[County Letterhead]

**NOTICE OF GRIEVANCE RESOLUTION**

[Date]

[Beneficiary’s Name] [Treating Provider’s Name]

[Address] [Address]

[City, State Zip] [City, State Zip]

RE: YOUR GRIEVANCE

You or [Name of requesting provider or authorized representative], on your behalf, filed a grievance with the [County] on [DATE]. The [County] has reviewed your grievance. This notice describes steps taken to resolve your grievance.

[Using plain language, insert: 1. A summary of the grievance filed by the beneficiary; 2. Steps taken to resolve the grievance (e.g., investigation, speaking with provider); 3. A clear and concise explanation of how the grievance was resolved, including if it was resolved in favor of the beneficiary; and, 4. The reasons for the decision.]

If you are dissatisfied with the resolution of your grievance, you may file another grievance with the [County].

The County can help you with any questions you have about this notice. For help, you may call the [County hours of operation] at [24/7 toll-free telephone number]. If you have trouble speaking or hearing, please call TTY/TTD number [TTY/TTD] number, between [hours of operation] for help.

If you need this notice and/or other documents from the County 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 County] by calling [telephone number].

If the County does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at
1-888-452-8609.

[Signature Block]