Grievances
Individuals are encouraged to discuss issues regarding their mental health services directly with their mental health provider or the supervisor. Clients who are unable to resolve a concern about any aspect of their services, may file a grievance verbally by calling the Quality Management Coordinator at the number listed below, or by completing a written form. Forms are available in the reception area of all clinics and provider offices or by calling the Mental Health Plan at **(559) 673-3508**, toll free **(888) 275-9779** TTY **(800) 735-2929** or on the County website, http://madera-county.com/index.php/client-rights-and-information.

The following services are also available for assistance in resolving grievances:

Quality Management Coordinator
(559) 673-3508
(888) 275-9779 (toll free)

Patients' Rights Advocate
(559) 673-3508 ext. 1270
(888) 275-9779 (toll free)

State Ombudsman
(800) 896-4042 (toll free)

TTY **(800) 896-2512**

Email: MHOmbudsman@dhcs.ca.gov

You may ask anyone to act on your behalf at any time.

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.

REQUEST FOR

CHANGE OF MENTAL HEALTH

PROVIDER

MADERA COUNTY

BEHAVIORAL HEALTH SERVICES

Return completed form to:
Madera County Behavioral Health Services
Mental Health Plan
P.O. Box 1288
Madera, CA 93639
California Relay Operator – (English & Spanish)
Dial 711
English Speech to Speech – (866) 288-1909
Spanish Speech to Speech – (866) 288-4151
TTY (800) 735-2929

Revised 21 0909

MADERA COUNTY BEHAVIORAL HEALTH SERVICES
REQUEST FOR CHANGE OF MENTAL HEALTH PROVIDER

DATE: _____

TO: Mental Health Managed Care Program

FROM: _____
(Client Name - Please Print)

_____
(Print Parent or Guardian Name if request is for child or youth)

I request a change in my service provider, _____,
(Name of current service provider)
for the following reasons:

_____

_____ ☐ I would like to change my provider to a culturally/ethnically specific provider, or a gender specific or an age specific provider. Please let us know which you would prefer:

_____

You are encouraged to discuss your issues with your current provider or their supervisor.

CHECK ONE:_____ I have discussed my concerns with this person.
_____ I have not discussed my concerns with this person.

Request for Change of Psychiatrist

If request is for a change of psychiatrist, your psychiatrist will be notified only if feasible, appropriate and beneficial to your progress in treatment.

I understand serious consideration will be given to this request and that I can expect a response within ten working days.

Address: _____

May we send mail to you at this address? *Yes or No*

Telephone Number (Please indicate best time to call): _____

May we call you at this telephone number? *Yes or No*

May we leave a message for you at this telephone number? *Yes or No*

In order to process this request, I understand it may be discussed with the provider and other relevant staff members.

Signature:_____