

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

**TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

1. TRANSMITTAL NUMBER: 12-005	2. STATE NC
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE May 1, 2012	

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: CFR 440.167	7. FEDERAL BUDGET IMPACT: a. FFY 2013 (\$28,788,077) b. FFY 2014 (\$28,814,468)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A.1, Page 19, Attachment 3.1-A.1, Page 20, Attachment 3.1-A.1, Page 21, Attachment 3.1-A.1, Page 22, Attachment 3.1-A.1, Page 23, Attachment 3.1-A.1, Page 24, Attachment 3.1-A.1, Page 25, Attachment 3.1-A.1, Page 26, Attachment 4.19-B, Section 23, Page 6, Attachment 4.19-B, Section 23, Page 6b, Attachment 4.19-B, Supplement 1, Page 1b and Attachment 4.19-B, Supplement 2, Page 1	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A.1, Page 19, Attachment 3.1-A.1, Page 20, Attachment 3.1-A.1, Page 21, Attachment 3.1-A.1, Page 22, Attachment 3.1-A.1, Page 23, Attachment 3.1-A.1, Page 24, Attachment 3.1-A.1, Page 25, Attachment 3.1-A.1, Page 26, Attachment 4.19-B, Section 23, Page 6, Attachment 4.19-B, Section 23, Page 6b, Attachment 4.19-B, Supplement 1, Page 1b and Attachment 4.19-B, Supplement 2, Page 1

10. SUBJECT OF AMENDMENT:

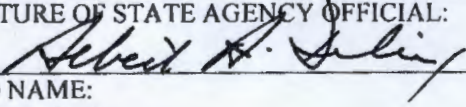
Personal Care Services -Child/Adults

11. GOVERNOR'S REVIEW (Check One):

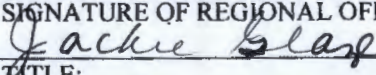
GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: SECRETARY

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

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: Albert A. Delia	
14. TITLE: Secretary	
15. DATE SUBMITTED: 4-03-2012	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 04-03-2012	18. DATE APPROVED: 4-4-2012
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 05-01-2012	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Jackie Glaze	22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health OPNS
23. REMARKS:	