DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF CHILD SUPPORT ENFORCEMENT

SUBMIT 4 COPIES

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR:TITLE IV-D OF THE SOCIAL SECURITY ACT	TRANSMITTAL NUMBER	STATE
	ACTION TRANSMITTAL NUMBER AND DATE	
TO: REGIONAL REPRESENTATIVE OFFICE OF CHILD SUPPORT ENFORCEMENT DEPARTMENT OF HEALTH AND HUMAN SERVICES REGION _____	PROPOSED EFFECTIVE DATE	

COMPLETE THE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT

TYPE OF PLAN MATERIAL (check one)

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

FEDERAL REGULATION CITATION

NUMBER OF THE PLAN SECTION OF ATTACHMENT	NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT

SUBJECT OF AMENDMENT

GOVERNOR'S REVIEW (check one)

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

SIGNATURE OF STATE AGENCY OFFICIAL (2 originals with signatures, required)	**FOR REGIONAL OFFICE USE ONLY**	
	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:	

FORM **OCSE-21-U4** (10-85)