**State of Tennessee**
**Health Facilities Commission**
**Andrew Jackson State Building**
502 Deaderick Street, 9th Floor, Nashville, TN 37243
**www.tn.gov/hfc** Phone: 615-741-7221

July 10, 2026 Sent Via Email

Abigail Jennings (cbhelpinghands.llc@gmail.com)
C. B. Helping Hands LLC
132 Grace Circle
Clinton, TN 37716

Facility Type: Home Health Agencies

Dear Abigail Jennings:

It is my pleasure to inform you that your application for licensure of C. B. HELPING HANDS, LLC located at 132 Grace Circle, Clinton, TN 37716 has been initially approved July 10, 2026. The license number shall be 730. For this initial approval to become final and permanent, your application must be ratified by the Commission pursuant to T.C.A. §68-11-206. The Commission will consider your application at its next meeting, scheduled for August 26, 2026 . **You are hereby authorized to commence operation pending the final decision of the Commission**.

**For certification purposes, please be advised it is your responsibility to contact your Health Facilities Commission regional office for participation in Medicare/Medicaid. The East Regional Office phone number is 865-594-0730.**

If the Commission **does** ratify the approval of your application, the license number listed above will become your permanent license number and a letter will be forwarded to you within three (3) business days; notifying you of the Commission's final decision.

If the Commission **does not** ratify the initial approval of your application, a letter will be forwarded to you providing an explanation and specific instructions as to any action(s) you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

Please contact me if I can be of further assistance.

Sincerely,
Donald Michael Black II
Donald Michael Black II
Health Facilities Commission

cc: East Tennessee Regional Office

# APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HHA License # (if applicable): 730 County: Anderson

Add Counties _____ Initial X Renovation _____ Satellite/Off Campus Location_____

Physical Plant/Services/New Addition _____ Relocation/Replacement Facility_____
**(Circle One)** **(Circle One)**

Facility Name: C.B Helping Hands LLC

Address: 132 Grace Circle City: Clinton Zip Code: 37716

Application and fee on file in Central Office (CO)?: Yes X No ____ CON #:_____

Project #: _____ Phase: _____ of _____

Facility approved for (if satellite/off campus site include address): Skilled Nursing, Home Health Aid Services, and Homemaker Services in All counties

Sprinklered: _____(Full 100%) Partial: _____(%)

Licensed bed count from: _____ to _____ Number of beds increased/decreased:_____

Total Licensed bed count:_____

If secured unit, number of beds in unit: _____ If Alzheimer's unit, number of beds in unit: _____
**(NOTE: If this is an increase in the number of beds in a secured Alzheimer's unit, indicate number of beds approved for the increase number only)**

Health Surveyor: *Connie Baker* Date: 7/6/2026

Fire Safety: _____ Date: _____

CD Approved: Yes____ No____ N/A____ Health Survey Required: Yes X No____; if Yes, please indicate which region: ETRO

Facility's Letter of Notification received in Licensure: Yes ____ No ____ N/A
**(Completed by Central Office Licensure Staff)**

CMS Paperwork (855, etc) approved and received in regional office: Yes ____ No ____ N/A
**(NOTE: With exception of Initial Licensure Approvals)**

Effective date: 7/10/2026 Licensure is recommended: Yes X No ____
**(Completed by Central Office Licensure Staff)**

*Tom A. Lane, RN/L* 7/6/2026
Regional Administrator/Facilities Construction Director or Designee Date

Donald Black 7/10/2026
Licensure Program Unit Staff Date

**State of Tennessee**
**Health Facilities Commission**
**Andrew Jackson State Building**
502 Deaderick Street, 9th Floor, Nashville, TN 37243
**www.tn.gov/hfc** Phone: 615-741-7221

May 27, 2026 Sent Via Email

Abigail Jennings (cbhelpinghands.llc@gmail.com)
C. B. Helping Hands, LLC
132 Grace Circle, Unit B
Clinton, TN 37716

Dear Abigail Jennings:

This is to acknowledge receipt of your application and fee to apply for licensure of C. B. Helping Hands, LLC. Please review the instruction sheet that you received with the application to apply for licensure so that you are aware of the process for obtaining licensure of your facility. If a certificate of need is required to provide services, you will need to contact Health Facilities Commission at (615) 741-2364.

