DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 09-009	2. STATE Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
    HEALTH CARE FINANCING ADMINISTRATION
    DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2009

5. TYPE OF PLAN MATERIAL *(Check One):*

☐ NEW STATE PLAN   ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN   X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
Deficit Reduction Act of 2005 [Section 1937 of the Social Security Act]	a. FFY 2007 - budget neutral b. FFY 2008 - budget neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.42-A page 1	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable):* Same

10. SUBJECT OF AMENDMENT:
This plan amendment changes the reassessment for compliance with section 1902(a)(68) of the Social Security Act from annually to at least every three years.

11. GOVERNOR'S REVIEW *(Check One):*
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

X OTHER, AS SPECIFIED: Review delegated
to Commissioner, Department for Medicaid
Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: Elilzabeth A. Johnson	Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621
14. TITLE: Commissioner, Department for Medicaid Services	
15. DATE SUBMITTED: October 8, 2009	
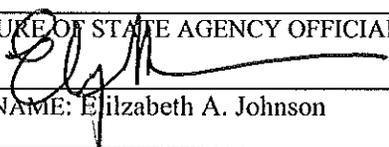
FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)