

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER 12.008	2. STATE: ILLINOIS
	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 July 1, 2012	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>) <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 (<i>Separate transmittal for each amendment</i>)		
6. FEDERAL STATUTE/REGULATION CITATION 1902(a)(10)(A)(ii)(1), 1902(r)(2)	7. FEDERAL BUDGET IMPACT a. FFY <u>2012</u> \$ <u>-5,900,000</u> b. FFY <u>2013</u> \$ <u>-26,100,000</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 8a to Attachment 2.6-A p. 3 Attachment 4.18 F pp. 1, 3, 5-7	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Supplement 8a to Attachment 2.6-A p. 3 Attachment 4.18 F pp. 1, 3, 5-7	
10. SUBJECT OF AMENDMENT Elimination of Eligibility for Parents and Caretaker Relatives from 133 Percent to 185 Percent of the Federal Poverty Level		
11. GOVERNOR'S REVIEW (<i>Check One</i>) <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED Not submitted for review by prior approval.
12. SIGNATURE OF AGENCY OFFICIAL:	16. RETURN TO	
13. TYPED NAME Julie Hamos	ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES 201 SOUTH GRAND AVENUE, 3rd Floor SPRINGFIELD, IL. 62763-0002 ATTENTION: Pat Curtis, Chief / Bureau of Medical Eligibility and Special Programs	
14. TITLE DIRECTOR		
15. DATE SUBMITTED 8/1/12		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED: 8/1/12	18. DATE APPROVED: 10/30/12	
PLAN APPROVED - ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/12	20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME Verlon Johnson	22. TITLE: Associate Regional Administrator	

23. REMARKS:

FORM CMS-179 (07-92)

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