Continuity of Care Request

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

Please ask receptionist about your **right** to **free language assistance** services as well as alternative formats of this brochure. If you have **physical limitations**, we will help you find available, appropriate and accessible services.

Med-Cal beneficiaries who meet medical necessity criteria for SMHS have the right to request continuity of care and given the option to continue treatment for up to 12 months with an out-of-network provider or a terminated network provider.

This policy applies to all Medi-Cal beneficiaries who are transitioning as follows:

- The provider has voluntarily terminated employment or contract with the MHP
- The provider's employment or contract has been terminated, for a reason other than issues related to quality of care or eligibility of the provider.
- Transitioning from one county MHP to another county MHP due to a change in beneficiary's county of residence
- Transitioning from an MCP to an MHP; or,
- Transitioning from Medi-Cal FFS to the MHP

How to request for Continuity of Care

A beneficiary, the beneficiary's authorized representatives, or the beneficiary's provider may make a direct request to the MHP in person, writing, or via telephone.

To approve the request of Continuity of Care, certain criteria's are to be met including but not limited to the following:

- The MHP is able to determine that the beneficiary has an existing relationship with the provider during the past 12 months prior to enrollment
- The beneficiary establishing residence in the county
- The provider meets the applicable professional standards under State law
- Provider agrees in writing to contractual terms and conditions

Date: ________________ DOB: ________________

Beneficiary Name: ____

Name of Legal Guardian (if Minor): ___________________________

Address: ____

Phone #: ____

Provider Information with which you would like to continue services

Name: ____

Address: ____

Phone Number: ____

Date you started services with provider? ______________________

If you are requesting an Expedited review of this request please briefly explain reason: _____________________________________

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I understand managed care staff will be authorized to contact any involved provider or other involved individual to discuss any and all information needed to evaluate and process this request.

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Signature/Date

Clients may file a Continuity of Care request either orally or in writing. Clients may authorize a representative to act on their behalf at any time.

Clients may request an **Expedited Continuity of Care Request** if the Standard process could jeopardize their life, health, or ability to regain maximum function.

If you need assistance completing this form please contact:

Quality Management Coordinator

(559) 673-3508

(888) 275-9779

Patients' Rights Advocate

(559) 673-3508 x. 1311

(888) 275-9779

Compliance Officer

(559) 673-3508 x 1311

State Ombudsman

(800) 896-4042

TTY (800) 896-2512

Email: MHOmbudsman@dhcs.ca.gov

Please return this completed form to the receptionist or mail in the self-addressed envelope to:

Madera County Behavioral Health Services
Mental Health Plan
P.O. Box 1288
Madera, CA 93639

TTY (800) 735-2929
Cal Relay Dial 711
Speech to Speech (866) 288-1909