

**LOS ANGELES COUNTY – HEALTH AGENCY
DEPARTMENT OF PUBLIC HEALTH – SUBSTANCE ABUSE PREVENTION AND CONTROL
SUBSTANCE USE DISORDER – COURT ACCESS, REFERRAL, AND ENTRY SYSTEM
SUD – CARES REFERRAL FORM**

Today's Date:	Court Location:	
Name of Defendant:	Date of Birth:	
Case #:	Judicial Officer:	
Penal Code:	Is Client AB 109? (Circle) YES NO	
Public Defender (PD) Name:	PD Phone #:	PD Fax # or Secure E-mail:

Choose one of the following options for a SUD treatment screening or assessment appointment.

(1) Client Engagement and Navigation Services (check off Service Planning Area (SPA) CENS location)

SPA 1

Tarzana Treatment Centers
44447 North 10th St. West
Lancaster, CA 93534
(661) 726-2630 (Phone)
(661) 723-3211 (FAX)

SPA 4

Homeless Health Care Los Angeles
2330 Beverly Blvd.
Los Angeles, CA 90057
(213) 744-0724 (Phone)
(213) 748-2432 (FAX)

SPA 7

California Hispanic Commission on
Alcohol and Drug Abuse
9033 Washington Blvd.
Pico Rivera, CA 90660
(562) 942-9625 (Phone)
(562) 942-9695 (FAX)

SPA 2

San Fernando Valley Community
Mental Health Center
14515 Hamlin Street
Van Nuys, CA 91411
(818) 285-1900 (Phone)
(818) 285-1906 (FAX)

SPA 5

Didi Hirsch Mental Health Services
11133 Washington Blvd.
Culver City, CA 90230
(310) 895-2300 (Phone)
(310) 895-2353 (FAX)

SPA 8

Behavioral Health Services
15519 Crenshaw Blvd.
Gardena, CA 90249
(310) 973-2272 (Phone)
(310) 973-7813 (FAX)

SPA 3

Prototypes
11100 E. Valley Blvd., Suite 116
El Monte, CA 91731
(626) 444-0705 (Phone)
(626) 444-0710 (FAX)

SPA 6

Special Services for Groups
Homeless Outreach Program
Integrated Care System
5715 S. Broadway Avenue
Los Angeles, CA 90037
(323) 948-0444 (Phone)
(323) 948-0443 (FAX)

(2) Criminal Justice SUD Treatment Provider (see attached provider list or <http://sapccis.ph.lacounty.gov/sbat/>)

(3) Substance Abuse Service Helpline (SASH): 1-844-804-7500

I agree to make an appointment at the CENS indicated above or CJ SUD treatment provider on the attached list by calling the telephone number provided to me. I further agree to appear at the CENS or CJ SUD treatment provider for a screening or assessment by a SUD counselor in order to be evaluated for SUD treatment services as part of the Court sentencing.

I understand that my failure to make and keep an appointment at the CENS or CJ SUD treatment Provider may result in sanctions in my case. I further understand that my failure to make and/or keep this appointment may be a factor considered by the Court in setting or modifying the terms and conditions of my sentence.

Signed: _____
Name of Defendant

Date: _____

Signed: _____
Public Defender/Court Supervising Personnel

Date: _____

SCREENING/ASSESSMENT RESULTS

The CENS or CJ SUD Treatment Provider from _____ recommends the following treatment services based on the American Society of Addiction Medicine screening/assessment:

- DEFENDANT ASSESSED AND DETERMINED NOT TO NEED SUD TREATMENT**
- DEFENDANT ASSESSED FOR TIER I – OUTPATIENT TREATMENT**
- ASAM Level 1 – OTP: Opioid Treatment Program/Medication for Addiction Treatment
 - ASAM Level 1.0: Outpatient Services
 - ASAM Level 2.1: Intensive Outpatient Services
- DEFENDANT ASSESSED FOR TIER II – RESIDENTIAL TREATMENT**
- ASAM Level 3.1: Low-Intensity Residential Services
 - ASAM Level 3.3: High-Intensity Residential Services, Population-Specific
 - ASAM Level 3.5: High-Intensity Residential Services, Non-Population Specific
- DEFENDANT ASSESSED FOR TIER III – WITHDRAWAL MANAGEMENT TREATMENT**
- ASAM Level 1-WM: Withdrawal Management Without Extended On-Site Monitoring
 - ASAM Level 3.2-WM: Residential Withdrawal Management (formerly Detoxification)
 - ASAM Level 3.7-WM: Inpatient Withdrawal Management – Medically Monitored
 - ASAM Level 4.0-WM: Intensive Inpatient Withdrawal Management – Medically Managed
- DEFENDANT RECOMMENDED FOR SUPPLEMENTAL SERVICES**
- Recovery Bridge Housing (requires enrollment in ASAM 1-OTP, 1.0, 2.1, or 1-WM)
 - Recovery Support Services

NOTES FROM SUD PROVIDER: _____

DEFENDANT REFERRED TO: _____

APPOINTMENT DATE: _____

Signed: _____
 Name of Defendant

Date: _____

Signed: _____
 SUD Provider

Date: _____