

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
09-008

2. STATE  
Wisconsin

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

4. PROPOSED EFFECTIVE DATE  
04/01/2009

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:

Sections 1917 SSA

7. FEDERAL BUDGET IMPACT:

a. FFY 2009 —\$750K

b. FFY 2010 —\$3,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 2.6-A, Supplement 9(b), pages 1 to 6

Attachment 2.6-A, Supplement 17 page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If applicable)

Same

New

10. SUBJECT OF AMENDMENT:

Deficit Reduction Act transfer of assets provisions

11. GOVERNOR'S REVIEW (Check One)

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ OTHER, AS SPECIFIED:

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Jason Helgeson

14. TITLE:

State Medicaid Director

15. DATE SUBMITTED:

June 29, 2009

16. RETURN TO:

Jason Helgeson

State Medicaid Director

Division of Health Care Access and Accountability

1 W. Wilson St.

P.O. Box 309

Madison, WI 53701-0309

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

June 29, 2009

18. DATE APPROVED:

SEP 25 2009

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

April 1, 2009

21. TYPED NAME:

Verlon Johnson

23. REMARKS:

20. SIGNATURE OF REGIONAL OFFICIAL:

22. TITLE:

Associate Regional Administrator