***NOTICE OF ACTION – ACTION TO TERMINATE, SUSPEND OR REDUCE PREVIOUSLY AUTHORIZED SERVICES***

Si tiene alguna pregunta, necesita ayuda con su apelacion, o necesita un interprete para ayudarle, llame [**Agency Name**] a [**Phone Number**]**.**.

***[Date]***

First Name Last Name [**Enrollee name or parent name if a child**]
Address
City, State Zip

Dear **[Enrollee name or for a child, parent name]**:

On **[Date of Action]**, [**Agency Name**] decided to **[end / put on hold / decrease {name of service}]**. This decision was made because **[give reason in simple terms]**. This decision is effective as of **[give effective date]**.

You have let us know that you are unhappy with this decision. Because you are unhappy with this decision, you or your provider can ask Salt Lake County Division of Behavioral Health Services (DBHS) for a review. Asking for this review is called an appeal.

To file an appeal, follow the steps on the instruction sheet enclosed with this letter. You have the right to keep getting **[name of service, or services if multiple services are affected]** during your appeal. If you want the services during your appeal, follow the instructions for letting us know. Keep in mind that you may have to pay for the services you get during your appeal if DBHS' decision is not in your favor.

If you have questions, need help filing your appeal, or need an interpreter to help you, call [**Agency Name**] at [**Phone Number**]**.** Ask to talk with someone about this Notice of Action.

Sincerely,

[Name]
[Title]

Enclosure: Instructions for Filing an Appeal
Appeal Request Form