BEHAVIORAL HEALTH REQUEST FOR CHANGE OF SERVICE PROVIDER

Date ____________________

Your Name ____

Phone # ___________________

Name of person filling this form, if not the client:

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Relationship to client: _____________________________________

Client Address: ____

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I request a change in my current service provider
_________________________________ for the following reasons:

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(Optional) I request a change to this provider:

____

Check one:

☐ I have discussed my concerns with my current provider

☐ I have not discussed my concerns with my provider

Signature: ____
Phone #: ____

Mail form to:

Humboldt County Behavioral Health
Quality Improvement Coordinator
720 Wood St.
Eureka, CA 95501

You may also contact the following people for help in resolving problems:

Quality Improvement Coordinator
707-268-2955, option #2
or
Toll Free 1-888-849-5728

Patients' Rights Advocate
707-268-2995

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FOR INTERNAL USE ONLY

Date received by Quality Improvement: _____________**Due Date**: _______________

Date forwarded: _______________To: _______________________________________

Decision

☐ Approved – New Provider:

____

Please print name

☐ Denied:

____

Reason

Date client notified: _________________ Date Provider(s) notified: __________________

Signature of Manager or Designee: ___________________________Date: ____________

Rev 5/5/2020