Placer County Systems of Care

Formal Request for Change of Service Provider/Request for Second Opinion

I am requesting a ☐ Change of Service Provider ☐ Second Opinion

Client Information-Your information or your child's information, if you are a parent/guardian		
Client's Name:	DOB:	☐ MH ☐ SUS ☐ CWS
Address:		Phone:

Request for Change of Service Provider
Name of Current Service Provider (Psychiatrist, Therapist, Case Manager, etc.):
Did you discuss your desire to change providers with the above service provider? ☐ Yes ☐ No
Please select the reason or reasons that best fits your reason for requesting this change: ☐ I don't feel my needs are being addressed and/or I am being listened to. ☐ A family member/friend is being treated by the same provider. ☐ I am concerned about the medications prescribed. ☐ I feel I would be more comfortable with a ☐ male ☐ female provider. ☐ Language Issues Please identify preferred language: _____ ☐ Cultural Issues: Please identify a cultural reference: _____ ☐ Other ☐ I do not wish to provide a reason.

Request for Second Opinion
The reason I am requesting a second opinion is:
Signature/Date of Request
Signature: Date of Request:
_____ _____
☐ I am the client. ☐ I am the parent or guardian of the client.

Turn in the form by any one of the following methods:

a. In person: Drop off at the clinic or office where you receive your services.
b. Mail to: SOC Quality Management Designee, 101 Cirby Hills Drive, Roseville, CA 95678
c. Fax to: SOC Quality Management Designee at (916) 872-6521

Every effort will be made to accommodate your request within our available resources. You will receive an answer within 60 calendar days of our receipt of your request.

If you have any questions, call the Quality Management Designee at (916) 787-8979 or (530) 886-5419.

For County Use Only
Resolution: Date Client Notified: _____
☐ I have completed a transfer summary for the next service provider to review
County Worker Signature:_____ Date: _____