San Mateo County Behavioral Health and Recovery Services

Change of Provider Request Form

You have the right to request a change of provider. Complete this form and give it to any staff member; they will forward it to the Unit Chief or Supervisor. The Unit Chief or Supervisor will review your request and respond to you within 2 weeks.

Your name (client): _____

If youth, name of parent/guardian requesting change: _____

I would like to change my: Psychiatrist ☐ Case Manager ☐ Therapist ☐
Social Worker ☐ Nurse ☐ Clinic ☐ Program ☐

Name of provider/clinic: _____

Your phone number(s) or contact information: _____

_____

Is this request due to a program's specific religious affiliation? Yes ☐ No ☐

OPTIONAL - Reason for requesting a change of service provider: _____

_____

_____

Client Signature: _____ Date: _____

Staff completing form on client's behalf: _____ Date: _____

FOR OFFICE USE ONLY **Completed Form: HS_BHRS_QM@smcgov.org or Fax 650-525-1762**

Date Manager/Supervisor Received: _____ **Client's MH#:** _____

Decision: _____

_____

_____

Date client informed of decision *(within 2 weeks of request)*: _____

For AOD/SUD Charitable Choice referrals – Date DHCS notified: _____

Manager/Supervisor Printed Name: _____ **Clinic:** _____

Manager/Supervisor Signature: _____ **Date:** _____

You also have the right to file a grievance. If you want to file a grievance, **do not use this form,** contact the Office of Consumer & Family Affairs at 1-800-388-5189.