CRIMINAL BACKGROUND CHECK: CHARACTER REFERENCE

REFERENCE FOR: _____

To operate or work in facility type: _____

Position title and brief job description:

_____

[You must enter your full name and facility type before giving this form to your reference for completion.]

The above-named individual has applied to operate or work in a mental health facility serving the client population indicated above. This person has selected you to write a reference statement on his/her behalf. Please complete the entire form. Your honest reply will help us ensure high-quality care in our licensed facilities.

Privacy Statement (California Civil Code §1798.17)

The information you provide on this form will be used by the Department of Health Care Services, Mental Health Services Division, Licensing and Certification Section to determine the above-named individual's eligibility to work in a mental health facility pursuant to California Welfare & Institutions Code §5405(d)(2)(E). Your name and contact information will be kept confidential as permitted by California Civil Code §1798.38 unless you are in a supervisory position with respect to the above-named individual. All information requested on this form is voluntary. However, failure to provide all of the information requested will result in your reference being given less weight, which may contribute to the Department's denial of the above-named individual's request to work in a mental health facility. Any information provided on this form will be disclosed only if required by law. For more information, contact: CBC Analyst, Mental Health Services Licensing and Certification, Department of Health Care Services, P.O. Box 997413, MS 2801, Sacramento, CA 95899-7413, phone (916) 324-2744.

Your name: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

Day-time telephone number: _____

1. How long have you known the person you are writing this reference for?

2. How do you know this person?

REFERENCE REQUEST FOR:_____

3. Please give your opinion of this person's character.

4. Please describe any interactions you have observed between this applicant and the client group he/she is requesting to serve. For example: clients may be children, mentally impaired adults, or the elderly.

5. Please describe any additional qualities about this person that you believe are relevant to his/her ability to work in a mental health facility. (Attach additional pages if desired.)

REFERENCE REQUEST FOR:_____

PLEASE FAX, EMAIL OR MAIL THE COMPLETED FORM TO:

Dept. of Health Care Services
Mental Health Services/ Licensing & Certification
P.O. Box 997413, MS 2801
Sacramento CA 95899-7413
mhcbc@dhcs.ca.gov
Fax: (916) 440-5496

PRINT YOUR NAME	YOUR SIGNATURE	DATE