

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

1. TRANSMITTAL NUMBER:  
09-02

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  
January 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

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

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supp. 6 to Attachment 2.6, Page 1-3;

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  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

Supp. 6 to Attachment 2.6, Page 1-3;

10. SUBJECT OF AMENDMENT:

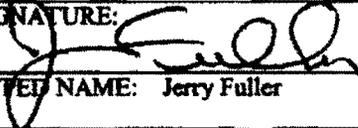
Income eligibility standards

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: MAY 5 2009

**PLAN APPROVED -- ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
JAN 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME: Barbara K. Richards

22. TITLE:

23. REMARKS:

Associate Regional Administrator  
Division of Medicaid &  
Children's Health