

**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.