DHCS

CARE Act Implementation

SUPPLEMENTAL GUIDE FOR THE CARE ACT DATA DICTIONARY 2.0

Contents

This Supplemental Guide is intended to be used alongside the Community Assistance, Recovery, and Empowerment Act Data Dictionary 2.0 to support CARE Act data entry and submission to the Department of Health Care Services (DHCS). This Guide features general and scenario-based reporting guidance.

A detailed change log describing all changes from Data Dictionary 1.0 and 2.0 can be downloaded here or viewed on the "Change Log" tab of Data File Template Option A and Data File Template Option B for Data Dictionary 2.0.

General Reporting Guidance

Legislative updates and amendments to the CARE Act Data Dictionary 2.0

Legislative updates related to CARE Act implementation and data reporting requirements were chaptered in the Fall of 2024. These include:

- Senate Bill (SB) 42: Amends provisions of the CARE Act, including referrals by facilities to county behavioral health (BH), communication between courts, alternatives to conservatorship, changes to CARE procedures, as well as collaboration on system performance. Additionally, it requires the Annual CARE Act Report to include data on facility referrals (SB 42 Brief here).
- Senate Bill (SB) 1400: Amends provisions of the Penal Code related to CARE referrals of individuals deemed incompetent to stand trial. Additionally, it expands reporting requirements related to CARE inquiries, referrals, and petitioned individuals (SB 1400 Brief here).

In accordance with SB 1400, DHCS is required to include the additional data elements in its annual CARE Act Report, beginning in 2026. Effective **January 1, 2025**, counties are expected to report on the expanded data requirements outlined in statute. Given the timing of the release of the revised Data Dictionary 2.0, DHCS understands there may be temporary data quality issues specific to the measures included in SB 1400. DHCS will collaborate with county partners to address and work through these issues, and counties are expected to begin collecting this data to the extent they are administratively available.

Below, we include highlights of the substantive changes that impact data collection and reporting:

Revised or New Definitions

- CARE participant: This term is now expanded beyond individuals who have a CARE plan or agreement, to include all individuals who are the subject of a petition for CARE proceedings and met prima facie.
- Elective client: This term is now expanded to include a CARE participant who was diverted to elective county services and supports (*formerly referred to as voluntary county services and supports*), regardless of CARE eligibility, resulting in the petition being dismissed by the court.

Two new terms were introduced to clarify the length of time a petitioned individual is tracked. These reporting requirements are shown below:

CARE Participants	Reporting Requirement
Active Participants: A CARE participant who is receiving county services and supports through a CARE plan, CARE agreement, or for their first 12 months as an elective client.	12 months for all CARE participants or up to a total of 24 months for those reappointed in a CARE plan.
Former Participants: An elective client who has received the first 12 months of elective services, or a CARE participant who enters into a CARE agreement, or a CARE plan, but who has either graduated from CARE, or for whom CARE Act proceedings were dismissed or terminated.	12 months for all former participants continuing to receive elective county services and supports. County BH agencies shall report data on former participants to the extent administrative data is available.

Petitioned Individuals

Expanded reporting requirements for petitioned individuals include:

- Outreach and engagement efforts during CARE Initiation Period.
- Services provided during the CARE Initiation Period.
- County recommendation for CARE petition dismissal.
- County determination of ineligibility for CARE, including conditions met to establish clinical stability, if applicable.
- Revised definition of Elective Clients, expanded to include all receiving county services and support, regardless of CARE eligibility, with implications for tracking clients over time.

The intent of these expanded reporting requirements is to capture county efforts being made on the front end, during the early petition process and understand if there are differences in care quality among those who receive services and supports outside the CARE process.

CARE Inquiries

County BH agencies shall report aggregate data on all inquiries received about the CARE Act. CARE inquiries include, but are not limited to, inquiries received by phone, warmlines, voicemail messages, emails, and in-person conversations or consultations. The intent of these data requirements is to quantify county BH efforts related to CARE inquiries and connections to services and supports, prior to CARE petition.

For counties utilizing SurveyMonkey to submit CARE data, a new SurveyMonkey Form is available to submit data on aggregate CARE inquiries. For counties utilizing the Data File Templates, Option A and Option B for Data Dictionary 2.0 now include a new "CARE Inquiries" tab where counties will enter this data in aggregate, as defined in the Data Dictionary 2.0.

