



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 12-014	2. STATE NC
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 July 1, 2012	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <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 (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 4130.10		7. FEDERAL BUDGET IMPACT: a. FFY 2013 \$0 b. FFY 2014 \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A.1 Page 7c.1b, Attachment 3.1-A.1 Page 7c.5, Attachment 3.1-A.1 Page 7c.7a, Attachment 3.1-A.1 Page 15a, Attachment 3.1-A.1 Page 15a.2-B, Attachment 3.1-A.1 Page 15a.2-C, Attachment 3.1-A.1 Page 15a.2-D, and Attachment 3.1-A.1 Page 15a.3a.		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 3.1-A.1 Page 7c.1b, Attachment 3.1-A.1 Page 7c.5, Attachment 3.1-A.1 Page 7c.7a, Attachment 3.1-A.1 Page 15a, Attachment 3.1-A.1 Page 15a.2-B, Attachment 3.1-A.1 Page 15a.2- C, Attachment 3.1-A.1 Page 15a.2-D, and Attachment 3.1-A.1 Page 15a.3a.	
10. SUBJECT OF AMENDMENT: Endorsement language changed to Credential			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <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/REGIONAL 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: Albert A. Delia			
14. TITLE: Secretary			
15. DATE SUBMITTED: 09/17/2012			

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17. DATE RECEIVED: 09/07/12	18. DATE APPROVED: 11/21/12
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/12	20. 
21. TYPED NAME: Jackie Glaze	22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns
23. REMARKS:	