Please remember that if you are applying for a facility that requires architectural plan review contact Plans Review for complete details and procedures at (615) 741-6998. You must submit those plans along with the plans review fee prior to scheduling a survey. **For Homes for the Aged facilities specifically; TCA-368-11-202 allows "schematics shall be submitted to the department for approval of plans and specifications, converting and existing single-family dwelling" with six (6) or less beds.**

It is your responsibility to contact the East Tennessee Regional Office to request a survey of your facility. Please submit the request in writing to Tom A. Lane, Regional Administrator, 7175 Strawberry Plains Pike, Knoxville, Tennessee 37243. If you would like to email the request, you can email sara.e.walker@tn.gov.

Your application and fee will be held in a pending status until you are recommended by the Regional Office for licensure. Once the recommendation for licensure is received from the regional office, your facility will receive a letter for "Initial Approval." Admission of patients MAY NOT occur until the facility's receipt of the "Initial Approval" letter. Your application will be presented before the Board for Licensing Health Facilities Commission for ratification and final approval at the next regularly scheduled commission meeting. Your facility CAN operate once you receive the "Initial Approval."

This application will only be good for one (1) year from the date of receipt. If the initial licensure has not occurred within that one (1) year period, you will be required to submit a new application and fee unless you have contacted our office in writing extending your application.

In the event that a certificate of need is required prior to obtaining a license for this facility the application file will be closed the day following the expiration date of the certificate of need.

Should you have any questions or if I can be of assistance to you please call me at (615) 770-6922 or you may email me at eddie.stewart@tn.gov.

Sincerely,

Eddie J. Stewart
Eddie J. Stewart
Health Facilities Program Manager
Health Facilities Commission
Licensure Unit

ETRO Emailed
ITSO emailed 5/27/26
ejs

RECEIVED MAY 12 2026

F # 730
A # 13358

# HOME HEALTH SERVICES
# APPLICATION FOR INITIAL LICENSURE

*All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at https://www.tn.gov/hfc/division-of-licensure-and-regulation/hfc-licensure/licensure-applications.html. Please check this website periodically for updates.*

Name of the Facility/Agency C.B. Helping Hands LLC

**Location of the Facility:**

Street 132 Grace Cir unit B City Clinton

County Anderson State Tennessee Zip 37716

Phone Number ( 865-351-0536 Fax Number ( 865-435-3155

Twenty-four (24) Hour Emergency Phone Number ( 865-712-3129

E-Mail Address cbhelpinghands.llc@gmail.com

**Administrator Information:**

Administrator Abigail Jennings

Have you (Administrator) ever been convicted of a crime involving injury or harm to person(s), financial or business management (e.g., assault, battery, robbery, embezzlement, fraud)? Yes ____ No X

If yes, what charge(s)? N/A

Location of Conviction N/A Date ____
(City) (County) (State)

**Mailing address if different from the Facility location address:**

Name C. B. Helping Hands LLC

Street 132 Grace Cir

City Clinton State TN Zip 37716

**Ownership of Building:**

Name Abigail Jennings Phone Number ( 865-712-3129

Street 132 Grace Cir

City Clinton State TN Zip 37716

1. Check type: Hospital Based ____ Nursing Home Based ____ Free Standing X

2. Check type: Licensed only Agency X Licensed/Medicaid Certified ____

3. Check type of services provided:

| | | | |
|---|---|---|---|
| a. Skilled Nursing | X | f. Home Health Aid Services | X |
| b. Physical Therapy | | g. Medical Supplies and Appliances | |
| c. Occupational Therapy | | h. Homemaker Services | X |
| d. Speech Therapy | | i. Other (please specify) | |
| e. Medical Social Services | | | |

4. Do you have a Certificate of Need (CON)? Yes ____ No X

If yes, what is the geographic area served by the Agency: (list county or counties) If additional space is needed, please use a separate page.

