County of Fresno

DEPARTMENT OF BEHAVIORAL HEALTH
SUSAN L. HOLT
DIRECTOR OF BEHAVIORAL HEALTH
PUBLIC GUARDIAN

The Fresno County Mental Health Plan (FCMHP) is required by law to provide continuity of care for Specialty Mental Health Services (SMHS). This means that you can stay with your out-of-network or terminated mental health network provider for up to 12 months. All eligible Medi-Cal beneficiaries who meet medical necessity criteria for SMHS and have seen their provider at least once in the last 12 months have the right to request continuity of care. Your provider must also be willing to work with Fresno County Mental Health Plan (FCMHP).

You, your authorized representative, or your provider can make a request to the FCMHP. You can make your request in person, writing, or by telephone. If you would like to make a request in writing, fill out this form. When you are finished, please mail it to:

Fresno County
Department of Behavioral Health
Managed Care Division
P.O. Box 45003
Fresno, California 93718-9886

Forms and stamped, addressed envelopes are available at all mental health service sites.

You will receive a letter as soon as we receive your request. You will receive a decision letter within 30 calendar days. You may request a decision be made within fifteen (15) days if your

condition requires more immediate attention or three (3) calendar days if there is a risk of harm, defined as an imminent and serious threat to your health.

If you need this brochure in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact the Fresno County Mental Health Plan by calling 1-800-654-3937. For hearing impaired, dial 711 to reach the California Relay Service.

If you want to speak to someone about this, you can call Fresno County Mental Health Plan Managed Care Division at 559-600-4645 (Monday-Friday 8 am–5 pm), Fresno County Mental Health Access Line at 1-800-654-3937 (available 24 hours a day/7days a week), Ombudsman Service 1-888-452-8609 or Patients' Rights Advocate (559) 492-1652.

CONTINUITY OF CARE (Please print):

Last Name:	First Name:	Middle Name:	Date of Request:
Date of Birth:	Medi-Cal or Social Security Number:		Gender:
Address:	Unit #	City/State:	Zip Code:
Phone Number:		Alternate Phone Number:	
What date did you begin treatment with your provider?	How long have you been in treatment with your provider? ___ Day(s) ___ Month(s) ___ Year(s)		
What was the last date you were seen by your provider?	If you have another appointment, when is it scheduled?		
Are you asking this request be expedited within 15 days rather than the standard 30 days due to pressing care needs? Yes ☐ No ☐ If yes, explain:			
Does this request require immediate attention (within 3 days) due to risk of harm to self or others? ☐Yes. ☐No. If yes, explain:			

Provider Name:	Contact Person:	
Agency (If applicable):		
Address:	City:	Zip Code:
I understand that by signing this form managed care staff will be authorized to contact the provider listed to discuss any and all information needed to review and process this request.		
Signature:	Print Name:	
Date:	Relationship to the Beneficiary (If other than Self):	