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

PROVIDER CHOICE VERIFICATION

Client Name: _____ ID No: _____

Assessment Provider Certification: Based on my assessment of the client's needs and my clinical judgment, I recommend the following voucher(s) be issued to the client referenced above

[ ] Early Intervention **[ ]** Recovery support

_____ _____
Assessment Provider Signature Date

Case Manager Certification: I certify that I made available to the client the CARE Provider Directory, either in hard copy or by viewing it online. I encouraged the client to make multiple provider choices based on need, location, and personal preference, and explained to him/her the types of services the providers offer, hours of operation, setting, whether they are faith-based, participant requirements, and other information to help the client make an informed choice. We narrowed down the choices to the programs shown below (which includes at least two providers not limited to multiple locations of the same organization, and at least one to which the client has no religious objection). The client selected the provider(s) checked:

✓	Treatment/Early Intervention Provider Options
✓	**Recovery Support Provider Options**

_____ _____
Case Manager Signature Date

Client Certification: I was given a copy of the CARE Client Handbook and I understand that I have a right to make a genuine free choice of where I receive my CARE services. I certify (agree) that the case manager made available to me the CARE Provider Directory from which to choose my service provider, gave me information about the providers to help me choose, and I selected the provider(s) that is checked above.

_____ _____
Client Signature Date

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