The County Mental Health Plan and Drug Medi-Cal Organized Delivery System takes your concerns seriously. We will make reasonable effort to meet your needs. You will not be subject to discrimination, or any other penalty for filing a Changing Your Treatment Plan form.

To: Quality Improvement Behavioral Health Services

Request Treatment Staff Change Form

Client Name:	**Date of Birth:**	**Today's Date:**
Current Address:		**Phone#:**
Parent / Guardian Name (if under 18 years old):		
I am an eligible minor who has consented to my own care: ☐ **Yes** ☐ **No**		
Current Doctor Is:		
Current Coordinator Is (if applicable):		
Current Therapist Is (if applicable):		

Check one:

I request a change in my current: ☐ Doctor ☐ Care Coordinator/ Manager ☐ Therapist ☐ Other Provider

Name of staff member I want to change is:_____

Reasons for Request:

Check yes or no:

I have discussed my concerns with my current provider: ☐ Yes ☐ No

If no, please explain (optional): _____

_____

IF THIS IS REGARDING A GRIEVANCE / COMPLAINT, PLEASE COMPLETE THE GRIEVANCE RESOLUTION REQUEST BROCHURE

For Office Use Only

Date Received:	Date Resolved:	Resolved by:
Resolution:		