EXHIBIT 281

MODEL LETTER COMMUNITY MENTAL HEALTH CENTER (CMHC) THAT HAS CEASED OPERATING

(**Date**)

Community Mental Health Center Name
Address
City, State, ZIP Code

Dear _____:

RE: Provider Number (**Provider Number**)

This is to notify you that we determined that (**name and address of provider**) has closed on (**actual date of closing, or if unknown, date established by the RO**). Under the provisions of 42 CFR Part 489.52(b)(3), your provider agreement with the Secretary of Health and Human Services will be terminated (**date**). No payment can be made under the Medicare program for services on or after that date.

This determination is based on the following: On (**date**), this office sent you a notice concerning (**purpose of notice**). The notice which was sent to your facility's last address of record was subsequently returned to this office by the U.S. Postal Service as undeliverable. We then contacted (**list the names of all other entities that were contacted; e.g., State survey agencies, State mental health associations, etc., and the date they were contacted**) in an effort to locate your facility. Those attempts were unsuccessful. We also contacted (**name of servicing intermediary**) and were informed that your facility stopped billing (or has never submitted bills, if applicable) Medicare on (**last day of billing**).

The (**name and address of provider**) will no longer participate in the Medicare program (Title XVIII of the Social Security Act) effective (**date**). The agreement between (**name of provider**) and the Secretary of Health and Human Services will be terminated on (**date of termination**) in accordance with the Social Security Act.

If you disagree with this notice, you must respond in writing to this office within 15 days of the date of this notice. We will publish a public notice of your facility's termination in the (**name of local newspaper**).

If your facility is reopened and you again wish to participate as a CMHC provider, you should contact (**name of State survey agency**). They will assist you in taking the actions necessary to become certified for participation as a provider. Please let me know if you have any questions concerning this action.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)