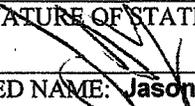
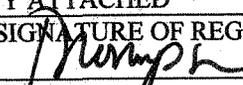


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: #12-04	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2012	
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 1902(a) of the Social Security Act		7. FEDERAL BUDGET IMPACT: a. FFY 01/01/12 - 09/30/12 \$ 0 b. FFY 10/01/12 - 09/30/13 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A - Pages 103, 108		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-A - Pages 103, 108	
10. SUBJECT OF AMENDMENT: Service Intensity Weights (SIW) and average Length-of-stay (LOS) (FMAP = 50%)			
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: New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237	
13. TYPED NAME: Jason A. Helgerson			
14. TITLE: Medicaid Director & Deputy Commissioner Department of Health			
15. DATE SUBMITTED: April 10, 2012			

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17. DATE RECEIVED:	18. DATE APPROVED: APR 27 2012
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN - 1 2012	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, CMCS
23. REMARKS:	