

**Medi-Cal Specialty Mental Health Services Program  
NOTICE OF ACTION  
(Delays in Grievance/Appeal Processing)**

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

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

The mental health plan for \_\_\_\_\_ County has not processed your  
 grievance  appeal  expedited appeal on time.

Our records show you made your request on  
\_\_\_\_\_

You requested that \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We are sorry for the delay in answering your request. We will continue to work on your request and hope to provide you with a decision soon.

**If your request was about the denial of or a change in the mental health services you receive from the mental health plan and you do not want to wait for our decision, you may request a state hearing to consider the denial or change. You may also ask that the state hearing consider the reason for the delay.**

If your request was about another issue, 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.