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 MADERA STREET ADDRESS: 200 SOUTH G STREET MAILING ADDRESS: CITY AND ZIP CODE: MADERA, CALIFORNIA 93637 BRANCH NAME: CIVIL DIVISION		
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 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.

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

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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):*

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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)