

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

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

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

As the designated agency for the San Diego County Mental Health Plan, \_\_\_\_\_  
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 received 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.