N/A

5. Do you provide services to a pediatric population? Yes ____ No X

If yes, what counties? ____

6. Is your agency a provider in the EEOICPA federal program? Yes X No ____

If yes, what counties? Anderson, Roane, Knox, Campbell, and surrounding counties (See Attachment)

7. Provide proof of the ability to meet the financial needs of the facility. See attached financial statement and supporting documentation

**OWNERSHIP OF BUSINESS:**

1. a. Check the type of Legal Entity:

Individual ____ Partnership ____ Corporation ____ Limited Liability Company X

Church Related ____ Government/County ____ Other ____

b. Check one: For Profit X Non-profit ____

c. Legal Entity checked in 1.a:

Name C.B. Helping Hands LLC Phone Number ( 865-351-0536

Address 132 Grace Circle Clinton, TN 37716

d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:

| Name | Street | City, State, Zip |
|---|---|---|
| Shelia Inusah | 132 Grace Circle | Clinton TN 37716 |
| Andreaus Benjamin | 115 Foxwood Circle | Oliver Springs TN 37840 |

*(If additional space is needed, please use a separate sheet)*

e. If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility? Yes ____ No X

f. If no to e., who has said authority? N/A

2. a. Is your facility/organization accredited by a **federally approved** accrediting body including but not limited to JCAHO, CARF, etc.? **Provide proof of accreditation.** No

Yes _____ No x Expiration Date _____

3. Is this facility chain affiliated? Yes _____ No x

4. If you have a parent company please provide the following information:

Name N/A Phone Number (_____) _____

Address _____

5. a. If a corporation, is there a holding company? Yes _____ No x

b. If yes, list the name, address and phone number of the holding company:

Name N/A Phone Number (_____) _____

Street _____

City _____ State _____ Zip _____

6. a. Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states? Yes _____ No x

b. If yes, list names and addresses of all such facilities:

N/A

_____

7. a. Do you have a contract with a management firm to operate this facility? Yes _____ No x

If yes, specify dates: From N/A To _____

b. If yes, please specify name of firm: _____

Phone Number (_____) N/A

_____

Street City, State, Zip

8. For any item in (8) a-h below, please identify, explain and provide documentation of the item(s) noted if response is "Yes". Have either the licensed entity for any of the other health care facilities in Tennessee and/or other states on the list in question (6.b.) above, OR the management firm listed in question (7.) above; been subjected to any of the following within the last (5) years:

**a. Licensure**

i) denied a license ? Yes____No x

ii) had a license suspended or revoked by any state licensure agency? Yes____No x

iii) been subject to a final order or judgment in a state licensure action? Yes____No x

**b. Convictions**

i) convicted of a criminal offense related to that person's involvement in any program under any state or Federal health care program (including Medicare, Medicaid, and Tricare)? Yes____No x

**c. Exclusion**

i) excluded from participation in Federal health care programs (Medicare, Medicaid, CHIP, or Tricare) in the past? Yes____No x

***(Note: "Excluded" is defined as a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS-OIG) that they may no longer be a provider for any federally funded healthcare***

*program).*

**d. Termination/Suspension**

i) suspended or terminated from participation in Medicare or Medicaid/TennCare programs? Yes____No X

***(Note: This would include involuntary termination of a nursing facility or skilled nursing facility by the Centers for Medicare and Medicaid Services (CMS) or state Medicaid agency).***

**e. Fraud and Abuse**

i) paid through settlement, or civil or criminal fines, any monies to the federal government or any state as a result of any administrative or judicial proceeding based on allegations of fraud or abuse involving claims related to the provision of health care items and services? Yes No X

**f. Corporate Integrity Agreement**

i) Is presently an entity covered by and subject the terms of a corporate integrity agreement? Yes____No X

***(Note: If yes, provide a copy of CIA)***

**g. Bankruptcy**

i) filed bankruptcy under any provision of the United States Bankruptcy Code? Yes____No X

**h. Civil Monetary Penalty (CMP)**

i) paid to the Centers for Medicare and Medicaid Services or any state Medicaid agency a civil money penalty equal to or greater than $250,000.00 as a result of an enforcement action during a survey? Yes____No X

***Failure to provide true and correct copies of any documents related to the items list in 8(a-h) listed above may be grounds for referral of the application for special consideration, and/or may be grounds for disciplines.***

***If the applicant answered "Yes" to any of the questions (a)-(h) above, please provide copies of any documentation associated with the event and/or sanction. The documentation should provide the Health Facilities Commission with sufficient information regarding the nature of the event and/or sanction, the current status of the issue, as well as details regarding what corrective action shave been implemented (as applicable).***

## VERIFICATION BY NOTARY PUBLIC:

Signee for application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or agency for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated (TCA) § 68-11-201.

