

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
09-01

2. STATE
Alaska

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
March 1, 2009

5. TYPE OF PLAN MATERIAL (Check One):

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

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 435
1905(p)(2)(A) and 1905(p)(4) (PFI)

7. FEDERAL BUDGET IMPACT:
a. FFY 09 \$0
b. FFY 10 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 1 to ATTACHMENT 2.6-A, page 6.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

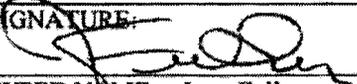
Supplement 1 to ATTACHMENT 2.6-A, page 6.

10. SUBJECT OF AMENDMENT:
Federal Poverty Levels

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:
Does not wish to comment

12. SIGNATURE: 
13. TYPED NAME: Jerry Fuller
14. TITLE: Medicaid Director
15. DATE SUBMITTED: March 25, 2009

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAR 24 2009

18. DATE APPROVED: JUN 17 2009

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: MAR 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL: 

21. TYPED NAME: Barbara K. Richards

22. TITLE: Associate Regional Administrator

23. REMARKS: Division of Medicaid & Children's Health

pen & inc changes authorized by the state on 4/29/09.