

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 10-020	2. STATE NC
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION		4. PROPOSED EFFECTIVE DATE July 1, 2010	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES			
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: Section 1915(g)(1)		7. FEDERAL BUDGET IMPACT: a. FFY 2010 (\$0.00) b. FFY 2011 (\$0.00)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Section 19, Page 1, Attachment 4.19-B, Section 19, Page 2, Attachment 4.19-B, Section 19, Page 3, Attachment 4.19-B, Section 19, Page 4, and Attachment 4.19-B, Section 19, Page 5		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, Section 19, Page 1, Attachment 4.19-B, Section 19, Page 2, Attachment 4.19-B, Section 19, Page 3, Attachment 4.19-B, Section 19, Page 4, and Attachment 4.19-B, Section 19, Page 5	
10. SUBJECT OF AMENDMENT: Targeted Case Management			
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:		16. RETURN TO:	
13. TYPED NAME: Lanier M. Cansler		Office of the Secretary Department of Health and Human Services 2001 Mail Service Center Raleigh, North Carolina 27699-2001	
14. TITLE: Secretary			
15. DATE SUBMITTED: 6/15/10			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 06/16/10		18. DATE APPROVED: 09/14/10	
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 email dated 09/08/10. Block #8: Changed to read: Attachment 4.19-B. Section 19 Pages 1, 2, 4, and 5; Block #9: Changed to read: Attachment 4.19-B. Section 19 Pages 1, 2, 4, and 5.			