

Notification of Endorsement Action

- Initial
 Additional (service)
 Change

September 15, 2008

The Guilford Center
232 N. Edgeworth Street
Greensboro, NC 27401-2218

Guilford County DSS
1203 Maple Street
Greensboro, NC 27405

Provider Federal ID #: 56-6000305
Provider NPI #: 1316130354
Provider Medicaid #: 8301209 B & G

Dear Mr. Hargett,

Your organization has been reviewed by The Guilford Center with the following results for the location and service indicated.

Name of the LME that Granted Business Verification: **The Guilford Center**
Provider Business Name: Guilford County Department of Social Services
Provider Contact Person: Mr. Brenden Hargett
Business Mailing Address: 203 Maple Street, Greensboro, NC 27405
Business Phone: (336) 641-3934
Site Address (specify provider name if different than above): 203 Maple Street, Greensboro, NC 27405
County: Guilford
Service Type(s): Community Support Children/ Adolescent , and Diagnostic Assessment

| STATUS | EFFECTIVE DATE |
|---|----------------|
| <input type="checkbox"/> Business Verification | |
| <input type="checkbox"/> Endorsement | |
| <input type="checkbox"/> Endorsement Pending | |
| <input type="checkbox"/> Due to Referral to DHSR (Date Pended) | |
| <input type="checkbox"/> Other (see comments) | |
| <input type="checkbox"/> Denial of Endorsement (see comments) | |
| <input checked="" type="checkbox"/> Withdrawal of Endorsement | |
| <input checked="" type="checkbox"/> Voluntary | 10/1/2008 |
| <input type="checkbox"/> Involuntary * | |
| Type of Withdrawal | |
| <input type="checkbox"/> Business Withdrawal | |
| <input checked="" type="checkbox"/> Enhanced Service(s) Withdrawal** | 10/1/2008 |
| <input type="checkbox"/> CAP-MR/DD services withdrawal | |
| Notification Sent Statewide <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 10/1/2008 |

NOTE: PLEASE FILL OUT APPLICABLE AREAS COMPLETELY. DO NOT USE "SAME AS ABOVE."

SUBSTANCE ABUSE SERVICES (if applicable)

SAIOP:

License type***

- .3700 and waiver; or
- .3700 and schedule of 12 hours/week or more; or
- .4400

SACOT:

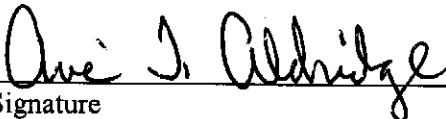
License type***

- .3700 and waiver; or
- .4500


Additional Comments (include reason for denial or withdrawal if applicable): _____

This is a voluntary withdrawal request of the provider due lack of provision of services to consumers. The agency states that they have not done enough community support children /adolescent services, at this point to warrant them going through the expense of the accreditation process.

Sincerely,

 _____ (LME Designee)
Signature

Ave T. Aldridge, Quality Assurance Specialist

 _____ (LME Designee)
Signature
Billie Pierce, Director

cc: DMH

- * Involuntary Withdrawal of Endorsement **must** be signed by Area Director.
- ** Under additional comments section, list each enhanced service to be withdrawn including: corresponding site specific address and Medicaid Number and primary reason for withdrawal.
- *** Attach copies of SA Licenses and or Waiver letters.

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