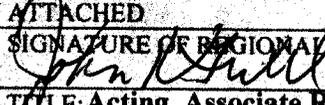


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER:  <b>11-05</b>	2. STATE  <b>New York</b>
		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>October 1, 2011</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 1925 (a) (1) of the Social Security Act, 42 CFR 435.112, ARRA of 2009 Section 5004</b>		7. FEDERAL BUDGET IMPACT: a. FFY 10/01/11-09/30/12    \$ 5.7 million b. FFY 10/01/12-09/30/13    \$ 6.0 million	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Supplement 12 to Attachment 2.6-A: Page 7</b>  <b>** SEE REMARKS</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>Supplement 12 to Attachment 2.6-A: Page 7</b>	
10. SUBJECT OF AMENDMENT: <b>Transitional Medical Assistance Eligibility Criteria Change (FMAP = 50%)</b>			
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: <b>New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237</b>	
13. TYPED NAME: <b>Jason Helgerson</b>			
14. TITLE: <b>Medicaid Director &amp; Deputy Commissioner NYS Department of Health</b>			
15. DATE SUBMITTED: <b>December 13, 2011</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>March 5, 2012</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>October 01, 2011</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>John Guhl</b>		22. TITLE: <b>Acting, Associate Regional Administrator Division of Medicaid and State Operations</b>	
23. REMARKS:  <b>** By means of this SPA, New York State proposes to elect the option that allows families to have fewer than 3 of the last 6 months of Low Income Family eligibility, specifically at least 1 of the last 6 months, be considered eligible for Transitional Medical Assistance. This change allows for more low income families who have increased earned income and a dependent child under the age of 21 to retain their current level of public health insurance for a continued period of 12 months.</b>			