DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO 0938-0193

| **TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL** | 1. TRANSMITTAL NUMBER: **09-024** | 2. STATE **NC** |
|---|---|---|
| **FOR: HEALTH CARE FINANCING ADMINISTRATION** | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE<br>**October 1, 2009** | |

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

| 6. FEDERAL STATUTE/REGULATION CITATION: | 7. FEDERAL BUDGET IMPACT: |
|---|---|
| 42 CFR 430.130(d) | a. **FFY 2010** **($32,715,454)**<br>b. **FFY 2011** **($79,606,312)** |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br>**Attachment 3.1-A.1, Page 15a.2, Attachment 3.1-A.1,Page 15a.2a, Attachment 3.1-A.1,Page 15a.2c, Attachment 3.1-A.1,Page 15a.2e, Attachment 3.1-A.1,Page 15a.2g, Attachment 3.1-A.1,Page 15a.2h, and Attachment 3.1-A.1,Page 15a.2i** | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:<br>**Attachment 3.1-A.1, Page 15a.2, Attachment 3.1-A.1,Page 15a.2a, Attachment 3.1-A.1,Page 15a.2c, Attachment 3.1-A.1,Page 15a.2e, Attachment 3.1-A.1,Page 15a.2g, Attachment 3.1-A.1,Page 15a.2h, and Attachment 3.1-A.1,Page 15a.2i** |

10. SUBJECT OF AMENDMENT:

**Community Support - Adults**

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: SECRETARY

| 12. SIGNATURE OF STATE AGENCY OFFICIAL: [signature] | 16. RETURN TO: |
|---|---|
| 13. TYPED NAME:<br>Lanier M. Cansler | Office of the Secretary<br>Department of Health and Human Services<br>2001 Mail Service Center<br>Raleigh, North Carolina 27699-2001 |
| 14. TITLE:<br>Secretary | |
| 15. DATE SUBMITTED:<br>10-7-09 | |

FOR REGIONAL OFFICE USE ONLY

| 17. DATE RECEIVED: 10/07/09 | 18. DATE APPROVED: 01/27/10 |
|---|---|

PLAN APPROVED – ONE COPY ATTACHED

| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/09 | 20. SIGNATURE OF REGIONAL OFFICIAL: [signature] (for) |
|---|---|
| 21. TYPED NAME: Mary Kaye Justis, RN, MBA | 22. TITLE: Acting Associate Regional Administrator<br>Division of Medicaid & Children's Health Opns |

23. REMARKS:

FORM HCFA-179 (07-92)