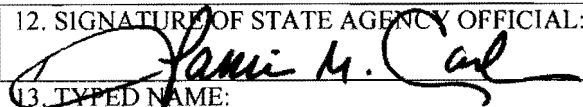



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: <div style="text-align: center;">11-041</div>	2. STATE <div style="text-align: center;">NC</div>
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <div style="text-align: center;">October 1, 2011</div>	
5. TYPE OF PLAN MATERIAL (Check One): <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> NEW STATE PLAN <input checked="" type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/> AMENDMENT </div> <div style="text-align: center; font-size: small;"> COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) </div>			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440.201		7. FEDERAL BUDGET IMPACT: a. FFY 2012 \$0 b. FFY 2013 \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Supplement 1, Page 1d		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, Supplement 1, Page 1d	
10. SUBJECT OF AMENDMENT: Local Education Agencies (LEA)			
11. GOVERNOR'S REVIEW (Check One): <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL </div> <div> <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: SECRETARY </div> </div>			
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: 8/2/11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 08/04/11		18. DATE APPROVED: 10/31/11	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 11/01/11		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Ophs	
23. REMARKS: Approved with the following changes to item 4 as authorized by State Agency on email dated 10/11/11: Blocked #4 changed to read: November 1, 2011.			