

# Notification of Endorsement Action

- Initial  
 Additional (service)  
 Change

April 6,, 2009

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

Phoenix Investments Group, LLC dba Angel Flight  
508 Quartz Drive  
Durham, NC, 27703-6648

Provider Federal ID #: 14-1912722  
Provider NPI #: 1124165113  
Provider Medicaid #: 3418199

Ms. Shoffner,

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

Name of the LME that Granted Business Verification: **Durham Center**  
Provider Business Name: **Phoenix Investments Group, LLC dba Angel Flight**  
Provider Contact Person: **Ms. Bridgett Shoffner**  
Business Mailing Address: **508 Quartz Drive, Durham, NC 27703-6648**  
Business Phone: **(336) 957-1725**  
Physical Site Address (specify provider name if different than above): 508 Quartz Drive,  
Durham, NC 27703-6648  
County: **Durham**  
Service Type(s): **CAP Waiver Services: Personal Care Services, and Home and Community Supports , Enhanced Personal Care Services**

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 (see comments)	
<input type="checkbox"/> Voluntary	
<input checked="" type="checkbox"/> Involuntary *	04/06/09

#### Type of Withdrawal

- Business Withdrawal  
 Enhanced Service(s) Withdrawal\*\*  
 CAP-MR/DD services withdrawal  
 Community Support Adult or Child Withdrawal \*\*\*

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

Notification Sent Statewide  Yes  No

**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 Required (include reason for denial or withdrawal): **Failure to comply with any provisions of the Standard Agreement; i.e. failure to maintain insurance coverage.**

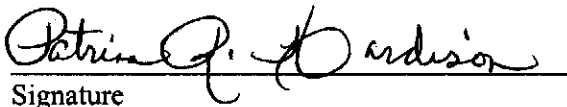
It is the provider's responsibility to enroll with the Division of Medical Assistance (DMA). Just as endorsement is service specific, so too is enrollment. You must enroll each service provided at each location with DMA. The website for DMA is <http://www.dhhs.state.nc.us/dma/> and the phone # is (919) 855-4050. Please contact them directly to assure that you are properly enrolled.  
and the phone # is (919) 855-4050. Please contact them directly to assure that you are properly enrolled.

Sincerely,

 (LME Designee)

Signature

Billie M. Pierce, Director

 (LME Designee)

Signature

Patrina R. Hardison MS QMHP, Quality Assurance Specialist

cc: DMH/DD/SAS ([endorsements.accountability@ncmail.net](mailto: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, Patrina Hardison, at The Guilford Center, Phone #(336) 641-6492. 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.