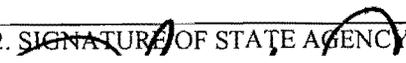


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 11-010	2. STATE NC
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2011	
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: 1915(g)(1)		7. FEDERAL BUDGET IMPACT: a. FFY 2011 \$ 0 b. FFY 2012 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A.1, Page 15a.7 B, Attachment 3.1-A.1, Page 15a.7 C, Attachment 3.1-A.1, Page 15a.7 D, Attachment 3.1-A.1, Page 15a.7 E, Attachment 3.1-A.1, Page 15a.7 F, Attachment 3.1-A.1, Page 15a.7 G, and Attachment 4.19-B, Section 3, Page 5h		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A.1, Page 15a.7 B, Attachment 3.1-A.1, Page 15a.7 C, Attachment 3.1-A.1, Page 15a.7 D, Attachment 3.1-A.1, Page 15a.7 E, Attachment 3.1-A.1, Page 15a.7 F, Attachment 3.1-A.1, Page 15a.7 G, and Attachment 4.19-B, Section 3, Page 5h	
10. SUBJECT OF AMENDMENT: Peer Support			
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: 6/14/11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 06/16/11		18. DATE APPROVED: 07/22/11	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/11		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Davida Kimble		22. TITLE: Division of Medicaid & Children's Health Opns.	
23. REMARKS:			