Signee also certifies that a policy has been implemented to inform all employees of their obligation under TCA § 71-6-103 to report incidents of abuse or neglect.

Shelia Inusah — Applicant Signature

Owner / Director — Title or Position

Date

**STATE OF TENNESSEE**

County of Anderson

The above named applicant (print name) Shelia Inusah, being by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents thereof: that the statements concerning the above named facility or agency, therein contained, are correct and true to his/her own knowledge.

Subscribed to and sworn to on this 17th day of April (Month) 2026 (Year)

Notary Public: Tyler M. Pyle

My commission expires: 07/08/2029

**FEE SCHEDULE: (FEES ARE NON-REFUNDABLE) $1,404**

**State of Tennessee**
**Health Facilities Commission**
502 Deaderick Street, Andrew Jackson Building, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-2364 hsda.staff@tn.gov

# INITIAL NOTIFICATION OF HOME HEALTH ACCREDITATION FOR CON EXEMPTION

**Instructions: This form must be filed with the Health Facilities Commission by any person who intends to establish a health care institution or initiates any service specified in T.C.A. 68-11-1607 (a) (3) pursuant to the exemption provided in T.C.A. 68-11-1607 (r) or T.C.A. 68-11-1607 (r) This form must be emailed to hsda.staff@tn.gov.**

1. **REPORTING DATE:** 05/21/2026

2. **NAME AND ADDRESS OF PROVIDER**

C.B.HELPING HANDS L.L.C.
**Name**

132 GRACE CIR
**Address**

CLINTON | TN | 37716
**City** | **State** | **Zip**

3. **CONTACT PERSON OR AUTHORIZED AGENT REPORTING EXEMPTION**

ABIGAIL JENNINGS | RN/ADMIN
**Name** | **Title**

cbhelpinghands.llc@gmail.com
**Email Address**

C.B.HELPING HANDS L.L.C
**Company Name**

132 GRACE CIR
**Address**

CLINTON | TN | 37716
**City** | **State** | **Zip**

| 865-351-0536 | 865-435-3182 |
| --- | --- |
| **Phone Number** | **Fax Number** |

4. IF SEEKING THE ESTABLISHMENT OF A HOME HEALTH AGENCY UNDER EXEMPTION, DATE OF LICENSE SUBMISSION:

05/11/2026

5. IF CURRENTLY LICENSED, PROVIDE LICENSE #:

N/A

LIST CURRENT LICENSED COUNTIES:

COUNTIES LICENSED UNDER EEOICPA:

~~ANDERSON, ROANE,KNOX,CAMPBELL,AND SURROUNDING COUNTIES~~

COUNTIES LICENSED UNDER PEDIATRIC

N/A

COUNTIES LICENSED AS HOME INFUSION ONLY:

N/A

LIST ANY EXISTING CERTIFICATE OF NEED LIMITATIONS/CONDITIONS:

NONE

6. DESCRIPTION OF EXEMPTED ACTIVITY:

PRIVATE PAY AND EEIOCPA ONL Skilled Nursing, Home Health Aid Service Home Maker Services

LIST OF EXEMPTED COUNTIES TO BE ADDED UNDER THE FOLLOWING TYPES:

PEDIATRIC:

N/A

EEOICPA:

ANDERSON,ROANE,KNOX,CAMPBELL AND SURROUNDING COUNTIES (see Attachment 7)

7. **NAME AND ADDRESS OF PROVIDER**

C.B.HELPING HANDS L.L.C.
**Name**

132 GRACE CIR
**Address**

| CLINTON | TN | 37716 |
|---|---|---|
| **City** | **State** | **Zip** |

8. **ACCREDITATION (must be completed within 2 years of initial licensure)**

**Please Check**
*(Be advised that some accreditation organizations require 10 or more patients at a minimum before starting accreditation proceedings.)*

- ■ Community Health Accreditation Program, Inc.
- ■ Accreditation Commission for Health Care and/or other accrediting body with deeming authority for home health services from CMS and participation in the Medicare Quality Initiatives
- ■ Outcome and Assessment Information Set, and Home Health Compare, or other nationally recognized accrediting organization, for Home Health projects;

