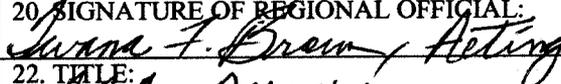


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 08-007	2. STATE Indiana
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE April July 1, 2009 January 1, 2010	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	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: Section 1920 of the Act Section 1902(a)(47) of the Act	7. FEDERAL BUDGET IMPACT: a. FFY 2009 \$ 1.1 million \$443,592 b. FFY 2010 \$ 2.5 million \$1.8 million \$1,369,760 FFY 2011 \$ 1,917,190	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Pages 11 and 21(b) Attachment 2.2-A, Page 23 Attachment 2.6-A, Page 25	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Pages 11 and 21(b) Attachment 2.2-A, Page 23 Attachment 2.6-A, Page 25	
10. SUBJECT OF AMENDMENT: Presumptive eligibility for pregnant women.		

11. GOVERNOR'S REVIEW (Check One): <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: Indiana's Medicaid State Plan does not require the Governor's review. See Section 7.4 of the State Plan
12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Patricia Casanova Director of Medicaid Indiana Office of Medicaid Policy and Planning 402 West Washington Street, Room W382 Indianapolis, IN 46204 ATTN: Bridget McLaughlin, State Plan Coordinator
13. TYPED NAME: Patricia Casanova	
14. TITLE: Director of Medicaid	
15. DATE SUBMITTED: Original SPA submission date: August 29, 2008 HCFA 179 revisions: February 10, 2009 (pen and ink) and resubmitted, (typed) September 23, 2009; to revise effective date and fiscal impact: November 19, 2009; resubmitted January 6, 2010.	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: 08-29-09	18. DATE APPROVED: FEB 04 2010
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 02-04-10	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Verlon Johnson	22. TITLE: AKA, DMCHG
23. REMARKS:	