

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: SC 11-002	2. STATE South Carolina
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE 03/01/11	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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: In accordance with federal regulations (42 CFR 431.53)	7. FEDERAL BUDGET IMPACT FMAP 3/11-9/11((4,260,248) x 7/12 x 73.06%) 10/1/11 - 2/12 ((4,260,248) x 5/12 x 70.24%) a. FFY 2011 \$(1,815,648) b. FFY 2012 \$(1,246,834)
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 2 to Attachment 3.1-A, Pages 1 & 2 Attachment 3.1-A, Limitation Supplement; pages 9c thru 9h; and Attachment 4.19-B, pages 6h, 6h.2, 6h.3 & 6h.4	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 2 to Attachment 3.1-A, Pages 1 & 2 Attachment 3.1-A, Limitation Supplement; pages 9c thru 9h; and Attachment 4.19-B, pages 6h, 6h.2, 6h.3 & 6h.4
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10. SUBJECT OF AMENDMENT:
Transportation

11. GOVERNOR'S REVIEW (Check One):

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: Anthony E. Keck	South Carolina Department of Health and Human Services Post Office Box 8206 Columbia, SC 29202-8206
14. TITLE: Director	
15. DATE SUBMITTED: March 4, 2011	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 03-04-11	18. DATE APPROVED: 05-27-11
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 03-01-11	20. SIGNATURE OF REGIONAL OFFICIAL:
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21. TYPED NAME: Jackie Gilaze	22. TITLE: Associate Regional Administrator Division of Medicaid and Children's Health Opns
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23. REMARKS:
Approved with the following addition to Block 9:
"Delete Atch 4.19-B, page 6h.5 from the State Plan"