You may request Santa Cruz County Behavioral Health (SCCBH) to consider if, in the absence of continued services with your provider, you would suffer serious detriment to your health, or be at risk of hospitalization or institutionalization.

How Do I Know if I Qualify?

- If you are already under treatment for the condition identified and:
- If medical necessity criteria have been met;
- If your provider qualifies and is willing to work with SCCBH;
- If you are at risk of serious detriment to your health if the relationship with the provider ends abruptly.
- If all above criteria are met, you may be allowed to continue care with your provider for 3-12 months, based on need.

When You Have Completed the Form

Turn-in your completed form at the reception counter in North or South County Mental Health or Substance Use clinic where you receive services. Or, you may mail the form to:

Quality Improvement Department
Behavioral Health
1400 Emeline Avenue
Santa Cruz CA 95060

Quality Improvement Department
Santa Cruz County Behavioral Health Services
PO Box 962
Santa Cruz, CA 95061

COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

Transition / Continuity of Care Request

Toll free, Multilingual
1-800-952-2335

All eligible Medi-Cal beneficiaries who meet medical necessity criteria for Specialty Mental Health Services and / or Drug Medi-Cal Organized Delivery System Services (DMC-ODS) have the right to request continuity of care if you already have a current relationship with an eligible provider.

To: Quality Improvement Behavioral Health Services

Transition / Continuity of Care Request Form

Client Name:	**Date of Birth:**	**Today's Date:**
Current Address:	**Phone#:**	
Parent / Guardian Name (if under 18 years old):		
I am an eligible minor who has consented to my own care: ☐ **Yes** ☐ **No**		
Current Health Care Provider Name:		
Current Provider Address / Phone Number:		

I request to keep my current provider. I understand that I must be a Medi-Cal beneficiary.I understand that, if all criteria are met, I may be allowed to keep my current provider for 3-12 months. I understand that I will need to transfer my care to a provider within Santa Cruz County Behavioral Health's provider network.

Reasons for Request (Why do you need to keep your current provider)?

Signature: _____

Printed Name: _____ **Date:** _____

In making this request, I authorize Santa Cruz County Behavioral Health to contact my current provider to gather information to make an informed decision concerning my request for Continuity of Care.

We will let you know we received your request within 3 business days.

For Office Use Only

Date Received:	Date Resolved:	Resolved by:
Resolution:		
Prior Relationship Exists: ☐ Yes ☐ No Provider Meets Standards: ☐ Yes ☐ No Provider agrees to contract: ☐ Yes ☐ No		
Medical Necessity Criteria Met: ☐ Yes ☐ No Serious Risk Criteria Met: ☐ Yes ☐ No		
Approved ☐ Denied ☐ Denial NOABD Sent: ☐ Yes ☐ No		