State of California — Health and Human Services Agency

Department of Health Care Services
Program Services Division — CARE
MS 2601
PO Box 997413
Sacramento, CA 95899-7413

California Access to Recovery Effort

(CARE 3) Revised June 2013

REFERRAL LETTER

To:

Provider Name: _____

Street Address: _____

City: _____ Zip Code: _____

From:

Case Manager: _____ 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 intake documents to assist you with treatment/recovery support planning. The enclosed documents are checked below:

- ☐ Consent for release of information
- ☐ Referral Completion form (blank)
- ☐ Assessment summary and level of care determination
- ☐ Other Information (specify):_____

The client has been issued a voucher for:

____ Early Intervention

____ Recovery Support

As soon as the client is admitted to your program, please FAX the completed Referral Completion form to the case manager at the number shown.

CARE CALL CENTER | 1-866-350-8773 | OFFICE HOURS: MON - FRI, 8 AM TO 5 PM