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: **12-013**

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: **January 1, 2013**

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:
CFR 440.167

7. FEDERAL BUDGET IMPACT:
a. **FFY 2013 $8,975,848**
b. **FFY 2014 $7,492,339**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A.1, Page 19, Attachment 3.1-A.1, Page 20, Attachment 3.1-A.1, Page 21, Attachment 3.1-A.1, Page 23, Attachment 4.19-B, Section 23, Page 6, and Attachment 4.19-B, Supplement 1, Page 1b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A.1, Page 19, Attachment 3.1-A.1, Page 20, Attachment 3.1-A.1, Page 21, Attachment 3.1-A.1, Page 23, Attachment 4.19-B, Section 23, Page 6, and Attachment 4.19-B, Supplement 1, Page 1b

10. SUBJECT OF AMENDMENT:

Personal Care 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: [redacted]

13. TYPED NAME:
Albert A. Delia

14. TITLE:
Secretary

15. DATE SUBMITTED: 7-19-2012

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:
07/20/12

18. DATE APPROVED: 11/30/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01/01/13

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME:
Jackie Glaze

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

23. REMARKS:

Approved with the following changes to item 8 and 9 as authorized by State Agency e-mail dated 11/08/12:

Blocked #8 changed to read: Attachment 3.1-A.1 pages 19 thru 29; Attachment 4.19-B Section 23 page 6 and Attachment 4.19-B, Supplement 1 page 1b.

Blocked #9 changed to read: Attachment 3.1-A pages 19 thru 26; Attachment 4.19-B Section 23 page 6 and Attachment 4.19-B, Supplement 1 page 1b.