



REQUEST FOR CHANGE OF SERVICE PROVIDER

The Michigan Mental Health Code, Act 258 of 1974 guarantees the right of recipients to a choice of mental health professional or physician within certain limits. This provision, MCLA 330.1713, §713, Choice of physician or mental health professional, states, "A recipient shall be given a choice of physician or other mental health professional...."

1. *...in accordance with the policies of the community mental health services program, licensed hospital, or service provider under contract with the community mental health services program, or licensed hospital providing services; and*
2. *...within the limits of available staff in the community mental health services program, licensed hospital, or service provider under contract with the community mental health services program, or licensed hospital."*

Northern Lakes CMHA policy and procedure Choice/Change of Provider states that Northern Lakes and its contracted providers will make every effort to accommodate your choice in a timely manner if there is an alternative, credentialed provider available, and there is not a conflict of interest or other justifiable clinical reason to deny your request.

Although you are not required to do so under law or policy, we encourage you to let us know your reasons for requesting a change of provider so that we may find a way to resolve any questions or problems you may have with your current provider. You may talk with your provider, or your assigned worker (if different), their assigned supervisor, or the Recipient Rights Officer. If you still wish to request a change and to facilitate the transfer in a timely manner, please answer the following questions (You may request that this form be filled out by your provider):

- I, _____
(print name)
- My current provider's name is _____
- I understand that my request may be limited by the conditions listed above.

Recipient or Guardian Signature _____ date _____

Action taken by workforce member assisting recipient: _____

Signature of workforce member _____ date _____

Action taken by Supervisor receiving request: _____

Signature of receiving Supervisor _____ date _____

Original to Recipient Record