FACILITY REFERRAL TO COUNTY

Referring Facility Contact Information			
Today's Date:	First Name:	Last Name:	
Facility Name:	Provider E-Mail:	Provider Phone Number:	
Facility Address:	City:	Zip Code:	
Fax Number:			

Individual Referred for CARE Act Proceedings			
First Name:	Last Name:		
Primary Phone Number:	Secondary Phone Number:	E-Mail:	
Physical Address (if the physical address is unknown, write "Unknown"):	City:	Zip Code:	
If the individual's physical address is unknown, please provide the last known location and any additional information to assist with locating the individual:			
County of Residence (if the county of residence is unknown, write "Unknown"):			
Name of the County to which the referral is being sent:			
Start Date of Involuntary Hold:	End Date of Involuntary Hold:		
Medi-Cal Client Index Number (if applicable):	Social Security Number (if available):		

Notes for County Behavioral Health Agency
Please indicate any information that will help with a successful transition. For example, the reason for hospitalization, client-specific needs, client support system, etc.

Documentation of Authority to Make a Referral

By signing below, I confirm that I am a licensed behavioral health professional employed or contracted by the facility, who has knowledge of the individual's case, has been involved in the individual's treatment during their involuntary hold, and believes that the individual meets or is likely to meet criteria to qualify for the CARE process in California Welfare & Institutions Code section 5972, or I have been designated to sign on behalf of this individual.

Printed Name of licensed behavioral health professional:	Signature:
License type and number:	Date:

OR

Printed name of designee:	Signature:
License type and number (write "N/A" if not applicable:	Date: