



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

Fill out this form and give to BHRS staff. They will send the form to Quality Improvement to process.
OR, if filling out electronically, after completing, click the SUBMIT FORM button for the form to be emailed to QI.

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



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

**THIS SIDE - COMPLETED BY QUALITY IMPROVEMENT**

Date Received: \_\_\_\_\_

Consumer chart #: \_\_\_\_\_

**Chart Location**

<b>Merced</b>	<b>Los Banos</b>	<b>Livingston</b>
<input type="checkbox"/> Adult	<input type="checkbox"/> Adult	<input type="checkbox"/> Adult
<input type="checkbox"/> Youth	<input type="checkbox"/> Youth	<input type="checkbox"/> Youth
<input type="checkbox"/> CUBE	<input type="checkbox"/> AOD	<input type="checkbox"/> AOD
<input type="checkbox"/> Youth Placement	<input type="checkbox"/> Wellness Center	
<input type="checkbox"/> DDP		
<input type="checkbox"/> Older Adult		
<input type="checkbox"/> Marie Green		
<input type="checkbox"/> Institutional Placement		

**CONSUMER DEMOGRAPHICS**

Gender: \_\_\_\_\_

Age: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

Race: \_\_\_\_\_

Preferred Language: \_\_\_\_\_

Date letter mailed: \_\_\_\_\_

Date Provider change effective: \_\_\_\_\_

Disposition:

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\_\_\_\_\_  
Signature/Title/Date

**CHANGE OF PROVIDER REQUEST**