

Notification of Endorsement Action

March 24, 2009

- Initial
- Additional (service)
- Change

The Guilford Center
232 N. Edgeworth St.
Greensboro, NC 27401

Bigmerica Inc. dba Help Systems of Health Care
Attn: Deon Robinson
P.O. Box 2841
Elizabeth city, NC 27906-2841

Provider Federal ID #: 20-3300959
Provider NPI #: 1740431907
Provider Medicaid #: 8302462

Dear Bigmerica Inc., dba Help Systems of Health Care,

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: Bigmerica, Inc. dba Help Systems of Health Care
 Provider Contact Person: Deon Robinson
 Business Mailing Address: P.O. Box 2841 Elizabeth City, NC 27906-2841
 Business Phone: 252-337-7700
 Physical Site Address (specify provider name if different than above): 7800 Airport Center Dr., Suite 401, Greensboro, NC 27409-9091
 County: Guilford
 Service Type(s): Community Support Services Team, Intensive In Home, Diagnostic Assessment

STATUS	EFFECTIVE DATE
<input type="checkbox"/> Business Verification	mm/dd/yy
<input type="checkbox"/> Endorsement	mm/dd/yy to mm/dd/yy
<input type="checkbox"/> Endorsement Pending	
<input type="checkbox"/> Due to Referral to DHSR (Date Pended)	mm/dd/yy
<input type="checkbox"/> Other (see comments)	
<input checked="" type="checkbox"/> Denial of Endorsement (see comments)	03/25/09
<input type="checkbox"/> Withdrawal of Endorsement (see comments)	
<input type="checkbox"/> Voluntary	mm/dd/yy
<input type="checkbox"/> Involuntary *	mm/dd/yy
Type of Withdrawal	
<input type="checkbox"/> Business Withdrawal	mm/dd/yy
<input type="checkbox"/> Enhanced Service(s) Withdrawal**	mm/dd/yy
<input type="checkbox"/> CAP-MR/DD services withdrawal	mm/dd/yy
<input type="checkbox"/> Community Support Adult or Child Withdrawal ***	mm/dd/yy
Notification Sent Statewide <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	3/25/09

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

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 Required (include reason for denial or withdrawal): Bigmerica dba Help Systems of Health Care is being denied endorsement according to the policies and procedures of endorsement for the following reasons:

1. The information provided during the application process was false or misleading such that disclosing that information would have resulted in an endorsement denial. (Page 8, letter F., number 4)
2. On the basis of an on-site review, it is determined that the provider is not equipped to provide the services for which application for endorsement was made or the provider does not have available the professionals required to provide or supervise treatment. (Page 9, number 5)
3. The applicant does not have the physical address where services can be provided, does not have a place where client records can be stored in accordance with HIPPA requirements or does not meet other requirements necessary to do business. (Page 9, number 7)

A provider organization that achieves business verification but fails to meet site/service specific requirements must wait six (6) months to re-apply for services with the Endorsing Agency that denied the site/service endorsement.

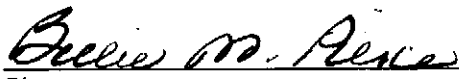
You have the right to appeal this decision. Information regarding the appeals process can be found in the Policy and Procedures for Endorsement of Medicaid Reimbursable MH/DD/SA Services (revision effective 12/03/07) at <http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm#ep1207>

Sincerely,



Signature (LME Designee)

Sylvia Davis, Quality Assurance Specialist



Signature

Billie M. Pierce, Director

Page 2 of 3

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

cc: DMH/DD/SAS (endorsements.accountability@ncmail.net)

- * Involuntary Withdrawal of Endorsement **must** be signed by the Endorsing Agency CEO (LME Director).
- ** Under additional comments section, list each service to be withdrawn including: corresponding site specific address and Medicaid Number and primary reason for withdrawal.
- *** If this Notification of Endorsement Action communicates a denial or withdrawal of endorsement, you may appeal this decision. *If this endorsement action affects Community Support-Child and/or Community Support - Adult Services, to appeal, you must file a Community Support Provider Petition within 30 days of the date of this letter. (You may obtain a copy of the form by calling the DHHS Hearing Office at (919) 647-8200.)* Instructions for filing your *Community Support-Child and/or Community Support - Adult Services* appeal are on the petition.

Your appeal rights are set forth in Section 10.15A.(e2) of S.L. 2007-107. *If this endorsement action pertains to any services other than Community Support-Child and/or Community Support-Adult, you must file an appeal with the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) within 15 days of the date of this letter.* Your appeal rights are set out in G. S. 122C-151.4 and in administrative rules at 10A N.C.A.C. 27G.0810.

If you have questions regarding this notice please contact Sylvia Davis at 641-4365. For questions about the Community Support appeal process or the petition, please contact the DHHS Hearing Office at (919) 647-8200. For questions about the appeal process for services other than Community Support, contact the DMH/DD/SAS Operations Section at (919) 715-2780.

- **** Attach copies of SA Licenses and or Waiver letters.