

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: SPA #09-001	2. STATE Delaware
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 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: Section 1902(c)(2), Section 1931 of the Act		7. FEDERAL BUDGET IMPACT: a. FFY 2009 \$-0- b. FFY 2010 \$-0-	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 8A to Attachment 2.6-A, Page 2 (NEW PAGE) Supplement 12 to Attachment 2.6-A, Page 2a Attachment 2.2-A, Page 14		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): N/A Supplement 12 to Attachment 2.6-A, Page 2a Supplement 8a to Attachment 2.6-A Addendum Attachment 2.2-A, Page 14	
10. SUBJECT OF AMENDMENT: Decennial Census: To provide for all wages paid by the U. S. Census Bureau for temporary employment related to Census activities to be excluded.			
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's comments under separate correspondence	
12. SIGNATURE OF STATE AGENCY OFFICIAL: Harry B. Hill -- signature --		16. RETURN TO:	
13. TYPED NAME: Harry B. Hill, Director, Division of Medicaid and Medical Assistance		Harry B. Hill Director, Division of Medicaid and Medical Assistance P.O. Box 906 New Castle, Delaware 19720-0906	
14. TITLE: Designee for Rita M. Landgraf, Secretary, Delaware Health and Social Services			
15. DATE SUBMITTED: May 7, 2009			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 5/7/09		18. DATE APPROVED: JUL 31 2009	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 4/1/09		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Ted Gallagher		22. TITLE: Associate Regional Administrator	
23. REMARKS:			