State of California – Health and Human Services Agency

Department of Developmental Services
Office of Community Appeals and Resolutions

Notification of Resolution (NOR)

DS 1822 (Rev. 03/2023)

*Required Fields

*What is the DDS Tracking Number? ______

*Is there an existing OAH Case Number? ☐ Yes ☐ No

If yes, what is the OAH Case number? ______

Name of Person this Appeal was for:

*First Name:	*Last Name:	*Date of Birth:

What regional center is providing this NOR?	Unique Client Identifier (UCI), if any

Name of Authorized Representative (if applicable):

First Name:	Last Name:	Relationship to Claimant:

*The appeal request has been withdrawn through the following process:
(Please check the appropriate box)

☐ Resolved before Informal Meeting	Date of Resolution:
☐ Resolved at Informal Meeting	Date of Resolution:
☐ Resolved at Mediation	Date of Resolution:
☐ Withdrawn without Resolution	Date of Resolution:

Summarize the resolution, or why the appeal was withdrawn without resolution:

Confidential Client Information, California Welfare and Institutions Code Sections 4514 and 5328, Health Insurance Portability and Accountability Act.

By my signature below I certify that the information on this form is true.

Person who appealed, or Authorized Representative Signature:	Date:

Regional Center or State Operated Facility Signature:	Date:

You must sign and date in the space above. This may be signed in ink or electronically. By typing your name, you are agreeing that you have electronically signed this form.

TO BE COMPLETED BY REGIONAL CENTER OR STATE-OPERATED FACILITY STAFF WHEN UNABLE TO OBTAIN THE SIGNATURE OF THE PERSON WHO APPEALED OR THEIR AUTHORIZED REPRESENTATIVE.

I certify under penalty of perjury that I personally spoke with the person who appealed, or their authorized representative, and that person indicated to me that the issues identified for appeal have been resolved and the appeal no longer is necessary. A copy of this form will simultaneously be distributed to the Department, the person who appealed or their authorized representative, and the Office of Administrative Hearings.

Regional Center or State-Operated Facility Signature:	Date:

You must sign and date in the space above. This may be signed in ink or electronically. By typing your name, you are agreeing that you have electronically signed this form.

☐ Administratively Closed (Must Explain)

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