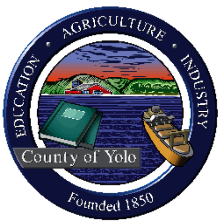

COUNTY OF YOLO

Health & Human Services Agency
Behavioral Health

MR#: ________
For Office Use Only

Change of Provider Request Form

If you believe that your current provider is not meeting your treatment needs and would like to request a change in provider, please fill out this form and return to the receptionist at the clinic where you are receiving services. Requesting a change of provider does not put you at risk of being denied behavioral health services or having the type of services you are receiving change.

Requests for change of provider will be reviewed carefully by the clinic supervisor and approved, as appropriate. You will be informed of the outcome of your request by letter or phone call.

You can get help with filling out this form from a clinic staff member at the location where you are receiving services, from Quality Management at **(530) 666-8788**, or from the Patients' Rights Office at **(800) 970-5816**.

MR#: ____________
For Office Use Only

Date of Request: ___________________

Client Name: ____

Date of Birth: ________________ Phone Number: ______________

☐ Client is a Minor ☐ Client is a Conservatee

Guardian Name: ____

1. Current Provider: ____

2. Why are you asking to change your provider?

Check all that apply.

☐	**Communication** (example: doesn't listen; doesn't return calls; I don't understand what they are saying)
☐	**Cultural Issues** (example: doesn't understand my cultural background)
☐	**Gender** (example: requesting a specific gender) Specify:____
☐	**Language** (example: requesting a specific language) Specify: ____
☐	**Medication Issues** (example: side effects, need second opinion, need to change medication)
☐	**Recommended** (example: recommended by clinician or family)

☐	**Request for a specific doctor/clinician** Change to: ____
☐	**Rude and/or unprofessional**
☐	**Scheduling concerns** (example: delays in between appointments; long wait time in the lobby)
☐	**Telemedicine/telehealth** (example: requesting face-to-face treatment)
☐	**Treatment Concerns**
☐	**Other:**____

3. What type of change do you want to see?

4. Please describe your specific concerns:

COUNTY OF YOLO

Health & Human Services Agency
Behavioral Health

MR#____________
For Office Use Only

Change of Provider Request Form

THIS SIDE IS FOR STAFF USE ONLY

Name of Site: ____________________

Type of Provider: ☐ **Case Manager** ☐ **Clinician** ☐ **Nurse/ LVN/ Psych Tech** ☐ **Psychiatrist** ☐ **Other**

Current Services Provided: ____________________

☐	**Approved**			
	New Provider Name:			
	Next Appointment:			
	Client Informed On:			
	Informed Client Via:	☐ **Mail**	☐ **Phone**	☐ **Unable to Contact Client**

☐	**Denied**			
	Reason:			
	Client Informed On:			
	Informed Client Via:	☐ **Mail**	☐ **Phone**	☐ **Unable to Contact Client**

Print Name: **Sign:** **Date:**

Clinical Supervisor

Print Name: **Sign:** **Date:**

Medical Director

Note: This form should be sent to the Quality Management Unit at 137 N. Cottonwood St., Suite 2500 Woodland, CA 95695 within 5 calendar days following the date the request for a change was made.