

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 10-015	2. STATE NC
FOR: HEALTH CARE FINANCING ADMINISTRATION		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 (<i>Check One</i>): <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 (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1915(g)(1)		7. FEDERAL BUDGET IMPACT: a. FFY 2010 (\$ 3,059,504) b. FFY 2011 (\$12,238,016)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Section 19, Page 3 and Attachment 4.19-B, Section 9, Page 4		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B, Section 19, Page 3 and Attachment 4.19-B, Section 9, Page 4	
10. SUBJECT OF AMENDMENT: Targeted Case Management			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <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: 6-11-10			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 06/11/10		18. DATE APPROVED: 09/03/10	
PLAN APPROVED – ONE COPY ATTACHED			
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 09/02/10. Block #8 Changed to read: Attachment 4.19-B, Section 19 page 3 and Supplement 1 to Attachment 3.1-A, pages 1 thru 22. Block #9 Changed to read: Attachment 4.19-B, Section 19 page 3 and Supplement 1 to Attachment 3.1-A pages 1 thru 10 and pages 11 thru 22(New).			