

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR**

**ACTION REFERRAL**

TO <i>Mells</i>	DATE <i>10-2-06</i>
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DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER  <i>000286</i>		<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____	
2. DATE SIGNED BY DIRECTOR  <i>Ci Kern</i>		<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____	
		<input type="checkbox"/> FOIA DATE DUE _____	
		<input checked="" type="checkbox"/> Necessary Action	

APPROVALS <small>(Only when prepared for director's signature)</small>	APPROVE	* DISAPPROVE <small>(Note reason for disapproval and return to preparer.)</small>	COMMENT
1.			
2.			
3.			
4.			



**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Centers for Medicare & Medicaid Services

Center for Medicaid and State Operations  
Finance, Systems, and Budget Group  
7500 Security Boulevard  
Baltimore, MD 21244

Mr. Robert M Kerr  
Executive Director  
Department of Health and Human Services  
P.O. Box 8206  
Columbia, S.C. 29202-8206

**RECEIVED**

OCT - 2 2006

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

Dear Sir or Madam:  
SUPPLEMENTAL

The grant award listed below has been approved for the period 07/01/2006 - 09/30/2006 under the State Children's Health Insurance Program, Appropriation No. 750/30515.

**State Children's Health Insurance Program  
Payments**

**\$(32,649,064)**

The above listed grant award provides Federal funds for expenditures made in accordance with your State child health plan approved under Title XXI of the Social Security Act. Computation of the award is shown on the enclosed statement.

With the acceptance of this award, you agree to comply with the requirements of the Cash Management Improvement Act (CMIA) of 1990 as codified in 31CFR Part 205 and with the requirements of 45 CFR Part 92.

Any questions you may have in connection with this grant award should be referred to the appropriate Centers for Medicare & Medicaid Services Regional Office financial contact for your State.

Payment under this award will be made by the Department of Health and Human Services, Payment Management System administered by the Division of Payment Management (DPM), Program Support Center (PSC). Inquiries regarding payment should be directed to:

Telephone Number 1-877-614-5533

Director, Division of Payment Management  
Post Office Box 6021  
Rockville, Maryland 20852-0605

Please transmit a copy of this grant award document to the State official authorized to request funds from the Division of Payment Management.

Sincerely yours,

Director,  
Division of Financial Management

Enclosures 3  
CMS HCFA-1151(7-90)

THIS AWARD IS FUNDED UNDER HHS SINGLE LETTER OF CREDIT NO. 75-08

CENTRAL REGISTRY SYSTEM  
ENTITY IDENTIFICATION NUMBER (CRS/EIN) 157-600-0286-Z3

[illegible]

\* CURRENT QUARTER FUNDING

FOOTNOTES

STATE: South Carolina

QUARTER/FISCAL YEAR FOURTH/2006

SEP 2 / 2006

- A. \$ (0) represents the expenditure amounts reported for the State Children's Health Insurance Program (SCHIP) under M-SCHIP and SCHIP as reported on the FY 2002 through FY 2004 quarterly expenditure reports, as reflected on the fourth quarter FY 2004 Form CMS-21C (certified as of November 30, 2004) and applied against the FY 2000 reallocation. The total draws to your FY 2000 reallocation SCHIP Payment Management System (PMS) subaccount, REDIST00, must reflect this amount.
- B. \$ (32,649,064) represents the total of your previous grant authorization to your REDIST00 PMS subaccount and is equal to your total FY 2000 SCHIP reallocation.
- C. \$ (32,649,064) represents the total adjustment to reduce the previous authorization in your REDIST00 PMS subaccount as shown in footnote B \$ (32,649,064) to the level of actual SCHIP expenditures as referenced in footnote A \$0.

Refer any questions you have on the above, to your Regional Office contact or Debbie Abshire on 410-786-9291. See Attachment 1.