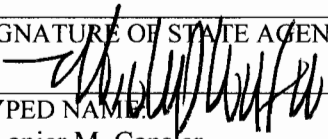
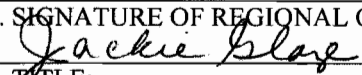


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 12-003	2. STATE NC
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE February 1, 2012	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <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 (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: CFR 440.167		7. FEDERAL BUDGET IMPACT: a. FFY 2012 (\$0.00) b. FFY 2013 (\$0.00)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A.1, Page 19, Attachment 4.19-B, Section 23, Page 6, Attachment 4.19-B, Section 23, Page 6b, and Attachment 4.19-B, Supplement 2, Page 1		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 3.1-A.1, Page 19, Attachment 4.19-B, Section 23, Page 6, Attachment 4.19-B, Section 23, Page 6b, and Attachment 4.19-B, Supplement 2, Page 1	
10. SUBJECT OF AMENDMENT: Personal Care Services -Child/Adults			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <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: 1-20-12			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 01/20/12		18. DATE APPROVED: 02/28/12	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 02/04/12		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns	
23. REMARKS: Approved with the following changes to item 4 as authorized by State Agency on email dated 02/22/12: Blocked #4 changed to read: February 4, 2012. Blocked #8 changed to read: Attachment 3.1-A.1, page 19; Attachment 4.19-B Section 23 page 6 and 6b; Attachment 4.19-B Supplement I, page 1b; Attachment 4.19-B, Supplement 2, page 1.			