

Notification of Endorsement Action

August 26, 2009

- Initial
- Additional
- Change

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

Provider Federal ID #: 27-0270104
 Provider NPI #: 1396971685
 Provider Medicaid #:

Reign & Inspirations, LLC
 218 S. Swing Rd. Ste. 1
 Greensboro, NC 27409-2051

Dear Reign & Inspirations, LLC:

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: Reign & Inspirations, LLC

Provider Contact Person: Danielle D. Little and Sheneika M. Alford

Business Mailing Address: 218 S. Swing Rd. Ste. 1 Greensboro, NC 27409-2051

Business Phone: (336) 471-5342

Physical Site Address (specify provider name if different than above): 218 S. Swing Rd. Ste. 1 Greensboro, NC 27409-2051

County: Guilford

Service Type(s): Diagnostic Assessment

STATUS	EFFECTIVE DATE
<input type="checkbox"/> Business Verification	mm/dd/yy / / to / /
<input type="checkbox"/> Endorsement	mm/dd/yy
<input type="checkbox"/> Endorsement Pending	mm/dd/yy
<input type="checkbox"/> Due to Referral to DHSR (Date Pended)	mm/dd/yy
<input type="checkbox"/> Other (see comments)	mm/dd/yy
<input checked="" type="checkbox"/> Denial of Endorsement (see comments)	08/26/09
<input type="checkbox"/> Withdrawal of Endorsement (see comments)	mm/dd/yy
<input type="checkbox"/> Voluntary	mm/dd/yy
<input type="checkbox"/> Involuntary *	mm/dd/yy
Type of Withdrawal	mm/dd/yy
<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	08/26/09

SUBSTANCE ABUSE SERVICES (if applicable)

SAOP:

License type*****

.3700 and waiver; or

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

.4400

SACOT:

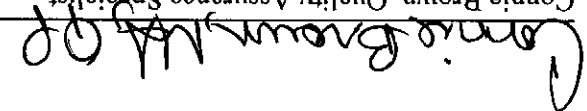
License type*****

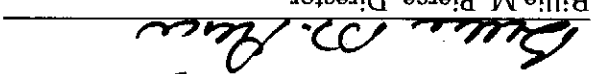
.3700 and waiver; or

.4500

Additional Comments Required (include reason for denial or withdrawal): 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 professional required to provide or supervise treatment.

Sincerely,


Connie Brown, Quality Assurance Specialist
(LME Designee)


Billie M. Pierce, Director

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 _____ (LME Rep. Name) _____, at _____ Phone# _____. 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.