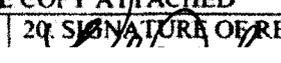


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-002	2. STATE OHIO
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE September 1, 2009	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 435.914		7. FEDERAL BUDGET IMPACT: a. FFY 2009 \$ 0 b. FFY 2010 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 2.6-A; page 24		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachement 2.6-A; Page 24 (91-27)	
10. SUBJECT OF AMENDMENT: Updating effective date of retroactive coverage period. Coverage is available beginning the first day of the third month before the date of application if the individual would have been eligible at any time during that month, had they applied.			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Governor has delegated signature authority to ODJFS Director. Director has delegated signature authority to Medicaid Director	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Becky Jackson OHP/Bureau of Health Plan Policy Ohio Department of Job and Family Services P.O. BOX 182709 Columbus, Ohio 43218	
13. TYPED NAME: JOHN R. CORLETT			
14. TITLE: MEDICAID DIRECTOR			
15. DATE SUBMITTED: 5-7-09			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: AUG 05 2009	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: September 1, 2009		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Verlon Johnson		22. TITLE: Associate Regional Administrator	
23. REMARKS:			

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF OHIO

CITATION CONDITION OR REQUIREMENT

42 CFR
435.914

11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

- Aged, blind, disabled.
- AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

- Aged, blind, disabled.
- AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

- Aged, blind, disabled.
- AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied:

- Aged, blind, disabled.
- AFDC-related.

TN# 09-002
Supersedes
TN# 91-27

Approval Date: AUG 05 2009

Effective Date: 9/1/2009