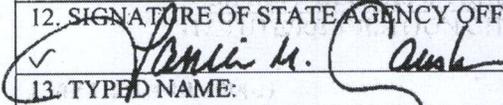
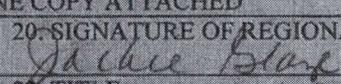


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 10-013	2. STATE NC
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2010	
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: 42 CFR 440.130(d)		7. FEDERAL BUDGET IMPACT: a. FFY 2010 \$ 0.00 b. FFY 2011 \$ 0.00	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A.1 Page 7c.1, Attachment 3.1-A.1 Page 7c.1a, Attachment 3.1-A.1 Page 7c.4, Attachment 3.1-A.1 Page 7c.6, and Attachment 3.1-A.1 Page 15a.6		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A.1 Page 7c.1, Attachment 3.1-A.1 Page 7c.4, Attachment 3.1-A.1 Page 7c.6, and Attachment 3.1-A.1 Page 15a.6	
10. SUBJECT OF AMENDMENT: Critical Access Behavioral Health Agency (CABHA)			
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: 4-30-10			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 04/30/10		18. DATE APPROVED: 06/25/10	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 04/01/10		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Gilgze		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 06/24/10. Block #8 Attachment 3.1-A.1 pages 7c.1, 7c.1a, 7c.4, 7c.6 and 15a.6 Changed to read: Block #8, Attachment 3.1-A.1 Page 7c.1, Attachment 3.1-A.1 Page 7c.1a, Attachment 3.1-A.1 Page 7c.1b, Attachment 3.1-A.1 Page 7c.1c, Attachment 3.1-A.1 Page 7c.4, Attachment 3.1-A.1 Page 7c.6, Attachment 3.1-A.1 Page 15a, Attachment 3.1-A.1 Page 15a-i, Attachment 3.1-A.1 Page 15a-ii and Attachment 3.1-A.1 Page 15a.6. Block #9 Attachment 3.1-A.1 pages 7c.1, 7c.4, 7c.6 and 15a.6. Change to read: Attachment 3.1-A.1 Page 7c.1, Attachment 3.1-A.1 Page 7c.4, Attachment 3.1-A.1 Page 7c.6, Attachment 3.1-A.1 Page 15a and Attachment 3.1-A.1 Page 15a.6			