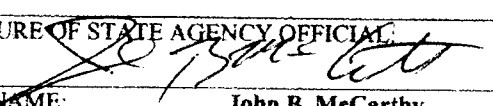
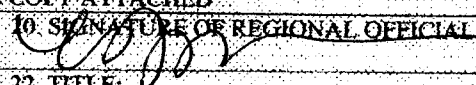


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>11 - 007</b>	2. STATE <b>OHIO</b>
<b>FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2011	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> <b>AMENDMENT</b>			
<b>COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)</b>			
6. FEDERAL STATUTE/REGULATION CITATION: 1905(a)(19) of the Social Security Act; 1915(g)(2) of the Social Security Act; 42CFR430.12(c); 42CFR440.169; 42CFR440.225; 42CFR441.18		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, Item 19-a, Page 1 of 1  Supplement 1 to Attachment 3.1-A, Pages 1-C through 8-C [Target Group C: DODD] [Pages 1 through 8]		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A, FROM PRE-PRINT PAGE 8, Item 19, Page 1 of 1 (TN# 90-38); Supplement 1 to Attachment 3.1-A, From Pre-Print Page 8, Pages 1-C and 2-C (TN # 05-004); Appendix A to Attachment 3.1-A, Preprint Page 8, page 1-C, pages 1 through 6 (TN # 05-004) <b>DELETE</b>	
10. SUBJECT OF AMENDMENT: Medicaid coverage of targeted case management services provided to individuals with mental retardation and developmental disabilities			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> <b>OTHER, AS SPECIFIED:</b> <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <b>Governor has delegated signature authority to ODJFS Director. Director has delegated signature authority to Medicaid Director</b> <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:  Becky Jackson OHP/Bureau of Policy and Health Plan Services Ohio Department of Job and Family Services P.O. BOX 182709 Columbus, Ohio 43218	
13. TYPED NAME: <b>John B. McCarthy</b>			
14. TITLE: <b>STATE MEDICAID DIRECTOR</b>			
15. DATE SUBMITTED: <b>6.30.11</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>06-30-11</b>		18. DATE APPROVED: <b>SEP 28 2011</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>07-01-11</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Verlon Johnson</b>		22. TITLE: <b>Associate Regional Administrator</b>	
23. REMARKS:			

**Instructions on Back**