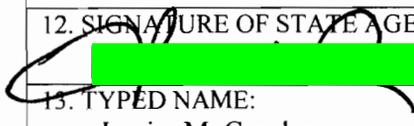
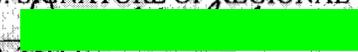


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 10-031	2. STATE NC
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2011	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: CFR 440.167		7. FEDERAL BUDGET IMPACT: a. FFY 2011 (\$ 76,539,557) b. FFY 2012 (\$145,631,706)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A.1, Page 19; Attachment 3.1-B, Page 8, Attachment 3.1-B, Page 9; Attachment 4.19-B, Section 23, page 6; and Attachment 4.19-B, Supplement 1, Page 1b		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A.1, Page 19; Attachment 3.1-B, Page 8, Attachment 3.1-B, Page 9; Attachment 4.19-B, Section 23, page 6; and Attachment 4.19-B, Supplement 1, Page 1b	
10. SUBJECT OF AMENDMENT: Discontinuing Personal Care Services			
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: 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: 10/22/10			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 10/25/10		18. DATE APPROVED: 04/15/11	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/11		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Opns	
23. REMARKS: <p>Approved with the following changes to items 8 and 9 as authorized by State Agency on emails dated 3/16/11 and 04/06/11.</p> <p>Block #8 Changed to read: Attachment 3.1-A.1 Pages 19 thru 26, pages 27 thru 31; Attachment 4.19-B, Section 23 page 6 and Attachment 4.19-B Supplement 1 page 1b.</p> <p>Block #9 Changed to read: Attachment 3.1-A.1 Pages 19 thru 26; Attachment 4.19-B, Section 23 page 6 and Attachment 4.19-B Supplement 1 page 1b.</p>			