TRANSMITTAL AND NOTICE OF APPROVAL OF	I. TRANSMITTAL NUMBER:	2. STATE
	SC 11 - 015	1
STATE PLAN MATERIAL	SC 11-VI3	South Carolina
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	
HEALTH CARE FINANCING ADMINISTRATION	07/11/11	
DEPARTMENT OF HEALTH AND HUMAN SERVICES		
5. TYPE OF PLAN MATERIAL (Check One):	Lunion	
□ 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)		
		n amendment)
6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:	
CFR 447.52		\$ 27,134)
		\$108,353)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERS	
	OR ATTACHMENT (If Applicable):	
Attachment 4.18-A, Page I		
	Attachment 4.18-A, Page 1	
10. SUBJECT OF AMENDMENT:		
Adjust co-payments.		
11. GOVERNOR'S REVIEW (Check One):		
GOVERNOR'S OFFICE REPORTED NO COMMENT	☐ OTHER, AS SPEC	CIFIED:
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED		ited by the Governor to
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		
	Terrest and approve a	n State I lans
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:	
12, SIGNATURE OF WITTE ROBRET OF FIGHE.	70. RETORIV 10.	
	South Carolina Department of Health and Human Services	
13. TYPED NAME:	Post Office Box 8206	
Anthony E. Keck	Columbia, SC 29202-8206	
14. TITLE:	Columbia, 5C 29202-0200	
Director		
15. DATE SUBMITTED:		
July 11, 2011		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED: 07/14/11	18. DATE APPROVED:	01/17/12
PLAN APPROVED - ONE COPY ATTACHED		
PLAN APPROVED—ONI	COPY ATTACHED	
		RICIAL:
19. EFFECTIVE DATE OF APPROVED MATERIAL:	COPY ATTACHED 20. SIGNATURE OF REGIONAL OF	FICIAL:
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/11/11	20. SIGNATURE OF REGIONAL OF	_
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OF	ministrator
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/11/11 21. TYPED NAME: Jackie Glaze	20. SIGNATURE OF REGIONAL OF A CLUE LOS 22. TOLE: Associate Regional Ac	ministrator
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19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/11/11 21. TYPED NAME: Jackie Glazc 23. REMARKS: Approved with the following changes to item 8 and 9 as authorized by Sta	20. SIGNATURE OF REGIONAL OF A CALL SCAR STATE Associate Regional Ac Division of Medicaid & Children of Medicaid &	ministrator
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19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/11/11 21. TYPED NAME: Jackie Glaze 23. REMARKS: Approved with the following changes to item 8 and 9 as authorized by Sta Pages 1 And 3 Block#8 changed to read. Attachment 4.18-A pages and Attachment 4.18 Page 14-3	20. SIGNATURE OF-REGIONAL OR Associate Regional Ac Division of Medicaid & Childre the Agency on email-dated 10/15/11: -C page 3.	ministrator
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