

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER:  <b>10-027</b>	2. STATE  <b>NC</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		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  <b>January 1, 2011</b>	
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 1917(b)(1)(C)(iii)(IV) of the Social Security Act		7. FEDERAL BUDGET IMPACT: a. <b>FFY 2010- 2011</b> <b>\$0</b> b. <b>FFY 2011- 2012</b> <b>\$0</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Title of Attachment Page 2; Page 53b; and Supplement 8c to Attachment 2.6-A Pages 1 and 2.</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>Title of Attachment Page 2; and Page 53b</b>	
10. SUBJECT OF AMENDMENT:  <b>LONG TERM CARE PARTNERSHIP</b>			
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:  fob Lanier M. Cansler			
14. TITLE:  Secretary			
15. DATE SUBMITTED:  10-6-10			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:  10/12/10		18. DATE APPROVED:  01/06/11	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL:  01/01/11		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 item 9 as authorized by State Agency on email dated 11/06/10. Block # 9 Changed to read: Supplement 8c to Attachment 2.6-A pages 1 and 2			