**Re-Entry Treatment Team Referral Form**

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**Referral Criteria:**

* Adults (18+)
* Recent Criminal Justice Involvement
* Resident of Alameda County
* Mental Health Primary Diagnosis

**Referral Date**:

**Referral Source**

Name:

Agency:

Phone: Email:

**Client Information**

Name: \_\_\_\_\_\_

Date of Birth: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (If homeless, city of residence): \_\_\_\_\_\_\_\_\_\_\_

Other Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Information:

**Program Needs**

Reason for Referral (include mental health risk factors):

Additional Information:

**BAY AREA COMMUNITY SERVICES**

Northern Alameda County\*

Shanice Kelley | 510-613-0330

referrals@bayareacs.org

**LA FAMILIA**

Central, Eastern, and Southern County\*

Kathy Roberts, LMFT | 510-881-5921

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