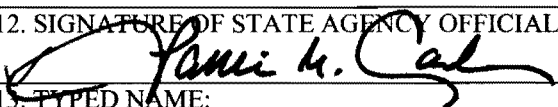
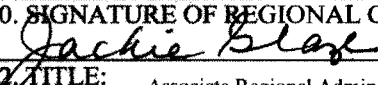


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: <div style="text-align: center;">11- 053</div>	2. STATE <div style="text-align: center;">NC</div>
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: 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 440.60; 42 CFR 440.120; 42 CFR 440.130; 42 CFR 440.225; 42 CFR 441.10; 42 CFR 441.30 and 42 CFR 433.56		7. FEDERAL BUDGET IMPACT: a. FFY 2012 \$139,454 b. FFY 2013 \$1,233,301	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 16 to Attachment 2.6-A, Page 1, Page 2 and Page 3.		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): N/A	
10. SUBJECT OF AMENDMENT: Asset Verification System			
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: 10/25/11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: <div style="text-align: right;">10/27/11</div>		18. DATE APPROVED: <div style="text-align: right;">1/20/12</div>	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <div style="text-align: right;">10/01/11</div>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <div style="text-align: right;">Jackie Glaze</div>		22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns	
23. REMARKS: <div style="margin-top: 20px;"> <p>Approved with the following changes to item 4 as authorized by State Agency on email dated: 1-10-12</p> <p><u>Block# 6 changed to read:</u> Section 1940(a) of the Act.</p> </div>			