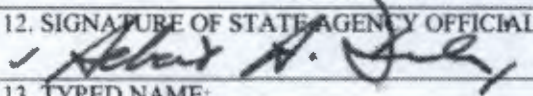
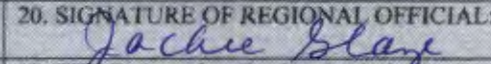


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER:  12-009	2. STATE  NC
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE  July 1, 2012	
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:  Section 1905(a)		7. FEDERAL BUDGET IMPACT: a. FFY 2011 \$0 b. FFY 2012 \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 3.1-A.1 Page 7c.1c, 7c.3, 7c.3a, 7c.3b, 7c.3c, 7c.3d, 7c.3e, 7c.3f, 7c.3g, 7c.3h, 7c.3i, 7c.3j, 7c.3k; Attachment 3.1-A.1, Page 15a.ii, 15a.1, 15a.2, 15a.2a, 15a.2b, 15a.2c, 15a.2d, 15a.2e, 15a.2f, 15a.2g, 15a.2h, 15a.2i, 15a.2j, and 15a.3		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Attachment 3.1-A.1 Page 7c.1c, 7c.3, 7c.3a, 7c.3b, 7c.3c, 7c.3d, 7c.3e, 7c.3f, 7c.3g, 7c.3h, 7c.3i, 7c.3j, 7c.3k; Attachment 3.1-A.1, Page 15a.ii, 15a.1, 15a.2, 15a.2a, 15a.2b, 15a.2c, 15a.2d, 15a.2e, 15a.2f, 15a.2g, 15a.2h, 15a.2i, 15a.2j, and 15a.3	
10. SUBJECT OF AMENDMENT:  Community Support – Adult and Community Support – Child Language Removal			
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: Albert A. Delia			
14. TITLE: Secretary			
15. DATE SUBMITTED: 7-19-12			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 07/20/12		18. DATE APPROVED: 10/17/12	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/12		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns	
23. REMARKS:			