DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **11-034**

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
October 1, 2011

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ 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 2012 ($3,098,084)**
b. **FFY 2013 $1,570,660**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Section 13, Page 1, Attachment 4.19-B, Section 13, Page 2, Attachment 4.19-B, Section 13, Page 3, Attachment 4.19-B, Section 13, Page 4, Attachment 4.19-B, Section 13, Page 5, Attachment 4.19-B, Section 13, Page, Attachment 4.19-B, Section 13, Page 7, Attachment 4.19-B, Section 13, Page 8, Attachment 4.19-B, Section 13, Page 9, Attachment 4.19-B, Section 13, Page 10,
Continued on Attached page

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Section 13, Page 1, Attachment 4.19-B, Section 13, Page 2, Attachment 4.19-B, Section 13, Page 3, Attachment 4.19-B, Section 13, Page 4, Attachment 4.19-B, Section 13, Page 5, Attachment 4.19-B, Section 13, Page, Attachment 4.19-B, Section 13, Page 7, Attachment 4.19-B, Section 13, Page 8, Attachment 4.19-B, Section 13, Page 9, Attachment 4.19-B, Section 13, Page 10,
Continued on Attached page

10. SUBJECT OF AMENDMENT:
Rehabilitation Services

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: SECRETARY

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Lanier M Cansler

13. TYPED NAME:
Lanier M. Cansler

14. TITLE:
Secretary

15. DATE SUBMITTED:
8/2/11

16. RETURN TO:
Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
08/04/11

18. DATE APPROVED:
03/05/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
11/01/11

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Glaze

21. TYPED NAME:
Jackie Glaze

22. TITLE:
Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS:

Approved with the following changes to item 4 as authorized by State Agency on email dated 02/27/12:

Blocked #4 changed to read: November 1, 2011.