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	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)*:

☐ 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: **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.lc, 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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A.1 Page 7c.lc, 7c.3, 7c.3a, 7c.3b, 7c.3c, 7c.3d, 7c.3e, 7c.3f, 7c.3g, 7c 3h, 7c.3i, 7c.3j, 7c.3k;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)*:

☐ 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: [signature]	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	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 07/20/12	18. DATE APPROVED: 10/17/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/12	20. SIGNATURE OF REGIONAL OFFICIAL: Jackie Glaze
21. TYPED NAME: Jackie Glaze	22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns

23. REMARKS: