and make a statement. And if the respondent agrees, the court may also allow you to participate in the rest of the CARE Act proceedings. If you live with the respondent; are the spouse, parent, sibling, child, or grandparent of the respondent; or are someone who has authority to act as a parent, the court will provide ongoing notice to you throughout the CARE Act proceedings, including notice of when a court proceeding is postponed or when the case is dismissed. However, the court will not provide this notice if the court decides that giving notice to you would not be in the best interest of the respondent or their treatment.

If the petition is dismissed and later the respondent's situation changes, you may file a new petition with the court.

9 What is a vexatious litigant?

A *vexatious litigant* is a person whom a court has found to have used the court process to harm or annoy other people by repeatedly suing them or filing other papers against them without a good reason.

A CARE Act court may find that a person is a vexatious litigant if that person files more than one CARE Act petition that is not true or is intended to disturb, harm, or annoy the respondent. Once declared a vexatious litigant, a person may be placed on a vexatious litigants list kept by the Judicial Council. The court may enter an order that prevents a vexatious litigant from filing any new litigation, including other types of cases (not just CARE Act petitions), without first getting permission from the trial court presiding judge. If such an order is issued, the court may fine a person who does not follow the order or send them to jail for contempt of court.

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* (form MC-410) to make your request. You can also ask the Americans with Disabilities Act 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.

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):*		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF		
STREET ADDRESS:		
MAILING ADDRESS:		
CITY AND ZIP CODE:		
BRANCH NAME:		
CARE ACT PROCEEDINGS FOR *(name):*		
RESPONDENT		
PETITION TO BEGIN CARE ACT PROCEEDINGS		CASE NUMBER:

For information on completing this form, see *Information for Petitioners—About the CARE Act* (form CARE-050-INFO), visit the CARE Act webpage on the self-help website at https://selfhelp.courts.ca.gov/care-act, or contact your local court's self-help center. To find the location and hours of the self-help center, click https://selfhelp.courts.ca.gov/self-help/find-self-help.

1. **I *(enter your name here):***
   am asking the court to find that *(name of the person you want services for, who is called the respondent):*

   is eligible to participate in the CARE Act process. The respondent was born on *(date of birth, if you know it):* or
   I do not know the respondent's date of birth, but the respondent is *(approximate age, in years):* years old.

2. I am 18 years of age or older and *(check all categories that apply to you):*
   a. ☐ A person who lives with the respondent.
   b. ☐ A spouse or registered domestic partner, parent, sibling, child, or grandparent of the respondent.
   c. ☐ A person authorized to act in place of the respondent's parent.
   d. ☐ The director of the county behavioral health agency of this county.*
   e. ☐ A licensed behavioral health professional who is or has been, within the past 30 days, treating or supervising the treatment of the respondent.*
   f. ☐ The director of a hospital in which the respondent is hospitalized.*
   g. ☐ 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 the respondent;* or
      (2) ☐ in whose institution the respondent resides.*
   h. ☐ The respondent.
   i. ☐ 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.
   j. ☐ The public guardian or public conservator of this county.*
   k. ☐ A conservator or proposed conservator referred from a proceeding under Welfare and Institutions Code section 5350.
   l. ☐ The director of adult protective services of this county.*
   m. ☐ The director of a California Indian health services program or tribal behavioral health department that has, within the past 30 days, provided or is currently providing behavioral health services to the respondent.*
   n. ☐ A California tribal court judge before whom the respondent has appeared within the past 30 days.*

   * *If you are in a category above that is followed by *, you may designate someone to file the petition on your behalf. If you have been designated to file a petition by a person in a category followed by *, check that category and enter **your** name above.*

3. I have interacted with the respondent as follows *(describe when (give the date) you last saw them, and what happened when you interacted with the respondent):*

☐ If you need more space for your answer, please use a separate piece of paper and label it as Attachment 3.

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

4. a. The respondent lives or was last found at *(give the respondent's address if they have one and you know it, including a post office box where they get mail; otherwise, describe where the respondent lives, the last location where they were staying, or locations where they are frequently found):*

   b. The respondent's other contact information is:
   (telephone number, if any): The respondent ☐ does ☐ does not respond to text messages.
   (email address, if any):

   c. I believe that the best ways to contact the respondent are *(check all that apply):*
   (1) ☐ by visiting them in person
   (2) ☐ by calling them on the phone
   (3) ☐ by sending them text messages
   (4) ☐ by sending them email
   (5) ☐ by sending them mail
   (6) ☐ other *(describe):*

   d. ☐ The respondent needs assistance ☐ reading ☐ hearing or understanding ☐ speaking English.
   The respondent's preferred language is *(specify one or more languages):*

5. The respondent *(check a or b; if you check b, you must also check either (1) or (2)):*
   a. ☐ Is a resident of the county in which this petition is filed.
   b. ☐ Is not a resident of the county in which this petition is filed.
   The respondent's county of residence is *(if you know it):*
   (1) ☐ The respondent is located in the county in which this petition is filed.
   (2) ☐ The respondent is a defendant or respondent in a criminal or civil proceeding pending in the superior court of the county in which this is filed.

