

A060000000745

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP ☐ WAIT ☐ MAIL

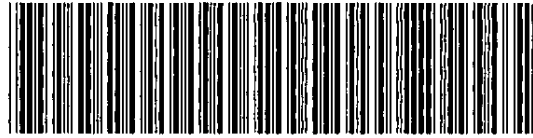
(Business Entity Name)

(Document Number)

Certified Copies \_\_\_\_\_ Certificates of Status \_\_\_\_\_

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FILED

2017 JUN -5 AM 8:26  
SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

RECEIVED

2017 JUN -5 PM 4:20  
SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

K. SALY

JUN - 6 2017

CORPORATION SERVICE COMPANY  
1201 Hays Street  
Tallahassee, FL 32301  
Phone: 850-558-1500

ACCOUNT NO. : I20000000195

REFERENCE : 670346 5028257

AUTHORIZATION

COST LIMIT : \$ 52.50

ORDER DATE : June 5, 2017

ORDER TIME : 3:50 PM

ORDER NO. : 670346-005

CUSTOMER NO: 5028257

DOMESTIC FILINGS

NAME: THE COMMUNITY BASED CARE  
PARTNERSHIP, LTD.

XX ARTICLES OF DISSOLUTION

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

           CERTIFIED COPY  
XX            PLAIN STAMPED COPY  
           CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Melissa Zender - EXT#

EXAMINER'S INITIALS: \_\_\_\_\_

**COVER LETTER**

**TO:** Registration Section  
Division of Corporations

**SUBJECT:** The Community Based Care Partnership, Ltd.  
(Name of Florida Limited Partnership or Limited Liability Limited Partnership)

The enclosed Certificate of Dissolution and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to:

Maria Ayub  
(Contact Person)

Magellan Health, Inc.  
(Firm/Company)

6950 Columbia Gateway Drive  
(Address)

Columbia MD 21046  
(City, State and Zip Code)

For further information concerning this matter, please call:

Maria Ayub at ( 410 ) 953-4702  
(Name of Contact Person) (Area Code and Daytime Telephone Number)

Enclosed is a check for the following amount:

- |                                                        |                                                                             |                                                                    |                                                                                               |
|--------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> \$52.50 Filing Fee | <input type="checkbox"/> \$61.25 Filing Fee<br>and Certificate of<br>Status | <input type="checkbox"/> \$105.00 Filing Fee<br>and Certified Copy | <input type="checkbox"/> \$113.75 Filing Fee,<br>Certified Copy, and<br>Certificate of Status |
|--------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|

**STREET ADDRESS:**  
Registration Section  
Division of Corporations  
Clifton Building  
2661 Executive Center Circle  
Tallahassee, FL 32301

**MAILING ADDRESS:**  
Registration Section  
Division of Corporations  
P. O. Box 6327  
Tallahassee, FL 32314

**CERTIFICATE OF DISSOLUTION  
FOR**

**FILED**  
**2017 JUN -5 AM 8:26**  
**SECRETARY OF STATE**  
**TALLAHASSEE, FLORIDA**

The Community Based Care Partnership, Ltd.

(Name of Florida Limited Partnership or Limited Liability Limited Partnership)

Pursuant to the provisions of section 620.1203, Florida Statutes, this Florida limited partnership or limited liability limited partnership, whose certificate was filed with the Florida Department of State on June 6, 2006, assigned Florida document number A06000000745, hereby submits this Certificate of Dissolution.

**FIRST:** Reason for dissolution: (State why partnership is submitting dissolution)

The entity no longer conducts any business.

**SECOND:** ☐ A Notice of Dissolution is attached.  
(Check box if attached.)

**THIRD:** Effective date, if other than the date of filing: Upon filing

*(Effective date cannot be prior to nor more than 90 days after the date this document is filed by the Florida Department of State.)*

Signatures of each general partner or the person appointed pursuant to s. 620.1803(3) or (4), F.S.:

Magellan Behavioral Health of Florida, Inc.

By: [Signature]  
John DiBernardi, Assistant Secretary

Community Based Care of Seminole, Inc.

By: [Signature]

Filing Fee: \$52.50  
Certified Copy (optional): \$52.50  
Certificate of Status (optional): \$8.75