California Access to Recovery Effort

(CARE) Form 5

REFERRAL LETTER

To:

Provider Name: ____

Street Address: ____

City: ______________________________ Zip Code: ______________

From:

Assessment Provider: ______________________ Fax: ______________

Location: ____

Contract Name: ______________________ Phone: ______________

Client Name: ______________________ Client ID: ______________

The client referenced above has selected your program for CARE services. Enclosed are copies of the client's appropriate assessment documents to assist you with treatment/recovery support planning. The enclosed documents are checked below:

- ☐ Consent for release of information
- ☐ Assessment
- ☐ Referral Completion form
- ☐ Level of care determination
- ☐ Other Information (specify):______________________________

The client has been issued a voucher for:

___ Outpatient Treatment

___ Adolescent Residential Treatment

____ Recovery Support

____ Residential Recovery Support

Authorization of the voucher is pending verification of the client's admission to your program. **Please FAX the completed Referral Completion form to the assessment provider at the number shown above within three days to verify client admission.**