System Referrals

System referrals are formal written requests on behalf of an individual that meets or is likely to meet CARE Act criteria submitted to county BH agencies from one of the following:

1. Misdemeanor proceedings for an individual determined incompetent to stand trial (MIST) upon a court finding that the defendant is ineligible for diversion.
2. Felony proceedings for an individual determined incompetent to stand trial (FIST) upon a court finding that the defendant is ineligible for diversion or diversion is terminated unsuccessfully.
3. Assisted Outpatient Treatment (AOT) proceedings.
4. A facility that provides assessment, evaluation, and crisis intervention, pursuant to Welfare and Institutions (W&I) Code section 5150, subdivision (a) or a designated facility as defined in W&I Code section 5008, subdivision (n).

This includes data on referral source, referral outcome, outreach and engagement efforts, services and supports provided, and reasons for not petitioning to CARE or not referring to county services. The intent is to capture outcomes of individuals referred from key system partners to ensure they are appropriately linked to BH services and supports.

For counties utilizing SurveyMonkey to submit CARE data, a new SurveyMonkey Form link is available to counties to submit data on system referrals. For counties utilizing the Data File Templates, the Data File Templates for Data Dictionary 2.0 (Option A and Option B) now include a new "System Referrals" tab where counties will enter individual-level data on system referrals, as defined in the Data Dictionary 2.0.

Updated Measurement Periods

SB 1400 expanded reporting requirements such that counties are now required to start reporting on efforts to serve individuals before the CARE Petition process. This resulted in the addition of a new measurement period – this is called **the Referral Period**.

Trial court, county BH agency, and public defender reporting responsibilities

Trial courts, county BH agencies, and public defenders have separate CARE Act data reporting requirements and mechanisms. These requirements are summarized below.

Trial courts report their data directly to the Judicial Council (JC), who in turn submits aggregated data to DHCS.

County BH agencies are required to submit individual-level data on system referrals and CARE petitions, and aggregate-level data on CARE inquiries, directly to DHCS. DHCS expects alignment between county and court-reported numbers of CARE plans ordered and CARE agreements approved. County BH agencies and trial courts are encouraged to communicate regarding these data points to ensure alignment.

Additionally, AB 102 requires the Legal Services Trust Fund Commission (LSTFC) at the State Bar of California to collect outcome data from each county's public defender office, qualified legal services projects (QLSP), and support centers.

When to begin reporting CARE Act data

County BH is required to begin reporting data to DHCS as follows:

CARE inquiries

County BH shall report aggregate data on all inquiries received about the CARE Act. A CARE inquiry includes, but is not limited to, inquiries received by phone, warmlines, voicemail messages, emails, and in-person conversations or consultations.

System Referrals

County obligation to begin reporting on system referrals is triggered when a formal written request on behalf of an individual that meets, or is likely to meet, CARE Act criteria is submitted to county BH agencies from one of the following:

1. Misdemeanor proceedings for an individual determined incompetent to stand trial (MIST) upon a court finding that the defendant is ineligible for diversion.
2. Felony proceedings for an individual determined incompetent to stand trial (FIST) upon a court finding that the defendant is ineligible for diversion or diversion is terminated unsuccessfully.
3. Assisted Outpatient Treatment (AOT) proceedings.
4. A facility that provides assessment, evaluation, and crisis intervention, pursuant to W&I Code section 5150, subdivision (a) or a designated facility as defined in W&I Code section 5008, subdivision (n).

Petitioned individuals

County obligation to begin reporting on petitioned individuals is triggered once the county BH agency files the petition or, if county BH is not the original petitioner, when the court orders county BH to file a written report.

When to discontinue reporting CARE Act data

The trigger to discontinue CARE Act reporting depends on how and when the individual exits the CARE process and whether they continue to receive services and supports from the county. County BH agencies are not required to report on former participants who no longer receive county services and supports, including those who are privately insured or who no longer reside in California.

For **system-referred individuals**, county BH agencies will report data related to the system referral under Section 5 of the Data Dictionary 2.0. County BH agencies will discontinue reporting data after one of the following System Referred Outcome (status) is achieved: petitioned to CARE or Not petitioned. County BH agencies will continue reporting on system-referred individuals (a) for whom a status is not yet determined, and (b) for individuals who are not petitioned, but pending enrollment in

county services and supports. When system-referred individuals are petitioned to CARE, county BH agencies will follow the reporting requirements for petitioned individuals.

