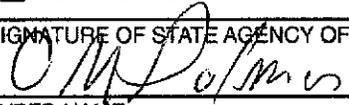
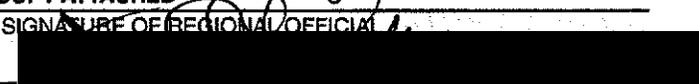


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <u>1 1 0 1 4</u>	2. STATE IOWA
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE August 1, 2011	
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 42 CFR 440.130		7. FEDERAL BUDGET IMPACT a. FFY '11 <u>\$ 1,396.34</u> b. FFY '12 <u>\$ 8,378.00</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Supplement 2 to Attachment 3.1-A, Page 13 Supplement 2 to Attachment 3.1-A, Page 12, 16 Supplement 2 to Attachment 3.1-A, Page 31a-31e Supplement 2 to Attachment 3.1-A, Page 31f-31h		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Supplement 2 to Attachment 3.1-A, Page 13 Supplement 2 to Attachment 3.1-A, Page 12, 16 Supplement 2 to Attachment 3.1-A, Page 31a-31e	
10. SUBJECT OF AMENDMENT Adds a person certified by the non-governmental Iowa Board of Substance Abuse certification as an alcohol and drug counselor under the rehabilitation provisions of the CFR.			
11. GOVERNOR'S REVIEW (Check One)			
<input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL 		16. RETURN TO CHARLES M. PALMER DIRECTOR DEPARTMENT OF HUMAN SERVICES 1305 EAST WALNUT 5TH FLOOR DES MOINES IA 50319-0114	
13. TYPED NAME CHARLES M. PALMER			
14. TITLE DIRECTOR			
15. DATE SUBMITTED 7-26-11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED July 26, 2011		18. DATE APPROVED January 8, 2013	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL August 1, 2011		20. SIGNATURE OF REGIONAL OFFICIAL 	
21. TYPED NAME James G. Scott		22. TITLE Associate Regional Administrator for Medicaid and Children's Health Operations	
23. REMARKS Pen and ink changes - Per state request			