8939387366

County of Los Angeles - Department of Mental Health

Local Mental Health Plan

TRI-CITY Mental Health Services

REQUEST FOR CHANGE OF PROVIDER

CONFIDENTIAL

Date ☐☐ / ☐☐ / ☐☐☐☐

For optimum accuracy, please print clearly using capital letters:

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

To request a change in your current provider, please submit this form to the Program Manager's office. Every effort will be made to accommodate your request. You will receive a decision within 10 working days. If you are a Medi-Cal beneficiary seeing a private provider in the community who is not part of a county operated or county contracted program, call the Beneficiary Services Program in the Patients' Rights Office at 800-700-9996 or 213-738-4949. The Mental Health Plan cannot guarantee that your provider will be changed. If you do not receive a decision on your request within 10 working days or you disagree with the decision, you may file a formal grievance.

Please answer all questions by filling in all blank areas as completely as possible and by shading in the appropriate circles.

SECTION A: BENEFICIARY/CLIENT INFORMATION

Client Name (First & Last) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Address (Number & Street) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐

State CA

Zip ☐☐☐☐☐

Phone Number (Area Code First) ☐☐☐ – ☐☐☐ – ☐☐☐☐

SECTION B: CURRENT PROVIDER INFORMATION

IMPORTANT: Please shade circles like this => ●

1. Service Location (Choose One):

- ○ 2008 N. Garey Ave
- ○ 1900 Royalty Dr

2. I am requesting a change in: (shade-in selection/ write name below):

○ Doctor ○ PT ○ Therapist ○ Case Manager ○ Program

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3. Please completely fill in the circle next to the reason(s) for requesting a change (this information is OPTIONAL):

- ○ A. Time/Schedule Change
- ○ B. Language
- ○ C. Age (too old/too young)
- ○ D. Gender (male/female)
- ○ E. Treating Family Member
- ○ F. Treatment Concerns
- ○ G. Medication Concerns
- ○ H. Lack of Assistance
- ○ I. I want Previous Provider
- ○ J. I want 2nd Opinion
- ○ K. Uncomfortable
- ○ L. Insensitive/Unsympathetic
- ○ M. Not Professional
- ○ N. Does not Understand Me
- ○ O. Not a Good Match
- ○ P. Other – Please Describe the reason(s) for requesting the change (OPTIONAL)

_____

- ○ R. I do not want to give a reason for my request

4. Have you discussed your concerns with your current provider? ○ Yes ○ No

If YES, please describe what you have done to try to resolve the problem _____

_____

SECTION C: SIGNATURE

I understand that I will be contacted about this request within 10 working days. I prefer to be contacted by:

- ○ Mail
- ○ Telephone

x _____

Signature of Person Making Request

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Please Print Your Name

Relationship to the Client: ○ Self ○ Parent ○ Legal Guardian ○ Conservator ○ Caregiver ○ Staff

Rec'd by(Initial and Date) _____ ☐☐ / ☐☐ / ☐☐

Copy Given to Client: ○ Yes ○ No

Welligent # ☐☐☐☐☐☐☐

Request #: _____

v(1)6/2014