SAN BERNARDINO COUNTY

Department of Behavioral Health

SIMON#: _____
For Office Use Only

Change of Provider Request Form – Side 1

If you believe that your current provider is not meeting your treatment needs and would like to request a change in provider, please fill out this form and return to the receptionist at the clinic where you are receiving services. Requesting a change of provider does not put you at risk of being denied behavioral health services or having the type of services you are receiving change.

Requests for change of provider will be reviewed carefully by the clinic supervisor and approved, as appropriate. You will be informed of the outcome of your request by letter or phone call.

You can get help with filling out this form from a clinic staff member at the location where you are receiving services, from the ACCESS Unit at (888) 743-1478, or from the Patients' Rights Office at (800) 440-2391.

Date of Request: _____

Client Name: _____

Date of Birth: _____ Phone Number: _____

☐ Client is a minor ☐ Client is a conservatee Guardian name: _____

1. Current provider: _____

2. Why are you asking to change your provider? _____

☐	Communication (e.g. doesn't listen; doesn't return calls; I don't understand what they are saying)
☐	Cultural Issues (i.e. doesn't understand my cultural background)
☐	Gender (i.e. requesting a specific gender) Specify: _____
☐	Language (i.e. requesting a specific language) Specify: _____
☐	Medication Issues (e.g. side effects; need second opinion; need to change medication)
☐	Recommended (i.e. recommended by clinician or family)
☐	Request for a specific doctor/clinician Change to: _____
☐	Rude and/or unprofessional
☐	Scheduling concerns (e.g. delays in between appointments; long wait time in the lobby)
☐	Telemedicine/telehealth (i.e. requesting face-to-face treatment)
☐	Treatment concerns
☐	Other: _____

3. What type of change do you want? _____

_____

4. Please describe your specific concerns: _____

_____

Department of Behavioral Health

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Change of Provider Request Form – Side 2

THIS SIDE IS FOR STAFF USE ONLY

Name of Site: _____

Type of Provider: ☐ **Case Manager** ☐ **Clinician** ☐ **Nurse/LVN/Psych Tech**
☐ **Psychiatrist** ☐ **Other**

Current Services Provided: _____

☐ **Approved**

New provider name: _____

Next appointment: _____

Client informed on: _____

Informed client via: ☐ **Mail** ☐ **Phone** ☐ **Unable to contact client**

☐ **Denied**

Reason: _____

Client informed on: _____

Informed client via: ☐ **Mail** ☐ **Phone** ☐ **Unable to contact client**

Print _____ **Sign** _____ **Date** _____
Clinic Supervisor

Print _____ **Sign** _____ **Date** _____
Clinical Medical Director
(if services provided are by a psychiatrist)

NOTE: This form should be sent to **QUALITY MANAGEMENT** at 303 E. Vanderbilt Way, San Bernardino, CA 92415-0026 by the **5th** day of the month, following the date the request for change was made.

LANGUAGE TAGLINES

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call *[1-888-743-1478]* (TTY: *[711]*).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *[1-888-743-1478]* (TTY: *[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 *[1-888-743-1478]* (TTY: *[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 *[1-888-743-1478]* (TTY: *[711]*).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *[1-888-743-1478]* (TTY: *[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 *[1-888-743-1478]* (TTY: *[711]*)。

Հայերեն **(Armenian)**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *[1-888-743-1478]* (TTY (հեռատիպ)՝ *[711]*):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *[1-888-743-1478]* (телетайп: *[711]*).

فارسی **(Farsi)**
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با تماس بگیرید *[1-888-743-1478]* (TTY: *[711]*).

LANGUAGE TAGLINES

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。*[1-888-743-1478]* (TTY: *[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 *[1-888-743-1478]* (TTY: *[711]*).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸ ੀਂ ਪੰਜਾਬ ਬੋਲਿ ਹੋ, ਤਾ ੀਂ ਭਾਸ਼ਾ ਧ ਿੱਚ ਸਹਾਇਤਾ ਸੇ ਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਿ ਹੈ। *[1-888-743-1478]* (TTY: *[711]*) 'ਤੇ ਕਾਲ ਕਰੋ।

الـ عربـ ية(Arabic)
ملحوظة: إذا كـ نت تـ تحدث اذكر الـ لغة، فـ إن خدمات الـ مـ ساعدة الـ لغوية تـ توافـ ر لـ ك بـ الـ مجان. اتـ صل بـ رقـ م *[1-888-743-1478]*
(رقم هاتـف الصم والبـ :كـم *[711]* .)

हिंदी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। *[1-888-743-1478]* (TTY: *[711]*) पर कॉल करें।

ภาษาไทย **(Thai)**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *[1-888-743-1478]* (TTY: *[711]*).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ រ ើសិនជាអ្នកនិយាយ ភាសាខ្ម , រសវាជំនួយមននកភាសា រោយមិនគិតៃ្លៃ គឺអាចមានសំវ ់ ់ំរ ើអ្នក។ ចូ ទូ ស័ព្ទ *[1-888-743-1478]* (TTY: *[711]*)។

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ *[1-888-743-1478]* (TTY: *[711]*).