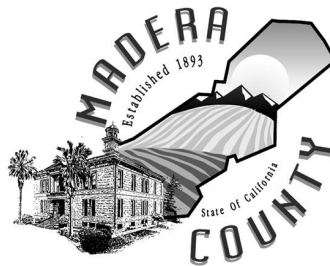


**REQUEST FOR
CHANGE OF MENTAL HEALTH
PROVIDER**

**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

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.

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: _____