

Mailing Date: \_\_\_\_\_ (Date this Letter will be Postmarked)

DATE

Individual's or Surrogate's Name  
Address  
Address

Dear [Name of Individual or Surrogate]:

This letter is to inform you of the eligibility determination decision for \_\_\_\_\_ (Name of Individual) \_\_\_\_\_. All the documentation required to make this determination has been received by this office.

\_\_\_\_\_ (Name of Individual) \_\_\_\_\_ has been determined not eligible for mental retardation services provided through the \_\_\_\_\_ (Name of County MH/MR Program) \_\_\_\_\_. This decision is based on the following:

\_\_\_\_\_ (insert reasons why individual is not eligible here) \_\_\_\_\_

You may request a meeting with this office to discuss the issue if you disagree with the eligibility determination. In addition, due process rights are afforded under Local Agency Law to \_\_\_\_\_ (Name of Individual) \_\_\_\_\_ to request an impartial hearing on the issue. An appeal must be filed within **30 calendar days** from the mailing date of this letter. Please submit the written appeal to:

\_\_\_\_\_ (Name and Address of County Program) \_\_\_\_\_

Please contact me if you have any questions regarding this letter or wish to have a meeting to discuss this issue. I may be reached by telephone at \_\_\_\_\_ (Telephone Number) \_\_\_\_\_.

Sincerely,

Name  
Intake Officer  
County MH/MR Program

cc: Individual's File  
Individual's Surrogate [if applicable]  
Intake Supervisor