For petitioned individuals, refer to the table below for reporting requirements:

CARE Participant Category	Reporting Requirement
Active Participants: A CARE participant who is receiving county services and supports through a CARE plan, CARE agreement, or for their first 12 months as an elective* client.	12 months for all CARE participants or up to a total of 24 months for those reappointed in a CARE plan.
Former Participants: An elective client who has received the first 12 months of elective services, or a CARE participant who enters into a CARE agreement, or a CARE plan, but who has either graduated from CARE, or for whom CARE Act proceedings were dismissed or terminated.	12 months for all former participants continuing to receive elective county services and supports. County BH agencies shall report data on former participants to the *extent administrative data is available*.

*An elective client is a CARE participant who was diverted to elective county services and supports (formerly referred to as voluntary county services and supports), resulting in the petition being dismissed by the court.

Linking CARE participants across multiple submissions

County BH agencies are required to report on key data variables that will be used to link CARE participants across data submissions, regardless of if SurveyMonkey or MOVEit file transfer application submissions are used. These linkage data variables will include county, first name, last name, date of birth, Social Security Number, Medi-Cal Beneficiary number, and petition number. CARE participants are not assigned a unique identifier.

Release of Information (ROI) for substance use disorder (SUD) services

Counties do not need to provide an ROI to DHCS for the purposes of CARE Act reporting. When working with the courts, please reference California W&I Code section 5977.4, which clarifies how county BH agencies may obtain and disclose SUD patient records and consult with your county counsel on the need to obtain an ROI.

CARE Act data privacy and security

Data metrics identified in W&I Code sections 5985 and 5986 for the Annual Report and Independent Evaluation will be shared in accordance with the DHCS Public Reporting Guidelines to maintain privacy and security.

Process for updating or correcting previously submitted data

For any corrections to CARE Act data submitted within the quarterly submission window:

- Counties will receive a quality assurance (QA) report within 45 business days of the data submission deadline; counties have 15 business days to resubmit corrections and/or update data, as needed.

For any corrections to CARE Act data outside of the quarterly submission window (i.e., on any previously submitted data):

- Please email CAREDataTeam@healthmanagement.com once resubmitted files are uploaded to the "Submission" folder within MOVEit using the file naming conventions for resubmissions ("Name of County_MMYYYY_Resubmission_DDMMYYYY"), where the first MMYYYY refers to the month and year of the data being reported and the second DDMMYYYY refers to the date data are resubmitted.
- Resubmission files must include all data for the reporting month (even if only one row/cell has been updated).
- Please provide a high-level summary of changes in a Word document and use the same naming convention as the resubmitted file ("Name of County_MMYYYY_Resubmission_DDMMYYYY"). Please upload this Word document to the "Submission" folder within MOVEit alongside your resubmitted file.
- Files submitted outside of the original quarterly QA opportunity will undergo another round of QA as part of preparations to finalize the dataset for the next Annual Report. Each county BH agency will be provided with an opportunity to review their own cumulative data for corrections, if needed, prior to Annual Report analysis and report development.

Collecting data on criminal justice involvement

Counties have developed various mechanisms for gathering information on criminal justice involvement among CARE participants. Some counties have set up data sharing agreements with local law enforcement agencies to facilitate regular exchange of information. Counties are encouraged to explore feasible mechanisms to support cross-collaboration and information exchange within their own counties.

Reporting on CARE Inquiries

Under Data Dictionary 2.0, counties are required to report:

- The **total number of CARE inquires received by source** (such as a community member, public guardian or conservator, or hospital or crisis stabilization unit provider or staff).
- The **focus of the inquiry** (such as CARE eligibility information, petition assistance, or housing services and supports).
- The **county's action following the inquiry** (i.e., the number of connections to services made as a result of the inquiry).

If a county can reasonably provide the information requested in the Data Dictionary 2.0 related to the inquiry, it should be reported. For example, county phone line call logs that reference CARE and county website assistance requests form submissions that reference CARE should be reported. County website analytics, such as click counts, should not be reported.

