Sometimes you may wish to change the treatment staff serving you. When this happens, you can request new staff to provide services. You can use this form to ask for different treatment staff.

When You Have Completed the Form

Turn-in your completed form at the reception counter in North or South County Mental Health or Substance Use clinic where you receive services. Or, you may mail the form to:

Quality Improvement Department
Behavioral Health
1400 Emeline Avenue
Santa Cruz CA 95060

Thank you for participating in your care.

What Happens Next?

You will be contacted to try to help find solutions for your concerns.

Information provided on this form will not become part of your medical records. It will remain in the Quality Improvement Department and will only be shared with other behavioral health staff on a need to know basis in order to resolve the problem. Information provided will be treated as confidential information per Santa Cruz County Behavioral Health policies and procedures.

Quality Improvement Department
Santa Cruz County Behavioral Health Services
PO Box 962
Santa Cruz, CA 95061

BEHAVIORAL HEALTH
HEALTH SERVICES AGENCY

Changing Your Treatment Staff

Toll free, Multilingual
1-800-952-2335

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

Name of person filling out this 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: _____

Reason for Request (check one):

☐ I have concerns and/or issues with my medication ☐ My provider is not a good fit

☐ I have communication difficulties with my provider ☐ I'm not happy with the services and/or care I receive from my provider

☐ The availability and/or frequency of my provider's appointments do not meet my needs

☐ Language capability of my provider ☐ Gender of provider ☐ Other reason

Describe the Reason 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

Please allow 30 days for request to be resolved

For Office Use Only

Date Received:	Date Resolved:	Resolved by:
Resolution:		