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: 09-02

2. STATE: Alaska

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, 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:
42 CFR 435

7. FEDERAL BUDGET IMPACT:
a. FFY 09 $0
b. FFY 10 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supp. 6 to Attachment 2.6, Page 1-3;

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supp. 6 to Attachment 2.6, Page 1-3;

10. SUBJECT OF AMENDMENT:
Income eligibility standards

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:
Does not wish to comment

12. SIGNATURE:

13. TYPED NAME: Jerry Fuller

14. TITLE: Medicaid Director

15. DATE SUBMITTED: March 25, 2009

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAR 24 2009

18. DATE APPROVED: MAY 5 2009

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Barbara K. Richards

22. TITLE:
Associate Regional Administrator
Division of Medicaid &
Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)