Reporting on System Referrals

County BH agencies are required to track "statutory referrals" which are defined as referrals that county BH agencies are required by law (see SB 42 Brief) to accept from certain facilities or entities (i.e., specific courts and LPS-designated facilities). For the purposes of the CARE Act, these referrals are referred to as "system referrals".

Reporting on System Referrals for CARE Act Data Reporting

"System referrals", as they are defined within the CARE Act Data Dictionary 2.0, are formal written requests on behalf of an individual that meets or is likely to meet CARE Act criteria submitted to county behavioral health agencies from one of the following:

- **Misdemeanor proceedings for an individual determined incompetent to stand trial (MIST)** upon a court finding that the defendant is ineligible for diversion. County BH serves as the petitioner for MIST referrals.

  Felony proceedings for an individual determined incompetent to stand trial (FIST) upon a court finding that the defendant is ineligible for diversion or diversion is terminated unsuccessfully. For FIST, the petitioner is not specified in statute. Coordination between judicial partners and county BH programs will be needed to determine the process for referral and petition.

- **Assisted Outpatient Treatment (AOT)** proceedings. County BH serves as the petitioner for AOT referrals.

- A **facility** that provides assessment, evaluation, and crisis intervention, pursuant to W&I Code section 5150, subdivision (a) or a designated facility as defined in W&I Code section 5008, subdivision (n).

County BH agencies should begin reporting individual-level data on these system referrals from the point at which the formal written referral is received. County BH will continue reporting on these system-referred individuals until the individual is either petitioned to CARE, not petitioned but accepts voluntary treatment and enrolls in any other county services and supports, or neither petitioned nor referred to any county services and supports. For more information, see the CARE Act Data Flowchart for System Referrals (Data Dictionary 2.0) here.

Requirements of Written System Referrals

A system referral must be a formal written request. Behavioral Health Information Notice (BHIN) 25-012 provides guidance on procedures for facilities to refer an individual to the CARE Act as part of discharge planning, and requirements for county behavioral health agencies to complete an assessment upon receipt of facility referrals. A facility or a county behavioral health agency may adopt the CARE Act referral form published on the DHCS website or develop and use its own form. More details can be found within BHIN 25-012 and a copy of the CARE Act Facility Referral Form Template is available here.

If a facility or a county behavioral health agency chooses to develop a referral form, rather than use the template linked above, the form shall include, at a minimum, all the following information, as available:

- Contact information, including name, telephone number, address, and email
- Medi-Cal Client Index Number (CIN)
- Social Security Number (SSN)
- Date of Birth
- Documentation of the authority for a referral with signature by the licensed behavioral health professional or their designee

Additional information on Department of State Hospitals (DSH) petitions

DSH may file a CARE petition for a client who has been restored, and thus, no longer considered incompetent to stand trial (IST). County BH agencies will receive the petition from the court along with a CARE-105 form, or a court order to conduct an investigation.

Prior to a petition filing, DSH may interface directly with county BH, but such interactions should be counted as CARE inquiries to the county BH agency, not a "system referral."

A training on statutory referral pathways can be found here.

Reporting on the One-Year Status Hearing

One-year status hearings occur in the 11th month of the CARE timeline and are required for all participants with CARE plans as well as participants with CARE agreements who reside in a county that requires them. Counties should adhere to the following guidance when reporting on 3.12.4 One-Year Status Hearing:

- **For CARE plan clients:** Select either Option 0 – No or Option 1 – Yes, depending on if this hearing has taken place or not.
- **For CARE agreement clients:**
  - If a county requires these hearings, select either Option 0 – No or Option 1 – Yes.
  - If a county does not require these hearings, you may select Option 2 – Not applicable.

Scenario-Based Data Entry Guidance

Guidance related to specific CARE Act data collection and reporting scenarios is provided below. This section will be updated as additional guidance becomes available. Please reach out to CAREDataTeam@healthmanagement.com to inquire about guidance related to specific scenarios not described here.

CARE participant participation in CARE spans across 2024 and 2025

Counties reporting on CARE participants that span across 2024 (when Data Dictionary 1.0 applies) and 2025 (when Data Dictionary 2.0 applies), should report based on the Data Dictionary version applicable to the month being reported.

