

**Medi-Cal Specialty Mental Health Services Program  
NOTICE OF ACTION  
(Lack of Timely Service)**

Date: \_\_\_\_\_

To: \_\_\_\_\_, Medi-Cal Number \_\_\_\_\_

The mental health plan for \_\_\_\_\_ County has not provided services within \_\_\_\_\_ working days of the date of the initial service request.

Our records show that you requested services, or services were requested on your behalf on \_\_\_\_\_

The following services were requested by you or on your behalf:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We are sorry for the delay in providing timely services. We are working on your request and hope to provide you with the requested service(s) soon.

**You may request a state hearing to consider the reason for the delay.**

The other side of this form explains how to request a state hearing.

This notice is required pursuant to Title 42, Code of Federal Regulations, Part 438, Subpart F.