# BENEFICIARY REQUEST FOR CHANGE OF PROVIDER FORM

**CONTRA COSTA COUNTY**
**BEHAVIORAL HEALTH SERVICES**

# LANGUAGE ASSISTANCE

## English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call (888) 678-7277 (TTY: 711).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call (888) 678-7277 (TTY: 711).

## Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 678-7277 (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 (888) 678-7277 (TTY: 711).

## Tagalog (Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (888) 678-7277 (TTY: 711).

## 한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (888) 678-7277 (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 (888) 678-7277 (TTY: 711).

**Հայերեն (Armenian)**

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (888) 678-7277 (TTY: 711).

**Русский (Russian)**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (888) 678-7277 (TTY: 711).

**فارسی (Farsi)**

**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد با (888) 678-7277 (TTY: 711) تماس بگیرید.

**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。(888) 678-7277 (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 (888) 678-7277 (TTY: 711).

**ਪੰਜਾਬੀ (Punjabi)**

ਧਿਆਨ ਦਿਓ :ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ ,ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (888) 678-7277 (TTY: 711)' ਤੇ ਕਾਲ ਕਰੋ।

**العربية (Arabic)**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (888) 678-7277 رقم هاتف الصم والبكم: 711

**हिंदी (Hindi)**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (888) 678-7277 (TTY: 711) पर कॉल करें।

**ภาษาไทย (Thai)**

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (888) 678-7277 (TTY: 711).

**ខ្មែរ (Cambodian)**

ប្រយ័ត្ន៖ រ សើ ិនជាអ្នកនិយាយ ភាសាខ្ម ,
រសវាជំនួយមននកភាសា រោយមិនគិត្ួ ួន
គឺអាចមានសំវា ់ ំរ អ្ើ នក។ ចូ ទូ សព្ទ (888) 678-7277 (TTY: 711)។

**ພາສາລາວ (Lao)**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ,
ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,
ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (888) 678-7277 (TTY: 711).

**What is a Grievance?**

A grievance is an expression of unhappiness about anything regarding your specialty mental health or DMC substance use disorder services that are not one of the problems covered by the appeal and State Hearing processes.

**The Grievance Process**

You can file a grievance anytime with the Contra Costa Mental Health Plan (MHP) or Drug Medi-Cal Organized Delivery System (DMC-ODS) if you are unhappy with the specialty mental health or substance use disorder services you are receiving from these plans or have another concern regarding them.

To get help with a grievance, you may contact any staff at your program, the Access Line at (888) 678-7277, Behavioral Health Services' Office of Quality Improvement at (925) 957-5160 or the Grievance Advocate at (925) 293-4942. The Contra Costa MHP or DMC-ODS will provide self-addressed envelopes at all the providers' sites for you to mail in your grievance. If you do not have a self-addressed envelope, you may mail your grievance directly to the address on this form. Grievances can be filed orally or in writing. Oral grievances do not have to be followed up in writing.

**The State Hearing Process**

The Contra Costa MHP and DMC-ODS must make a decision about your grievance within 90 calendar days from the date you filed your grievance. The timeframes for making a decision may be extended by up to 14 calendar days if you request an extension, or if the Behavioral Health Services believes that there is a need for additional information and that the delay is for your benefit. An example of when a delay might be for your benefit is when the Contra Costa MHP or DMC-ODS believes it might be able to resolve your grievance if they have more time to get information from you or other people involved. You can file for a State Hearing if your grievance wasn't resolved in time.

A State Hearing is an independent review conducted by the California Department of Social Services to ensure you receive the specialty mental health or substance use disorder services to which you are entitled under the Medi-Cal program.

You can request a State Hearing directly from the California Department of Social Services by writing to:

*California Department of Social Services*
*State Hearings Division*
*P.O. Box 944243, Mail Station 9-17-37*
*Sacramento, CA 94244-2430*

You can also call 1-800-743-8525 (TDD 1-800-952-8349) or a Grievance Advocate at (925) 293-4942.

CONTRA COSTA
HEALTH SERVICES

*OFFICE USE ONLY*
Request No. _____
Date Received_____

# REQUEST FOR CHANGE OF PROVIDER

CONTRA COSTA COUNTY
BEHAVIORAL HEALTH
SERVICES ADMINISTRATION
1340 Arnold Dr., Suite 200
Martinez, California 94553
Ph (925) 957-5160
Fax (925) 957-5156

If you have been unable to resolve a problem with your service provider by speaking directly to them or the supervisor of the program where you are receiving care, then you may request a change of a service provider by completing this form and giving it to the receptionist. The program supervisor will review your request and will notify you of his/her decision within ten (10) working days. For mental health, if you are a Medi-Cal beneficiary seeing an individual provider in the community who is not part of a county network of clinics, call the Behavioral Health Access Line at 1(888) 678-7277. Submitting a request does not guarantee that they will change your provider. If you disagree with the decision, you may file a formal grievance.

DATE _____

TO: PROVIDER/PROGRAM SUPERVISOR

FROM: _____
(Beneficiary Name)

_____
(Parent or Guardian if request is by or for a child or youth)

I request a change in my Current Provider

_____
(Please print name of current provider)

for the following reasons: (add additional pages as needed)

_____

_____

_____

Check One
- ☐ I have discussed my concerns with this provider.
- ☐ I have **NOT** discussed my concerns with this provider.

I understand serious consideration will be given to this request and that I can expect a response within ten (10) working days.

Respond to me by phone: _____
(Area Code and Telephone number)

or by mail: _____
(Street Address)

_____
(City, State, Zip Code)

## Our Mission

The mission of Contra Costa Behavioral Health, in partnership with consumers, families, staff and community-based agencies, is to provide welcoming, integrated services for mental health, substance abuse, homelessness and other needs that promote wellness, recovery, and resiliency while respecting the complexity and diversity of the people we serve.

## Our Vision

Contra Costa Behavioral Health envisions a system of care that supports independence, hope, and healthy lives by making accessible behavioral health services that are responsive, integrated, compassionate, and respectful.