COUNTY OF YOLO

Health & Human Services Agency
Behavioral Health

MR#: _____
For Office Use Only

Change of Provider Request Form – Side 1

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.

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? _____

☐ Communication (i.e. doesn't listen; doesn't return calls; I don't understand what they are saying)
☐ Cultural Issues (i.e. doesn't understand my cultural background)
☐ Gender (i.e. requesting a specific gender) Specify: _____
☐ Language (i.e. requesting a specific language) Specify: _____
☐ Medication Issues (e.g. side effects; need second opinion; need to change medication)
☐ Recommended (i.e. recommended by clinician or family)
☐ Request for a specific doctor/clinician Change to: _____
☐ Rude and/or unprofessional
☐ Scheduling concerns (e.g. delays in between appointments; long wait time in the lobby)
☐ Telemedicine/telehealth (i.e. requesting face-to-face treatment)
☐ Treatment concerns
☐ Other: _____

3. What type of change do you want? _____

4. Please describe your specific concerns: _____

COUNTY OF YOLO

Health and Human Services Agency
Behavioral Health

MR#: _____
For Office Use Only

Change of Provider Request Form – Side 2

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 _____ **Sign** _____ **Date** _____
Clinic Supervisor

Print _____ **Sign** _____ **Date** _____
Clinical Medical Director
(if services provided are by a psychiatrist)

NOTE: This form should be sent to the **QUALITY MANAGEMENT UNIT** at 137 N. Cottonwood St., Suite 2500, Woodland, CA 95695 within 5 days following the date the request for change was made.