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: **10-008**

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)*:

☐ 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:
42 CFR 430.130(d)

7. FEDERAL BUDGET IMPACT:
a. **FFY 2010 $ 52,355**
b. **FFY 2011 $212,713**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A.1, Page 7c.14, Attachment 3.1-A.1, Page 7g.1, Attachment 3.1-A.1, Page 7g.2, Attachment 3.1-A.1, Page 7g.3, Attachment 3.1-A.1, Page 7g.4, Attachment 3.1-A.1, Page 7g.5, Attachment 3.1-A.1, Page 7g.6, Attachment 3.1-A.1, Page 7g.6a, Attachment 4.19-B, Section 4, Page 2, and Attachment 4.19-B, Section 4, Page 2a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A.1, Page 7g.1, Attachment 3.1-A.1, Page 7g.2, Attachment 3.1-A.1, Page 7g.3, Attachment 3.1-A.1, Page 7g.4, Attachment 3.1-A.1, Page 7g.5, Attachment 3.1-A.1, Page 7g.6, Attachment 3.1-A.1, Page 7g.6a, Attachment 4.19-B, Section 4, Page 2, and Attachment 4.19-B, Section 4, Page 2a

10. SUBJECT OF AMENDMENT:
Early Intervention Rehabilitative Services

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: SECRETARY

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Lanier M. Cansler

14. TITLE:
Secretary

15. DATE SUBMITTED: 5/25/10

16. RETURN TO:
Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 05/27/10

18. DATE APPROVED: 05/16/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/10

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 the following changes to items 8 and 9 as authorized by State Agency on emails dated 04-07-11

Block # 8 Changed to read: Attachment 3.1-A.1, Page 7c.14, Attachment 3.1-A.1, Page 7c.15, Attachment 3.1-A.1, Page 7c.16, Attachment 3.1-A.1, Page 7c.17, Attachment 3.1-A.1, Page 7c.18, Attachment 3.1-A.1, Page 7g.1, Attachment 3.1-A.1, Page 7g.2, Attachment 3.1-A.1, Page 7g.3, Attachment 3.1-A.1, Page 7g.4, Attachment 3.1-A.1, Page 7g.5, Attachment 3.1-A.1, Page 7g.6, Attachment 3.1-A.1, Page 7g.6a, Attachment 4.19-B, Section 4, Page 2, and Attachment 4.19-B, Section 4, Page 2a.

Block # 9 Changed to read: Attachment 3.1-A.1, Page 7g.1, Attachment 3.1-A.1, Page 7g.2, Attachment 3.1-A.1, Page 7g.3, Attachment 3.1-A.1, Page 7g.4, Attachment 3.1-A.1, Page 7g.5, Attachment 3.1-A.1, Page 7g.6, Attachment 3.1-A.1, Page 7g.6a, Attachment 4.19-B, Section 4, Page 2, and Attachment 4.19-B, Section 4, Page 2a.