

# Notification of Endorsement Action

- Initial
- Additional (service)
- Change

March 24, 2009

The Guilford Center  
232 N. Edgeworth Street, 3<sup>rd</sup> Floor  
Greensboro, NC 27401

Sharon's Place  
4423 Summit Ave.  
Greensboro, NC 27405

Provider Federal ID #: 83-0388782  
Provider NPI #:  
Provider Medicaid #: 3408074

Dear Sharon's Place,

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: Sharon's Place  
 Provider Contact Person: Joni Morrison, Director  
 Business Mailing Address: 4423 Summit Avenue Greensboro, NC 27405  
 Business Phone: 336-358-8517  
 Physical Site Address (specify provider name if different than above): 4423 Summit Ave. Greensboro, NC 27405  
 County: Guilford  
 Service Type(s): CAP Waiver Service (Residential Supports)

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 type="checkbox"/> Denial of Endorsement (see comments)	mm/dd/yy
<input checked="" type="checkbox"/> Withdrawal of Endorsement (see comments)	
<input type="checkbox"/> Voluntary	mm/dd/yy
<input checked="" type="checkbox"/> Involuntary *	6/01/09
Type of Withdrawal	
<input checked="" type="checkbox"/> Business Withdrawal	6/01/09
<input checked="" type="checkbox"/> Enhanced Service(s) Withdrawal**	6/01/09
<input checked="" type="checkbox"/> CAP-MR/DD services withdrawal	6/01/09
<input checked="" type="checkbox"/> Community Support Adult or Child Withdrawal ***	6/01/09
Notification Sent Statewide <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	4/20/09

**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

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Additional Comments Required (include reason for denial or withdrawal): Your agency is receiving an involuntary withdrawal of endorsement due to his failure to meet other conditions of participation with the Division of Medical Assistance. As of February 01, 2009, the provider failed to meet a National Accreditation Benchmark for CAP / MR-DD services. Specifically, the provider failed to comply with 122C-81 in that nine months prior to the accreditation deadline and formal selection of an accrediting agency as documented by a letter from the agency to the provider acknowledging the provider's selection of that accrediting agency was not demonstrated. A provider failing to meet this benchmark shall be prohibited from admitting new clients to service. When a provider fails to meet this benchmark, the LME shall work with the provider to transfer all the provider's entire case load to another provider within four months of the date of the provider's failure to meet the benchmark. The transfer of the case load shall be in increments such that not fewer than twenty-five percent (25%) of the provider's total caseload shall be transferred per month. **The Department shall terminate the provider's enrollment in the Medicaid program within four months of the provider's failure to meet the benchmark.**

A provider that has its enrollment terminated in the Medicaid program as a result of failure to meet benchmarks for national accreditation or failure to continue to be nationally accredited may not apply for re-enrollment in the Medicaid program for at least one year following its enrollment termination.

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,

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Connie Brown, Quality Assurance Specialist

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Billie M. Pierce, Director

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 Connie Brown, The Guilford Center, (336)641-8017. 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.