

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 OFFICE OF CHILD SUPPORT ENFORCEMENT  
 Submit 2 Copies

|  |   |               |
|--|---|---------------|
| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: TITLE IV-D OF THE SOCIAL SECURITY ACT</b>  | TRANSMITTAL NUMBER                                  | STATE         |
|  | ACTION TRANSMITTAL NUMBER AND DATE                  |               |
| TO: REGIONAL REPRESENTATIVE<br>OFFICE OF CHILD SUPPORT ENFORCEMENT<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES<br>REGION _____  | PROPOSED EFFECTIVE DATE                             |               |
| TYPE OF PLAN MATERIAL (Check One)<br><input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS A NEW PLAN <input type="checkbox"/> AMENDMENT  |   |               |
| COMPLETE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT   |   |               |
| FEDERAL REGULATION CITATION  |   |               |
| NUMBER OF THE PLAN SECTION OR ATTACHMENT   | NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT |               |
| SUBJECT OF AMENDMENT   |   |               |
| GOVERNOR'S REVIEW (Check One)<br><input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED:<br><input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED<br><input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL |   |               |
| SIGNATURE OF STATE AGENCY OFFICIAL (1 Original signature required)   | <b>FOR REGIONAL OFFICE USE ONLY</b>                 |               |
|  | DATE RECEIVED                                       | DATE APPROVED |
| TYPED NAME:  | PLAN APPROVED – ONE COPY ATTACHED                   |               |
|  | EFFECTIVE DATE OF APPROVED MATERIAL                 |               |
| TITLE:   | SIGNATURE OF REGIONAL OFFICIAL                      |               |
| DATE OF SUBMITTAL:   | TYPED NAME:   |               |
| RETURN TO:   | TITLE:  |               |
|  | REMARKS:  |               |