BEHAVIORAL HEALTH AND RECOVERY SERVICES
CHANGE OF PROVIDER REQUEST (MH and SUD)

Fill out this form and give to BHRS staff and they will send the form to Quality Improvement to process.

Today's Date: _____

Consumer Name: _____ Consumer Date of Birth: _____

Parent/Guardian Name (if request is by/for a child or youth):_____

Name of provider you want to change from: _____

I REQUEST A CHANGE OF PROVIDER FOR THE FOLLOWING REASON(S):

Check one (check only one box):

☐ I have discussed my problems with this provider.
☐ I have **NOT** discussed my problems with this provider.
☐ I do **NOT** wish to have my problems discussed with this provider.

Respond to me by mail. My address is: _____

_____

I, _____, give my permission for the QI staff, to talk to my BHRS staff, family members or legal representative regarding any information that shall be needed to process my **CHANGE OF PROVIDER REQUEST**.

_____ _____
Signature of Consumer/Guardian/Legal Representative Date

CHANGE OF PROVIDER REQUEST

BEHAVIORAL HEALTH AND RECOVERY SERVICES
CHANGE OF PROVIDER REQUEST (MH and SUD)

THIS SIDE - COMPLETED BY QUALITY IMPROVEMENT

Date Received: _____ Consumer chart #:_____

Chart Location

☐ **Merced**	☐ **Los Banos**	☐ **Livingston**
☐ Adult	☐ Adult	☐ Adult
☐ Youth	☐ Youth	☐ Youth
☐ CUBE	☐ AOD	☐ AOD
☐ Youth Placement	☐ Wellness Center	
☐ DDP		
☐ Older Adult		
☐ Marie Green		
☐ Institutional Placement		

CONSUMER DEMOGRAPHICS	Gender:
Age:	Ethnicity:
Race:	Preferred Language:

Date letter mailed: _____Date Provider change effective: _____

Disposition:

_____

_____

_____

_____

_____

_____

_____
Signature/Title/Date

CHANGE OF PROVIDER REQUEST