For example, consider a scenario where an individual entered into a CARE agreement (Active Service Period) on August 1, 2024 and was dismissed from CARE on January 15, 2025, due to moving out of the county. In this scenario, counties should do the following:

- August, September, October, November, and December submissions (Aug 1-Dec 31) – Report based on Data Dictionary 1.0:
  - Report based on 3.3.10 Current CARE Status: Option 5 – Active participant (CARE Agreement).
- FIRST January submission (Jan 1-14) – Report based on Data Dictionary 2.0:

    - Report based on 3.3.10 Current CARE Status: Option 5 – Active participant (CARE Agreement).
- SECOND January submission (Jan 15) – Report based on Data Dictionary 2.0:
    - Report based on 3.3.10 Current CARE Status: Option 7 – Dismissed/Terminated from CARE agreement/plan/elective services (no longer receiving county services and supports).

CARE participant enters CARE Process Initiation Period mid-month (Reporting Baseline Information):

During the start of the CARE Process Initiation Period only, CARE participant information should include data that represents the entirety of the reporting month. The data reported during this period serves as baseline information for the CARE participant.

Consider the case scenario where a CARE participant enters the CARE Process Initiation Period on February 15th and the court approves a CARE agreement on March 25th. In reporting the data points during this CARE Process Initiation Period, include information for the entire month of February. For example, 3.9.3 Number of Jail Days should represent total jail days for the entire month of February.

- February submission (Feb 1-28):
    - Report based on 3.3.10 Current CARE Status: Option 1 – Pending Petition Disposition,
        - 3.9.3 Number of Jail Days: Report the number of jail days from Feb 1-28.

In the following month, when the CARE participant is assigned a CARE agreement on March 25, report the number of jail days as follows:

- FIRST March submission (Mar 1-24):
    - Report based on 3.3.10 Current CARE Status: Option 1 – Pending Petition Disposition,
        - 3.9.3 Number of Jail Days: Report the number of jail days from March 1-24.
- SECOND March submission (Mar 25-31):
    - Report based on 3.3.10 Current CARE Status: Option: 5 – Active CARE Agreement
        - 3.3.9 Number of Jail Days: Report the number of jail days from March 25-31.

This approach avoids duplication of counts for jail days in the same month.

CARE participant's Current CARE Status changes

When a change to a CARE participant's Current CARE Status (Data point 3.3.10) occurs, the data points associated with each status must be reported in full (see the CARE Act Data Flowchart for Petitioned Individuals (Data Dictionary 2.0)). Separate data submissions are required for each CARE

status that an individual is associated with during any given reporting month. See below for specific guidance related to timing of the CARE status change.

Change in CARE Status during the CARE Process Initiation Period

During the start of the CARE Process Initiation Period only, CARE participant information should include data that represents the entirety of the reporting month. The data reported during this period serves as baseline information for the CARE participant.

CARE agreement approved

Consider a scenario where a CARE participant's CARE proceedings were initiated on May 5 and their CARE agreement was approved by the court on May 20. Data associated with both the CARE Process Initiation Period and the Active Service Period must be reported within the same reporting month. In this case, counties would report:

- FIRST May submission (May 1-19):
  - Report based on 3.3.10 Current CARE Status: Option 1 – Pending petition disposition.
- SECOND May submission (May 20-31):
  - Report based on 3.3.10 Current CARE Status: Option 5 – Active participant (CARE agreement).

Petition dismissal

Consider a scenario where a CARE participant's CARE proceedings were initiated on June 10 and their case was dismissed by the court on June 28 due to the CARE participant moving away from the county. Associated data must be reported both for the CARE Process Initiation Period and the Dismissal, as follows:

- FIRST June submission (June 1-27):
  - Report based on 3.3.10 Current CARE Status: Option 1 – Pending petition disposition.
- SECOND June submission (June 28-30):
  - Report based on 3.3.10 Current CARE Status: Option 7 – Dismissed/Terminated from CARE agreement/plan/elective services (no longer receiving county services and supports).

Change in CARE Status during the Active Service Period

Petition dismissal

Consider a scenario where a CARE participant with a CARE agreement is dismissed by the court during the Active Service Period on July 5 but continues participation in elective county services and supports thereafter. County BH would report the following:

- FIRST July submission (July 1-4):
  - Report based on 3.3.10 Current CARE Status: Option 5 – Active participant (CARE agreement).
- SECOND July submission (July 5-31):
  - Report based on 3.3.10 Current CARE Status: Option 4 – Dismissed (Eligible receiving services/supports as Elective client).

