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

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 10-003

2. STATE: South Carolina

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
October 1, 2010

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:
1902(a)(10)(A)(ii)(XIV) of The Act

7. FEDERAL BUDGET IMPACT:
a. FFY 09-10 $135,932,984
b. FFY 10-11 $92,181,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 2.2-A, Page 23b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 2.2-A, Page 23b

10. SUBJECT OF AMENDMENT:
To convert our stand-alone CHIP program, Healthy Connections Kids (HCK).to our current Medicaid/CHIP Expansion using the same income limits to revise our Children's Health Insurance Program (CHIP) State Plan amendment.

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:
Ms. Forkner was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Emma Forkner

14. TITLE:
Director

15. DATE SUBMITTED:
July 29, 2010

16. RETURN TO:
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 07/29/10

18. DATE APPROVED: 10/19/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/09

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Opns

23. REMARKS:

Approved with following changes as authorized by State Agency on email dated 09/24/10:

Block #7a and 7b changed to read: FFY 11 $ N/C and 7b FFY 12 $ N/C.

FORM HCFA-179 (07-92)