Behavioral Health Department
Alameda County Health

NOTICE OF GRIEVANCE RESOLUTION

Date

Member's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: YOUR GRIEVANCE

You or *Name of requesting provider or authorized representative*, on your behalf, filed a grievance with the *Plan* on *date*. *Plan* has reviewed your grievance. This notice describes steps taken to resolve your grievance.

[Using plain language, insert for the following four requirements:
1. A summary of the grievance filed by the member;
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 member; and,
4. The reasons for the decision.]

If you are dissatisfied with the resolution of your grievance, you may file another grievance with the *Plan*.

The Plan can help you with any questions you have about this notice. For help, you may call *Plan hours of operation* at *24/7 toll-free telephone number*. If you have trouble speaking or hearing, please call TTY/TTD number *711*, between *hours of operation* for help.

If you need this notice and/or other documents from the Plan 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 *Plan* by calling *telephone number*.

If the Plan 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

Enclosed*:* Non-Discrimination Notice
Language Assistance Taglines

[Enclose notice with each letter]