In this scenario, counties are required to continue to report this CARE participant's data for 12 months of Active Service from the start date of their CARE agreement, as well as provide follow-up data for an additional 12 months thereafter.

Termination during Active Service Period

Consider a scenario where an elective client (that has been previously dismissed) is terminated from county services and supports on July 5. Data associated with the Active Service Period must be reported, in addition to the data points associated with the termination (3.3.12 Termination of Services Date and 3.3.13 Reason for Termination). County reporting on this individual will discontinue after the termination has been reported.

- FIRST July submission (July 1-4):
  - Report based on 3.3.10 Current CARE Status: Option 4 – Dismissed (Eligible receiving services/supports as Elective client)
- SECOND July submission (July 5):
  - Report based on 3.3.10 Current CARE Status: Option 7 – Dismissed/Terminated from CARE agreement/plan/elective services (no longer receiving county services and supports).

Change in CARE Status during the Follow-Up Period

Termination during Follow-Up Period

Consider a scenario where a CARE participant is terminated from county services and supports on May 25 during the Follow-Up Period. Counties should report the following:

- FIRST May submission (May 1-24):

    - Report based on 3.3.10 Current CARE Status: Option 8 – Graduated from CARE plan, after 12 months following a CARE agreement, or after 12 months of elective services.
- SECOND May submission (May 25):
    - Report based on 3.3.10 Current CARE Status: Option 9 – Terminated during the Follow-Up Period (no longer receiving county services and supports).

CARE participant begins as a system referral before being petitioned to CARE

Consider a scenario where an individual was referred to county BH from MIST proceedings on January 25. The county files a CARE petition for this individual on February 8. A CARE agreement is approved on February 20. The guidance below outlines how data should be reported for this individual for Section 5 of the Data Dictionary for System Referrals and Section 3 of the Data Dictionary for Petitioned Individuals.

System Referred Individual reporting:

Counties should report the 5.5.3 System Referral Outcome (Status) at the end of the reporting month.

- January submission (Jan 25-31):
    - Report based on 5.5.3 System Referral Outcome (Status): Option 5 – Status is not yet determined
        - 5.4 Housing Placements: Status as of Jan 25 (at time of referral).
        - 5.6 Outreach and Engagement Efforts: Total from Jan 25-31.
- February submission (Feb 1-7):
    - Report based on 5.5.3 System Referral Outcome (Status): Option 1 – Petitioned to the CARE process.
        - 5.4 Housing Placements: Status as of Jan 25 (at time of referral).
        - 5.6 Outreach and Engagement Efforts: Total from Feb 1-7.
        - 5.7.3 Stabilizing Medications and 5.7.4 Type of Stabilizing Medication (if applicable): Report if prescribed from Feb 1-7.

Petitioned Individual reporting:

- FIRST February submission (Feb 1-19):
    - Report based on 3.3.10 Current CARE Status: Option 1 – Pending petition disposition.
- SECOND February submission (Feb 20-28):

- Report based on 3.3.10 Current CARE Status: Option 5 – Active Participant (CARE agreement).

CARE participant's CARE Initiation Process spans several months due to difficulty locating or engaging the individual, extension of proceedings, or other reasons

County BH agencies should report CARE participant data for each month, even when delays or extensions occur.

Consider the following case scenario: a petition was filed on October 20 and the county BH agency was asked by the court to evaluate the merits of the petition on November 1. County BH needed more than 14 days to locate and engage with the CARE participant, and the court provided extensions for this reason. The petition was eventually dismissed on January 25 and the participant agreed to voluntarily engage in county BH services outside of CARE Court.

Counties should report data for this CARE participant for every month, including October, November, December and January corresponding to the 3.3.10 Current CARE Status: Option 1 – Pending petition disposition. Counties should also report the dismissal and start of elective services in January, as follows:

- October, November, December, and FIRST January submission (Oct 1-Jan 24):
  - Report based on 3.3.10 Current CARE Status: Option 1 – Pending petition disposition.
- SECOND January submission (Jan 25-30):
  - Report based on 3.3.10 Current CARE Status: Option 4 – Dismissed (eligible receiving services/supports as Elective client).