**I UNDERSTAND THAT A HOME HEALTH AGENCY THAT PROVIDES HOME HEALTH SERVICES WITHOUT A CERTIFICATE OF NEED TO PEDIATRIC AND/OR EEOICPA PATIENTS THAT FAILS TO COMPLY WITH THE ACCREDITATION REQUIREMENTS IS SUBJECT TO LICENSURE SANCTIONS.**

Abigail Jennings 5-21-26
**Signature** **Date**

ABIGAIL JENNINGS RN/ADMIN
**Printed Name**

C.B. Helping Hands LLC

(865) 351-0536
cbhelpinghands.llc@gmail.com
132 Grace Circle, Clinton, TN 37716

Good morning , Mr. Stewart,

Here is a list of counties you requested.

| | | | |
|---|---|---|---|
| ANDERSON | BLOUNT | MORGAN | PUTNAM |
| CAMPBELL | SCOTT | SEVIER | |
| ROANE | UNION | HAMILTON | |
| KNOX | LOUDON | CUMBERLAND | |

Also we will provide the following services:

SKILLED CARE, CASE MANAGEMENT, HOME HEALTH AIDE SERVICES AND HOMEMAKER SERVICES.

Thank you,

Abigail Jennings RN/ADMIN

C.B. HELPING HANDS LLC
132 Grace Circle
Clinton, Tennessee 37716
Email: cbhelpinghands.llc@gmail.com

Tennessee Department of Health
Health Facilities Commission
Nashville, Tennessee

# APPLICATION FOR LICENSURE—HOME CARE ORGANIZATION

April 2, 2026

To Whom It May Concern,

On behalf of **C.B. Helping Hands LLC**, I respectfully submit this application for licensure as a **Home Care Organization in the State of Tennessee.**

**C.B. Helping Hands LLC** is a non-medical home care agency committed to providing high-quality, compassionate, and client-centered care services to individuals in their homes. Our services are designed to support clients in maintaining independence, dignity, and safety while receiving assistance with activities of daily living.

Our agency operates under the guiding principle:
*"Care Rooted in Faith, Delivered with Excellence."*

We provide services through private pay and select insurance programs, including participation in applicable federal programs. All services are delivered in accordance with individualized care plans and physician-directed services.

ADMINISTRATION

- Owner/Director: **Shelia Inusah**
- Administrator: **Abigail Jennings, RN**

Both individuals meet all qualifications required for their respective roles and are committed to ensuring full compliance with all applicable state and federal regulations.

# C.B. HELPING HANDS LLC

Home Health Agency Licensure Application


**Owner/Director:**
Shelia Inusah

**Address:**
132 Grace Cir Unit B Clinton, TN 37716

**Phone:**
865-351-0536

**Email:**
cbhelpinghands.llc@gmail.com

**Division of Business and Charitable Organizations**
**Department of State**
State of Tennessee
312 Rosa L. Parks Avenue, 6th Floor
Nashville, Tennessee 37243
Phone: 615-741-2286
tncab.tnsos.gov/portal/

**Tre Hargett**
Secretary of State

03/23/2026

11501 Domain Drive, Suite 200
AUSTIN, TX 78758, USA

# Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepencies.

| | | | |
|---|---|---|---|
| Entity Name: | C.B.HELPINGHANDS LLC | | |
| SOS Control #: | 002096915 | Initial Filing Date: | 03/22/2026 |
| Entity Type: | Limited Liability Company (LLC) | Formation Locale: | TENNESSEE |
| Status: | Active | Duration Term: | Perpetual |
| Fiscal Year Close: | December | Annual Report Due: | 04/01/2027 |
| Business County: | Anderson | | |
| Managed By: | Member Managed | | |
| Obligated Member Entity: | No | | |

## Document Receipt

| | | | |
|---|---|---|---|
| Receipt #: 2026-344761 | | Filing Fee: | $300.00 |
| Payment: Credit Card - 3917796907 | | | $300.00 |

**Registered Agent Address:**
UNITED STATES CORPORATION AGENTS, INC.
5865 RIDGEWAY CENTER PARKWAY SUITE 384
MEMPHIS, TN 38120

