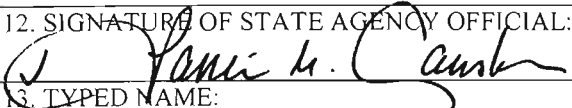
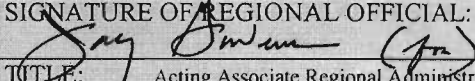


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-024	2. STATE NC
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE October 1, 2009	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input checked="" type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 430.130(d)		7. FEDERAL BUDGET IMPACT: a. FFY 2010 (\$32,715,454) b. FFY 2011 (\$79,606,312)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A.1, Page 15a.2, Attachment 3.1-A.1, Page 15a.2a, Attachment 3.1-A.1, Page 15a.2c, Attachment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): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: SECRETARY <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Office of the Secretary Department of Health and Human Services 2001 Mail Service Center Raleigh, North Carolina 27699-2001	
13. TYPED NAME: Lanier M. Cansler			
14. TITLE: Secretary			
15. DATE SUBMITTED: 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: 	
21. TYPED NAME: Mary Kaye Justis, RN, MBA		22. TITLE: Acting Associate Regional Administrator Division of Medicaid & Children's Health Opns	
23. REMARKS:			