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

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **10-013**

2. STATE: **NC**

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: **April 1, 2010**

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:
42 CFR 440.130(d)

7. FEDERAL BUDGET IMPACT:
a. **FFY 2010 $ 0.00**
b. **FFY 2011 $ 0.00**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A.1 Page 7c.1, Attachment 3.1-A.1 Page 7c.1a, Attachment 3.1-A.1 Page 7c.4, Attachment 3.1-A.1 Page 7c.6, and Attachment 3.1-A.1 Page 15a.6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A.1 Page 7c.1, Attachment 3.1-A.1 Page 7c.4, Attachment 3.1-A.1 Page 7c.6, and Attachment 3.1-A.1 Page 15a.6

10. SUBJECT OF AMENDMENT:
Critical Access Behavioral Health Agency (CABHA)

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:
✓ Lanier M. Cansler

13. TYPED NAME:
Lanier M. Cansler

14. TITLE:
Secretary

15. DATE SUBMITTED:
4-30-10

16. RETURN TO:
Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 04/30/10

18. DATE APPROVED: 06/25/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
04/01/10

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Glaze

21. TYPED NAME:
Jackie Glaze

22. TITLE:
Associate Regional Administrator
Division of Medicaid & Children's Health Opns

23. REMARKS:

Approved with the following changes to items 8 and 9 as authorized by State Agency on email dated 06/24/10.

Block #8 Attachment 3.1-A.1 pages 7c.1, 7c.1a, 7c.4, 7c.6 and 15a.6 **Changed to read: Block# 8.** Attachment 3.1-A.1 Page 7c.1, Attachment 3.1-A.1 Page 7c.1a, Attachment 3.1-A.1 Page 7c.1b, Attachment 3.1-A.1 Page 7c.1c, Attachment 3.1-A.1 Page 7c.4, Attachment 3.1-A.1 Page 7c.6, Attachment 3.1-A.1 Page 15a, Attachment 3.1-A.1 Page 15a-i, Attachment 3.1-A.1 Page 15a-ii and Attachment 3.1-A.1 Page 15a.6; Block #9 Attachment 3.1-A.1 pages 7c.1, 7c.4, 7c.6 and 15a.6; **Change to read** Attachment 3.1-A.1 Page 7c.1, Attachment 3.1-A.1 Page 7c.4, Attachment 3.1-A.1 Page 7c.6, Attachment 3.1-A.1 Page 15a and Attachment 3.1-A.1 Page 15a.6