Health & Human Services Agency
Behavioral Health & Recovery Services
Mental Health Plan

Request for Change of Provider
Mental Health Plan 24 hour Access Line
1-800-555-5906 (Toll Free)

This form is available in large print and audio. Please see the receptionist or call 1-800-555-5906.

Sí Usted Habla Español. Esta información está disponible en español, por favor vea la recepcionista o llame 1-800-555-5906

What If I Want To Change Doctors, Therapists Or Clinics?

You may obtain a formal request for a change of provider at any Mental Health Outpatient Clinic. Whenever possible the Mendocino County Mental Health Plan (MHP) will, at the request of the client, allow for a change of provider. The MHP may limit the choice to a contract provider with the MHP or Mendocino County Mental Health.
Your request for a change of provider, including culturally specific providers will be reviewed by the QAPI Clinical Manager and be given serious consideration. You can expect a response within ten (10) working days.

**How Do I Find A Provider For The Specialty Mental Health Services I Need?**

The MHP may put some limits on your choice of providers. The MHP must give you a chance to choose between at least two providers when you first start services, unless the MHP has a good reason why it can’t provide a choice (for example, there is only one provider who can deliver the service you need).

The MHP must also allow you to change providers. When you ask to change providers, the MHP must allow you to choose between at least two providers, unless there is a good reason not to do so.

**Questions and Concerns**

Consumers are encouraged to discuss their mental health services with their clinician or other service provider.

**How Do I Get A Copy Of The “Provider List”?**

You may get a list of providers by request at any MHP clinic, by calling toll-free (800) 555-5906, or by writing to the QAPI Program.
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-555-5906 (TTY: 1-800-735-2929).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-555-5906 (TTY: 1-800-735-2929).

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 1-800-555-5906（TTY：1-800-735-2929）

Tiếng Việt (Vietnamese)

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-555-5906 (TTY: 1-800-735-2929) 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino)

Hmoob (Hmong)
Punjabi (Punjabi)

ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਿੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ 1-800-555-5906 (TTY: 1-800-735-2929) 'ਤੇ ਕਲਾਸ ਵਹਾਂ

العربية (Arabic)

كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اصل إذا ملحوظة: (والبكم: رقم هاتف الصم 5906-555-800-1-800-735-2929)

Khmer (Cambodian)

ប្រយ័ត្ន៖ ររ សើ ិិនជាអ្នកនិយាយភាសាខ្មែរ, រវាជំនួយមននកភាសារឺអាចមាន ំួសិើនក។ ចូទូព្ទ 1-800-555-5906 (TTY1-800-735-2929)។

Lao (Lao)

ໂປດຊາບ: ຖ້ວວວ່ວ ທ່ວ້ນເວ ້ວພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫລືອດ້ວນພາສາ, ການບໍລິການຊ່ວຍເຫລືອດ້ວນພາສາ,ໂດຍບໍລິການ, ການບໍລິການ 1-800555-5906 (TTY: 1-800-735-2929)

Thai (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-555-5906 (TTY: 1-800-735-2929)
To request a change of provider complete the request form included with this brochure and give it to the receptionist or bring it or mail it to:

Mendocino County Mental Health Plan
Quality Assessment & Performance Improvement Program (QAPI)
1120 South Dora Street
Ukiah, CA 95482

For assistance completing this form you may contact the:

Patient’s Rights Advocate
(707) 463-4614

Mendocino County Mental Health Plan (MHP) offers free Language Line, interpreter assistance, American Sign Language, and California Relay Services (TTY/TDD) for beneficiaries requesting or accessing services.

These services may be requested at any Mental Health Plan Provider site or by calling 1-800-555-5906.

(Revised 12/5/2018)
REQUEST FOR A CHANGE OF PROVIDER

DATE: ____________________________

TO: Mental Health Quality Assessment & Performance Improvement Program (QAPI), 1120 South Dora Street, Ukiah, CA 95482

FROM: ____________________________________________

(Client Name)

(Parent or Guardian, if request is by or for child or youth)

I request a change of provider for the following reason(s):

________________________________________________________________________________

My current clinician is: ____________________________________________

CHECK ONE: □ I have discussed my concerns with this clinician
□ I have not discussed my concerns with this clinician

I understand that serious consideration will be given to this request and that I can expect a response within ten (10) working days.

RESPONSE TO ME BY TELEPHONE: ____________________________

(Telephone Number)

RESPONSE TO ME BY MAIL: ____________________________________________

(Street Address)

(City, State, Zip Code)