

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER:  10-007	2. STATE  NC
		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, 2010	
5. TYPE OF PLAN MATERIAL (Check One):  <input type="checkbox"/> NEW STATE PLAN <input checked="" type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:  SSA Section 1915(g)(1)		7. FEDERAL BUDGET IMPACT: a. FFY 2010 (\$ 8,933,938) b. FFY 2011 (\$71,471,502)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 1 to Attachment 3.1-A-Part E, Part I, Page 1, Supplement 1 to Attachment 3.1-A-Part E, Part I, Page 2, Supplement 1 to Attachment 3.1-A-Part E, Part I, Page 3, Supplement 1 to Attachment 3.1-A-Part E, Part I, Page 4, Supplement 1 to Attachment 3.1-A-Part E, Part I, Page 5 and Attachment 4.1-B, Section 19, Page 6,		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): N/A	
10. SUBJECT OF AMENDMENT:  TCM- Individuals with Mental Illness or Substance Use Disorders (MH/SA)			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: SECRETARY <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:  <i>[Signature]</i>		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: Lanier M. Cansler			
14. TITLE: Secretary			
15. DATE SUBMITTED: 5/14/10			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 05/14/10		18. DATE APPROVED: 07/16/10	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/10		20. SIGNATURE OF REGIONAL OFFICIAL:  <i>[Signature]</i>	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Opns	
23. REMARKS:  Approved with the following changes to items 8 and 9 as authorized by State Agency on email dated 07/19/10.  Block #8 Supplement 1 to Attachment 3.1-A-Part E, Part I, page 1, Supplement 1 to Attachment 3.1-A-Part I Page 2, Supplement 1 to Attachment 3.1-A-Part E, Part I Page 3, Supplement 1 to Attachment 3.1-A-Part E, Part I, Page 4, Supplement 1 to Attachment 3.1-A-Part E, Part I, Page 5, and Attachment 4.19-B, Section 19, Page 6. <b>Changed to read:</b> Block #8 Supplement 1 to Attachment 3.1-A-Part E, Part I, Page 1, Supplement 1 to Attachment 3.1-A-Part I Page 2, Supplement 1 to Attachment 3.1-A-Part E, Part I Page 3, Supplement 1 to Attachment 3.1-A-Part E, Part I, Page 4, Supplement 1 to Attachment 3.1-A-Part E, Part I, Page 5, Supplement 1 to Attachment 3.1-A-Part E, Part I, Page 6, and Attachment 4.19-B, Section 19, Page 6.			