



# California Access to Recovery Effort

(CARE)

Revised 12\_08

## REFERRAL LETTER

### To:

Provider Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### From:

Assessment Provider: \_\_\_\_\_ Fax: \_\_\_\_\_

Location: \_\_\_\_\_

Contact 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:

- |   |  |
|---|--|
| <input type="checkbox"/> Consent for release of information | <input type="checkbox"/> Referral Completion form    |
| <input type="checkbox"/> Assessment                         | <input type="checkbox"/> Level of care determination |
| <input type="checkbox"/> Other Information (specify): _____ |  |

The client has been issued a voucher for:

- \_\_\_ Outpatient Treatment
- \_\_\_ Methamphetamine Treatment (was identified as meeting the methamphetamine client definition)
- \_\_\_ Adolescent Residential Treatment
- \_\_\_ Recovery Support (from your program)
- \_\_\_ Recovery Support (from a different program) Specify provider # \_\_\_\_\_
- \_\_\_ Recovery Support Only
- \_\_\_ 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.**