6. Evidence supporting this petition includes *(you must check and provide at least one of the following):*
   a. ☐ The declaration of a licensed behavioral health professional (form CARE-101), attached and labeled as Attachment 6a.
   b. ☐ A statement or documents showing that the respondent has been hospitalized two or more times for involuntary treatment and that the most recent involuntary hospital stay ended less than 60 days ago.
   Note: As used in this form, "involuntary treatment" refers only to a 14-day hold 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, 5270.15, and 5270.70.
   (If you checked 6b above, please check (1) and provide the information below, or check (2) and attach the documents, or do both.)
   (1) ☐ I know personally that the respondent was hospitalized for involuntary treatment. *(Describe what happened each time, and explain how you know about it):*

   (2) ☐ I have attached documents showing that the respondent was hospitalized two or more times for involuntary treatment and labeled the documents Attachment 6b1, 6b2, 6b3, etc. *(Include, for example, your own signed declaration (only if you have personal knowledge of the respondent's involuntary treatment), copies of certifications for intensive treatment, signed declarations by persons who witnessed the respondent's involuntary treatment, or other records.)*

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7. To the best of my knowledge, the respondent meets each of the requirements below:
   ☐ *Check here if all the information requested in items 7a through 7f is included in form CARE-101. If it is, you can skip the rest of this question, if you choose. Otherwise, explain below.*
   Note: Some details you enter in items 7a through 7f may overlap. If you notice you're repeating yourself, you can say that you already gave the information and mention where you said it before.
   a. The respondent has a diagnosis as defined in the current *Diagnostic and Statistical Manual of Mental Disorders* of schizophrenia spectrum disorder or another psychotic disorder in the same class, or bipolar I disorder with psychotic features, except psychosis related to current intoxication. *(Explain below):*

   b. The respondent is currently experiencing a serious mental disorder, as defined in Welfare and Institutions Code section 5600.3(b)(2), because the disorder:
      (1) Is severe in degree and persistent in duration;
      (2) May cause, or has caused, behavior that interferes substantially with the respondent's primary activities of daily living; ***and***
      (3) May result, or has resulted, in the respondent's inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period.
      (Describe the seriousness, length, and effects of the respondent's mental disorder below):

   c. The respondent is not clinically stabilized in ongoing voluntary treatment. A respondent is clinically stabilized in ongoing treatment if both of the following are true:
      (1) The respondent's condition is stable and not deteriorating; and
      (2) The respondent is currently engaged in treatment and managing symptoms through medication or other therapeutic interventions.
      (Describe the respondent's current condition and any ongoing treatment below):

   d. At least one of the following is true *(complete (1) or (2) or both):*
      (1) ☐ The respondent is unlikely to survive safely in the community without supervision ***and*** the respondent's condition is substantially deteriorating. *(Explain why the respondent is unlikely to survive safely in the community, describe the type of supervision the respondent would need to survive safely, and describe how the respondent's physical or mental condition has recently grown worse):*

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7. d. (2) ☐ The respondent needs services and supports to prevent a relapse or deterioration that would be likely to lead to grave disability or serious harm to the respondent or others. *(Describe the services and supports needed by the respondent, and explain why the respondent would become gravely disabled or present a risk of harm to self or others without them):*

e. Participation in a CARE plan or CARE agreement would be the *least restrictive alternative* necessary to ensure the respondent's recovery and stability. *(Explain why no other less restrictive treatment plan would work as well for the respondent):*

f. The respondent is likely to benefit from participation in a CARE plan or CARE agreement because *(explain below):*

8. **OPTIONAL: Other information** *(if applicable, check any of the following statements that are true, and give the requested information if you know it):*

a. ☐ The respondent needs interpreter services or an accommodation for a disability. *(If you know, describe what they need):*

b. ☐ The respondent is served by a regional center. *(If you know, give the center's name and the services it provides to them):*

c. ☐ The respondent is or was a member of the state or federal armed services or reserves. *(If you know, give branch name):*

d. ☐ The respondent is an enrolled member of a federally recognized Indian tribe. *(If you know, give the tribe's name and mailing address):*

e. ☐ The respondent is receiving services from a California Indian health services program, a California tribal behavioral health department, or a California tribal court. *(If you know, give the name and mailing address of the program, department, or court):*

