Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 01L003	**(X3) Date Survey Completed** 03/26/2026
Name of Provider or Supplier Hc Partnership	**Street Address, City, State** 6869 5th Ave South, Birmingham, AL	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
N0000	A recertification survey was conducted on 3/24/26 to 3/26/26 at Hill Crest Behavioral Health Services. Standard level deficiencies were cited and will require an approved Plan of Correction.