

## 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](mailto: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

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: \_\_\_\_\_