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

8. f. ☐ The respondent is within a juvenile court's dependency, delinquency, or transition jurisdiction. *(If you know, provide the following):*
   (1) Court:
   (2) Case number:
   (3) The respondent's attorney in the juvenile court proceeding *(name):*
   (mailing address):
   (telephone number): *(email address):*

   g. ☐ The respondent has a court-appointed conservator. *(If you know, provide the following):*
   (1) Court:
   (2) Case number:
   (3) The respondent's attorney in the conservatorship proceeding *(name):*
   (mailing address):
   (telephone number): *(email address):*

9. **Court referral** *(complete this item only if it applies; if you don't know some of the requested information, leave that part blank):*
   ☐ This petition is filed in response to a referral of the respondent from another court proceeding.
   a. Court, department, and judicial officer:

   b. Case number:
   c. Type of proceeding from which the respondent was referred *(check one):*
   (1) ☐ Mental competence proceeding arising from a criminal prosecution (Pen. Code, §§ 1370, 1370.01)
   (2) ☐ Assisted outpatient treatment (Welf. & Inst. Code, §§ 5346–5348)
   (3) ☐ Lanterman-Petris-Short Act conservatorship (Welf. & Inst. Code, §§ 5350–5372)
   d. ☐ The referral order is attached and labeled as Attachment 9 *(optional).*
   e. The respondent's attorney in the referring proceeding *(name):*
   (mailing address):
   (telephone number): *(email address):*

10. Number of pages attached: _____

Date:

Type or Print Name of Attorney, if Any

▶ Signature of Attorney, if Any

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

To keep other people from seeing what you entered on your form, please press the Clear This Form button at the end of the form when finished.

MC-025

SHORT TITLE:	CASE NUMBER:

ATTACHMENT *(Number):* _____

(This Attachment may be used with any Judicial Council form.)

(If the item that this Attachment concerns is made under penalty of perjury, all statements in this Attachment are made under penalty of perjury.)

Page _____ **of** _____

(Add pages as required)

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CONFIDENTIAL

CARE-101

ATTORNEY OR PARTY 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):*		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF		
STREET ADDRESS:		
MAILING ADDRESS:		
CITY AND ZIP CODE:		
BRANCH NAME:		
CARE ACT PROCEEDINGS FOR *(name):* RESPONDENT		
MENTAL HEALTH DECLARATION—CARE ACT PROCEEDINGS		CASE NUMBER:

TO LICENSED BEHAVIORAL HEALTH PROFESSIONAL

This form will be used to help the court determine whether the 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.
      (6) ☐ nurse practitioner.
      (7) ☐ physician assistant.

   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 *(explain):*

   c. My license number is *(if applicable):*

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

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

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 item 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 as defined in the current *Diagnostic and Statistical Manual of Mental Disorders* of a schizophrenia spectrum disorder or another psychotic disorder in the same class, or bipolar I disorder with psychotic features, except psychosis related to current intoxication *(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 psychotic disorder, does not qualify.

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

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

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. A respondent is clinically stabilized in ongoing treatment if both of the following are true:
   (1) The respondent's condition is stable and not deteriorating; and
   (2) The respondent is currently engaged in treatment and managing symptoms through medication or other therapeutic interventions.
   (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 *(name)*: RESPONDENT	CASE NUMBER:

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

CONFIDENTIAL

CARE-105

ATTORNEY OR PARTY 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)*: Self-Represented		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF ORANGE STREET ADDRESS: 3390 Harbor Boulevard MAILING ADDRESS: 3390 Harbor Boulevard CITY AND ZIP CODE: Costa Mesa 92626 BRANCH NAME: Costa Mesa Justice Complex		
CARE ACT PROCEEDINGS FOR *(name)*: RESPONDENT		
ORDER FOR CARE ACT REPORT		CASE NUMBER:

1. The court has read and reviewed the petition filed by petitioner
   (name):
   (address):
   on *(date)*: asking the court to begin CARE Act proceedings for respondent
   (name):
   (address, if known):
2. The court has found that the petition 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;
   e. The information, including protected health information, necessary to support the determinations, conclusions, and recommendations in the report; and
   f. Other:
4. Before engaging the respondent and preparing the report, the county agency named in item 3 or its designee must use *Notice of Order for CARE Act Report* (form CARE-106) to serve notice of this order on petitioner, respondent, and respondent's counsel as provided in California Rules of Court, rule 7.2235(a).
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