

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

1. TRANSMITTAL NUMBER:  
09-013

2. STATE  
Wisconsin

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  
07/01/2009

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:

Section 1905(a)(4)(B) of the SSA and  
42 CFR Part 441 Subpart B

7. FEDERAL BUDGET IMPACT:

a. FFY 2009 ..... \$0K  
b. FFY 2010 ..... \$0K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  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

① Attachment 4.19-B, pages 16.d. and 16.e-1 to 16.e-4. ....  
② Attachment 3.1-A, Supplement 1, pages 1d - 1e  
③ Attachment 3.1-B, Supplement 1, pages 1d - 1e

Same  
- Same  
- Same

10. SUBJECT OF AMENDMENT:

School-based services.

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

OTHER, AS SPECIFIED:

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:  
06-29-09

18. DATE APPROVED:  
OCT 31 2011

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
07-01-09

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:  
Verlon Johnson

22. TITLE:  
Associated Regional Administrator

23. REMARKS: