

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: SC 10-003	2. STATE South Carolina
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<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
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TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE October 1, 2010
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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
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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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  Attachment 2.2-A, Page 23b
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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*):

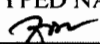
GOVERNOR'S OFFICE REPORTED NO COMMENT                       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED                      Ms. Forkner was designated by the  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL                      Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:  South Carolina Department of Health and Human Services Post Office Box 8206 Columbia, South Carolina 29202-8206
13. TYPED NAME: Emma Forkner	
14. TITLE: Director	
15. DATE SUBMITTED: July 29, 2010	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:                      07/29/10	18. DATE APPROVED: 10/19/10
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**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.