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7

8 *Exempt from filing fees pursuant to*
9 *Government Code § 6103*

10 IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA
11 IN AND FOR THE COUNTY OF SAN MATEO

12
13 IN RE

14
15 Respondent.

Case No.

CARE REPORT



CARE REPORT | INVESTIGATION

c. What evidence was obtained or examined to make this determination?

3. Is the person clinically stabilized in on-going treatment? Yes No Unknown
4. Is Respondent currently enrolled in a behavioral health program? Yes No Unknown
- a. If yes, describe behavioral health program, type of services client is receiving, frequency of services, and clinician providing services.

- b. Based on available information, are the Respondent's symptoms being adequately managed?
- Yes No Unknown/NA
- c. Does Respondent adhere to treatment plan recommendations, and/or express appropriate concerns?
- Yes No Unknown/NA

Please describe:

- N/A Unknown
5. Is Respondent prescribed psychotropic medications for behavioral health condition?
- Yes No Unknown
- a. If yes, is Respondent adherent to medication regimen? Yes No Unknown

6. How many crisis episodes/services (PERT, MCRT, and CWCRT) has the Respondent had in the past 12 months?

7. At least one of the following is true (check all boxes that apply):

Person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating; **AND/OR**

Person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to that person or to others.

Neither of the above are true/unable to determine.

- a. Does Respondent have history of meeting criteria for grave disability? Yes No Unknown
- Please describe:

b. Describe how Respondent's mental illness is contributing to being unsafe in the community:





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- c. Over the last six months, describe any decline in functioning related to Respondent’s ability to provide food, clothing, and shelter as a result of mental illness.

[Redacted text area]

- d. Does the Respondent have a history of homelessness? Yes No Unknown

- e. Is the Respondent currently experiencing homelessness, or at imminent risk of homelessness? Yes No Unknown

Please describe: [Redacted text area]

- f. Does the Respondent have a history of suicidal and/or homicidal ideation? Yes No Unknown

- g. List any psychiatric hospitalizations , including instances of danger to self (DTS), danger to others (DTO), or grave disability (GD) in the section below:

Date:	[Redacted]	Incident:	[Redacted]
Date:	[Redacted]	Incident:	[Redacted]
Date:	[Redacted]	Incident:	[Redacted]
Date:	[Redacted]	Incident:	[Redacted]

8. Has supporting documentation been received with the petition? Yes No Unknown

If yes, which type of supportive documentation was submitted?

- Declaration by a licensed behavioral health professional (CARE-101); OR
 Evidence that the person was detained for a minimum of two intensive treatments, the most recent one within the last 60 days.

Describe evidence: [Redacted text area]

9. Has the Respondent been placed on a 5150, 5260 and/or 5270.15 hold for treatment in past 60 days? Yes No Unknown

10. Would participation in CARE proceedings be the least restrictive alternative necessary to ensure the person’s recovery and stability? Yes No Unknown

Please explain:

- a. Is referral to CARE an LPS Diversion or Step Down? Yes No Unknown
 b. Is referral to CARE an AOT diversion or Step Down? Yes No Unknown
 c. Is referral to CARE an alternative to incarceration? Yes No Unknown





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d. Is referral to CARE a state hospital diversion? Yes No Unknown

Additional Information:

11. Would Respondent be likely to benefit from CARE proceedings? Yes No Unknown

Please describe:

12. Does Respondent have a history of involvement in adult mental health civil proceedings, such as AOT or LPS?

Yes No Unknown

If yes, please describe program, duration, and outcomes:

13. Does Respondent have a history of participation in collaborative courts, such as Pathways, Mental Health Diversion, DUI Court, etc.?

Yes No Unknown

If yes, please describe program, duration and outcomes:

FINDINGS:

Based on evidence collected and reviewed as part of this investigation, this Investigator has determined the following:

A CARE Plan is NOT recommended due to being unable to determine/unable to locate/contact the Respondent.

A CARE Plan is NOT recommended, as the Respondent does not meet eligibility criteria.





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A CARE Plan is NOT recommended, as the Respondent is likely to voluntarily enroll in treatment.

A CARE Plan is recommended, as the Respondent meets or is likely to meet CARE eligibility criteria and is likely to benefit from CARE proceedings.

Progress is being made to engage the Respondent. More information is needed to make a determination in this case, and BHRS requests a continuance of no more than 30 days to continue to engage the Respondent.

Other (Please describe)

Date: _____

Print Clinician name & Title

Signature of Clinician





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ATTACHMENTS:

- Release of Information
- Behavioral Health Assessment
- Behavioral Health treatment records
- Medication Records
- Psychiatric Assessment
- Client/Service Plan
- Physician Orders
- Diagnosis
- Billing records
- History & Physical Exam
- Alcohol/Drug Treatment Records
- Laboratory Results
- Medical Records/Imaging/Procedures
- Progress Notes
- Pharmacy Records
- Psychological Evaluation
- Nursing Notes
- Other:

