OMB Control No: 0970-0017
Expiration date: **/**/****

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

<table>
<tr><td rowspan="2">TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: TITLE IV-D OF THE SOCIAL SECURITY ACT</td><td>TRANSMITTAL NUMBER</td><td>STATE</td></tr>
<tr><td colspan="2">ACTION TRANSMITTAL NUMBER AND DATE</td></tr>
<tr><td>TO: REGIONAL REPRESENTATIVE
OFFICE OF CHILD SUPPORT ENFORCEMENT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGION ___________________________________</td><td colspan="2">PROPOSED EFFECTIVE DATE</td></tr>
<tr><td colspan="3">TYPE OF PLAN MATERIAL (Check One)
NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS A NEW PLAN AMENDMENT</td></tr>
<tr><td colspan="3">COMPLETE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT</td></tr>
<tr><td colspan="3">FEDERAL REGULATION CITATION</td></tr>
<tr><td>NUMBER OF THE PLAN SECTION OR ATTACHMENT</td><td colspan="2">NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT</td></tr>
<tr><td>SUBJECT OF AMENDMENT</td><td colspan="2"></td></tr>
<tr><td colspan="3">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</td></tr>
<tr><td rowspan="2">SIGNATURE OF STATE AGENCY OFFICIAL (1 Original signature required)</td><td colspan="2">FOR REGIONAL OFFICE USE ONLY</td></tr>
<tr><td>DATE RECEIVED</td><td>DATE APPROVED</td></tr>
<tr><td rowspan="2">TYPED NAME:</td><td colspan="2">PLAN APPROVED – ONE COPY ATTACHED</td></tr>
<tr><td colspan="2">EFFECTIVE DATE OF APPROVED MATERIAL</td></tr>
<tr><td>TITLE:</td><td colspan="2">SIGNATURE OF REGIONAL OFFICIAL</td></tr>
<tr><td>DATE OF SUBMITTAL:</td><td colspan="2">TYPED NAME:</td></tr>
<tr><td rowspan="2">RETURN TO:</td><td colspan="2">TITLE:</td></tr>
<tr><td colspan="2">REMARKS:</td></tr>
</table>

FORM OCSE-21-U4