**Principal Office Address:**
132 GRACE CIR
CLINTON, TN 37716
Anderson County, USA

Congratulations on the successful filing of your Articles of Organization - Limited Liability Company for **C.B.HELPINGHANDS LLC** in the State of Tennessee which is effective **03/22/2026**. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee. Please visit the Tennessee Department of Revenue website (www.tn.gov/revenue) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and receive it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

**Tracking Number**
**B2026274478**

# Articles Of Organization

**Division of Business and Charitable Organizations**
**Department of State**
State of Tennessee
312 Rosa L. Parks Avenue, 6th Floor
Nashville, Tennessee 37243
Phone: 615-741-2286
tncab.tnsos.gov/portal/

Control #: 002096915
Filed: 03/22/2026 05:02 AM
Tre Hargett
Secretary of State

**Tre Hargett**
Secretary of State

## Entity Information

**Entity Name:** C.B.HELPINGHANDS LLC

**Entity Type:** Limited Liability Company

**Fiscal Year Ending Month:** December

**Additional Designation:** *(No additional designation)*

**Series LLC ?**
☐ Yes ☑ No

**Principal Office Address**
132 GRACE CIR
CLINTON, TN 37716
Anderson County, USA

**Mailing Address**
132 GRACE CIR
CLINTON, TN 37716
Anderson County, USA

**Period of Duration:**
Perpetual

**Will this filing have a delayed effective date?**
☐ Yes ☑ No

**Nature of Business (NAICS):**
621610 - Home Health Care Services

**Other Provisions:**
*(No other provisions)*

Do you have additional uploads you would like to attach to this filing?
☐ Yes ☑ No

## Registered Agent Information

UNITED STATES CORPORATION AGENTS, INC.
5865 RIDGEWAY CENTER PARKWAY SUITE 384
MEMPHIS, TN 38120

## Member Information

**The Limited Liability Company will be:** Member Managed

**Do you have six or fewer members at the date of this filing?**
☑ Yes ☐ No

**Will this entity be registered as an Obligated Member Entity (OME)**
☐ Yes ☑ No

## Organizer's Signature

☑ By entering my name in the space provided below, I certify that I am authorized to file this document on behalf of this entity, have examined the document and, to the best of my knowledge and belief, it is true, correct and complete as of this day.

☑ The undersigned, acting as organizer of the limited liability company under the provisions of the Tennessee Revised Limited Liability Company Act, adopt the above Articles of Organization.

**Signed Electronically:** SHELIA GAIL INUSAH **Date:** 03/22/2026

**Tre Hargett**
Secretary of State

**Division of Business and Charitable Organizations**
**Department of State**
State of Tennessee
312 Rosa L. Parks Avenue, 6th Floor
Nashville, Tennessee 37243
Phone: 615-741-2286
tncab.tnsos.gov/portal/

**Date:** 03/22/2026

**Invoice:** 2026-344761

**Customer Information**

C.B.HELPINGHANDS LLC
11501 Domain Drive, Suite 200
AUSTIN, TX 78758, USA

| Tracking # | Description | Amount Paid |
|---|---|---|
| B2026274478 | Articles of Organization - Limited Liability Company for C.B.HELPINGHANDS LLC (LLC Filings) | $ 300.00 |

**Payment Details**

| | |
|---|---|
| Fee Total: | $ 300.00 |
| Payment Total: | $ 300.00 |
| Amount Due: | $ 0.00 |

**Payment Method**

Payment Type: Credit Card
Check/Confirmation Number: 3917796907

# C.B. HELPING HANDS MINISTRIES

Entity Type: Foreign Nonprofit Corporation
Formed in: NEW MEXICO
Term of Duration: Perpetual
Religious Type: Non-Religious
Benefit Type: Mutual Benefit Corporation

Status: Active
Control Number: 001418801
Initial Filing Date: 4/21/2023 11:05:00 AM
Fiscal Ending Month: December
AR Due Date: 04/01/2027

**Registered Agent**
SHELIA G BENJAMIN INUSAH
13296 SMITHWICK LN
OLIVER SPRINGS, TN 37840

**Principal Office Address**
132 GRACE CIR
CLINTON, TN 37716

**Mailing Address**
132 GRACE CIR
CLINTON, TN 37716

AR Standing: Good | RA Standing: Good | Other Standing: Good | Revenue Standing: N/A

History (6)