CARE participant's notice of ordered investigation is delayed

If the county BH agency is not the petitioner, they are required to begin reporting on CARE participants once they receive notice of a court-ordered investigation. The scenario below provides reporting guidance on a situation where there is a delay in county receipt of a court-ordered investigation.

Consider a scenario where an individual was the subject of a petition via a CARE-100 form on May 17. The court ordered an investigation via a CARE-105 form on May 25. County BH did not receive notice of the investigation until June 5. To support alignment between county- and court-reported data on number and timing of petitions, county BH should report the following data points in the reporting month of June (when county received the CARE-105 form), as follows:

- 3.3.7 Petition File Date: 05/17/2025 (per date on CARE-100 form)
- 3.3.8 Date of Investigation (Ordered): 05/25/2025 (per date on CARE-105 form)

CARE participant who entered into voluntary services and supports as an elective client is re-petitioned to CARE

Consider a scenario where a petitioned individual enters into voluntary services and supports as an elective client in Jan 2025. As a result, their petition is dismissed. Following court dismissal, the client does not adhere to their treatment plans and deteriorates, leading to a family member re-petitioning to CARE in May 2025.

For this **special case**, please close out reporting on the original petition in May 2025 using 3.3.10 Current CARE Status: Option 7. For the termination data points, report as follow:

- 3.3.12 Termination of services date
    - This termination date will be the date of re-petition for this CARE participant.
- 3.3.13 Reason for Termination: Option 99903 – Other
    - Under Other: specify "Individual has been re-petitioned to CARE"

County BH agencies should begin reporting for this re-petitioned individual as a new record under the new petition number, from the start of re-petition date, and follow reporting requirements as if were a newly petitioned case.

CARE participant enters into an LPS conservatorship

The two scenarios below describe how to approach CARE Act data collection when a CARE participant enters into an LPS conservatorship during the Active Service Period. The differentiator in these scenarios is related to whether or not the CARE petition is dismissed, as a result of the conservatorship.

Long-term conservatorship resulting in petition dismissal

Consider a scenario where a CARE participant entered into the Active Service Period with a CARE agreement on August 1. The court dismisses the petition on January 15 the following year due to the CARE participant entering a long-term LPS conservatorship. In this scenario, counties should report as follows:

- August, September, October, November, December, and FIRST January submissions (Aug 1-Jan 14):

    - Report based on 3.3.10 Current CARE Status: Option 5 – Active participant (CARE agreement).
- SECOND January submission (Jan 15):
    - Report based on 3.3.10 Current CARE Status: Option 7 – Dismissed/Terminated from CARE agreement/plan/elective services.

Counties will not be required to track this individual further, regardless of whether they continue to receive mandated county services and supports.

Temporary conservatorship resulting in CARE status continuation

Consider a similar scenario where a CARE participant entered into the Active Service Period with a CARE agreement on August 1. The CARE participant entered into a temporary LPS conservatorship on January 15 the following year. The petition was not dismissed by the court. In this scenario, counties should continue to report all data based under 3.3.10 Current CARE Status: Option 5 – Active participant (CARE agreement).

CARE participant transitions to Assisted Outpatient Treatment (AOT)

Consider a scenario where a CARE participant is dismissed/terminated from a CARE agreement or plan on April 15 and referred to mandated services under AOT. Counties should report as follows:

- FIRST April submission (April 1-14):
    - Report based on 3.3.10 Current CARE Status: Option 5 – Active participant (CARE agreement) or Option 6 – Active participant (CARE plan).
- SECOND April submission (April 15):
    - Report based on 3.3.10 Current CARE Status: Option 7 – Dismissed/Terminated from CARE agreement/plan/elective services (no longer receiving county services and supports).
        - 3.3.11 (a) Petition Dismissal Date: Date of court dismissal.
        - 3.3.11 (b) County Recommendation for Petition Dismissal: Option 5 – Client transitioned to a higher level of care (e.g., AOT).
        - 3.3.12 Termination of Services Date: Date of exit from elective services.
        - 3.3.13 Reason for Termination: Option 5 – Client transitioned to a higher level of care (e.g., AOT).

Counties will report 3.3.12 Termination of Services Date, even if the AOT program is delivered by county BH, because counties will be reporting on mandated services/supports under AOT separately.