



# California Access to Recovery Effort

(CARE 3)

Revised June 2013

## REFERRAL COMPLETION

Client Name: _____	Client ID: _____
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**Please check one of the following:**

- The client referenced above is considered appropriate to receive services from our agency and was admitted on \_\_\_\_\_ (date).
- The client referenced above is NOT considered appropriate to receive services from our agency for the following reason(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Recommended alternative referral(s): \_\_\_\_\_
- The client referenced above is considered appropriate to receive services from our agency but we do not have available capacity at this time.

**IF THE CLIENT WAS NOT ADMITTED TO YOUR PROGRAM, CONTACT THE CASE MANAGER LISTED ON THE REFERRAL LETTER IMMEDIATELY SO THE CLIENT CAN BE RE-REFERRED.**

Program Name: _____	Provider ID: _____
Program Address: _____	
Contact Name: _____	Phone No: _____

Please FAX this completed form to the case manager listed on the referral letter within 3 days of the client presenting to your program.

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