CHANGE OF PROVIDER REQUEST

Return completed form to the receptionist, or

Mail to:
Grievance Coordinator
2227 Capricorn Way, Suite 207
Santa Rosa CA 95407-5419

Phone: 707-565-7895/1-800-870-8786
TTY: 711

CLIENT RIGHTS

As a client of Sonoma County Behavioral Health (SCBH), you are entitled to:

- Be treated with dignity, respect and the utmost consideration for your privacy;
- Services provided in a safe environment;
- Request free interpreter services;
- Receive information on treatment options and alternatives, presented in a language and format you can understand;
- Request a change of provider, a second opinion, or a change in level of care;
- Participate in decisions regarding your health care, including the right to refuse treatment;
- Request and receive a copy of your medical records upon request (costs may apply) and ask that they be amended;
- Authorize a person to act on your behalf during the grievance, appeals or State Hearing process;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- File a grievance, and SCBH clients with Medi-cal can file an appeal, expedited appeal, or a request for a State Hearing without retaliation.

Sonoma County Department of Health Services - Behavioral Health Division: Mental Health Services

CHANGE OF PROVIDER REQUEST

To request a change in your current provider, return this completed form to the receptionist, your case manager, or mail to: Grievance Coordinator 2227 Capricorn Way, Suite 207 Santa Rosa, CA 95407-5419. Every effort will be made to accommodate your request. You will receive a decision within 10 business days from receipt of the request. Sonoma County Behavioral Health cannot guarantee that your provider will be changed. If you need assistance with completing this form you may ask any Behavioral Health staff or call 707-565-7895.

Date: __________ Service Location: _______________________ Provider Name: _______________________

Client Name: ____ Birth Date: _____________________

Address: ________________________________City:________________State:______Zip Code: ____________

Phone Number (__________)_____________________ Email: ______________________________________

Best Time(s) to Call: _____________________________ Contact Preference: ☐Phone ☐Email ☐Mail

Please select the reason(s) for requesting a change:

☐Time/Schedule Change	☐More Compatible Personality	☐Not Helpful
☐Location Change	☐More Culturally Sensitive	☐Insensitive/Unsympathetic
☐Language Preference	☐Treatment Concerns	☐Not Professional
☐Gender Preference	☐Medication Concerns	☐Doesn’t Listen
☐Age Preference	☐Not Receptive to Concerns	☐ I do not want to give a reason
☐Format Preference (telehealth/in-person)	☐Delay/Lack of Response	☐ Other
	☐Lack of Trust	

Please describe the reason(s) for requesting the change:

____

____

____

____

How many times has the client seen the current provider? ☐1 time ☐2-3 times ☐More than 3 times

Has the concern been discussed with the current provider? ☐Yes ☐No

Signature of Person making request: ____________________________________ ☐Self ☐Parent ☐Guardian

Phone Number of person making request if not client: ____

Sonoma County Department of Health Services - Behavioral Health Division: Mental Health Services

CHANGE OF PROVIDER REQUEST

RECEIPT OF CHANGE OF PROVIDER REQUEST (FOR MENTAL HEALTH PLAN USE ONLY)

To be c*ompleted by receiving staff:*

Received by:________________________ Date: ____________________ Program Name:____________________

To be completed by Program Manager/Specialist (PM/Spc):

PM/Spc Name:____________________ Date received by PM/Spc: __________ Decision: ☐Approved ☐Denied

Reason for Decision: ____

____

Next Appointment Date & Time:____________ New Provider Name (if applicable):_______________________

Date Communicated to Client: _______________ Date Communicated to Impacted Providers: _____________

LANGUAGE ASSISTANCE

English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call *24/7 toll-free 1-800-870-8786 toll free number or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call *707-565-6900 or 1-800-870-8786* (TTY: *1-800-735-2929 or 711*).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*) 번으로 전화해 주십시오.

繁體中文(Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*)。

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: *1-800-735-2929 or 711*) *1-800-870-8786 or 707-565-6900* تماس بگیرید.

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。*1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*) まで、お電話にてご連絡ください。

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ :ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ ,ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*)' ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم *1-800-870-8786 or 707-565-6900* (رقم هاتف الصم والبكم: *1-800-735-2929 or 711*

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। *[1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*) पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

ខ្មែរ(Cambodian)

ប្រយ័ត្ន៖ ររ សេី ិនជាអ្នកនិយាយ ភាសាខ្មែ , រសវាជំនួយមននកភាសា រោយមិនគិត្ួ ួន
គឺអាចមានសំរា ់ ំររ អ្េ ី នក។ ចូ ទូ ស័ព្ទ *1-800-870-8786 or 707-565-6900*
(TTY: *1-800-735-2929 or 711*)។

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້ າພາສາ ລາວ, ການບໍ ລິ ການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ ເສັ ຽຄ່ າ,
ແມ່ ນມີ ພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).