

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 09-03	2. STATE Alaska
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FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
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TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE April 1, 2009
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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: 1902(e)(12) of the Act 42 CFR 435	7. FEDERAL BUDGET IMPACT: a. FFY 10 09 (P+I) \$0 b. FFY 11 10 (P+I) \$0
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 2.2-A, Page 23d	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 2.2-A, Page 23d
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10. SUBJECT OF AMENDMENT:
DKC 12-month Continuous Eligibility

11. GOVERNOR'S REVIEW (Check One):

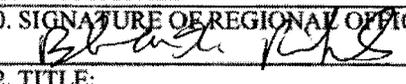
GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Does not wish to comment.
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Alaska Department of Health and Social Services PO Box 110601 Juneau, AK 99811-0601
13. TYPED NAME: Jerry Fuller	
14. TITLE: Medicaid Director, Alaska Dept. of Health and Social Services	
15. DATE SUBMITTED: March 25, 2009	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAR 25 2009	18. DATE APPROVED: APR 20 2009
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR - 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 + Ink changes authorized by the state on 4/1/09.