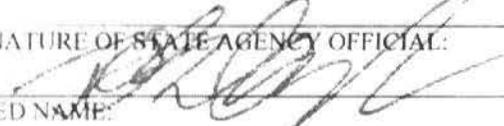
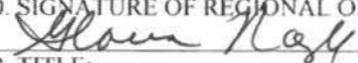


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>09-003</b>	2. STATE <b>California</b>
<b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>September 30, 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>Section 1940(a) of the Social Security Act (42 U.S.C. Section 1396w(a))</b>		7. FEDERAL BUDGET IMPACT: a. FFY 2009/10      \$900,000 b. FFY ongoing      \$900,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Supplement 16 to Attachment 2.6-A</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>None</b>	
10. SUBJECT OF AMENDMENT: <b>Asset Verification Through Access to Information Held by Financial Institutions</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      The Governor's Office does not <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL      wish to review the State Plan Amendment.			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: <b>Department of Health Care Services Attn: State Plan Coordinator 1501 Capitol Ave, Suite 71-4063, MS 4607 P.O. Box 997417 Sacramento, CA 95899-7417</b>	
13. TYPED NAME: <b>Toby Douglas</b>		17. DATE RECEIVED: <b>March 24, 2009</b>	
14. TITLE: <b>Chief Deputy Director of Health Care Programs</b>		18. DATE APPROVED: <b>APR 16 2009</b>	
15. DATE SUBMITTED: <b>March 24, 2009</b>		FOR REGIONAL OFFICE USE ONLY PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>September 30, 2009</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Gloria Nagle</b>		22. TITLE: <b>Associate Regional Administrator, DMHCO</b>	
23. REMARKS:			