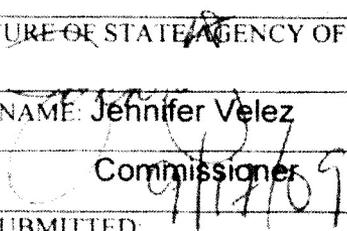


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>09-10-MA</b>	2. STATE <b>New Jersey</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>July 1, 2009</b>	
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:  <b>42 U.S.C. 1396d(a)(9); 42 C.F.R. 440.90</b>		7. FEDERAL BUDGET IMPACT  <b>a. FFY 2009 (\$0.924 million) b. FFY 2010 (\$ 3.695 million)</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Addendum to Att. 3.1-A, Page 9 Addendum to Att. 3.1-B Page 9</b>  <b>** SEE REMARKS</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>Same Same</b>	
10. SUBJECT OF AMENDMENT: <b>Clinic Services: Partial care services in independent clinics must be prior authorized by professional staff designated by the Department of Human Services.</b>			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <b>Not required, pursuant to 7.4 of the Plan</b> <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE/AGENCY OFFICIAL: 		16. RETURN TO: <b>Division of Medical Assistance and Health Services P.O. Box 712, #26 Trenton, NJ 08625-0712</b>	
13. TYPED NAME: <b>Jennifer Velez</b>			
14. TITLE: <b>Commissioner</b>			
15. DATE SUBMITTED: <b>7/1/09</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>JUL 08 2010</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>01 2009</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Sue Kelly</b>		22. TITLE: <b>Associate Regional Administrator Division of Medicaid and State Operations</b>	
23. REMARKS:  <b>Originally submitted pages Addendum Attachment 3.1A, Page 9 and Addendum to Attachment 3.1B, Page 9 have been replaced by revised pages submitted via State letter of May 12, 2010.</b>			