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: 09-03

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
April 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:
1902(e)(12) of the Act
42 CFR 435

7. FEDERAL BUDGET IMPACT:
a. FFY ~~10~~ 09 (PTF) $0
b. FFY ~~11~~ 10 (PTF) $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 2.2-A, Page 23d

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 2.2-A, Page 23d

10. SUBJECT OF AMENDMENT:
DKC 12-month Continuous Eligibility

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 OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Jerry Fuller

14. TITLE: Medicaid Director,
Alaska Dept. of Health and Social Services

15. DATE SUBMITTED: March 25, 2009

16. RETURN TO:
Alaska Department of Health and Social Services
PO Box 110601
Juneau, AK 99811-0601

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAR 25 2009

18. DATE APPROVED: APR 20 2009

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR - 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:

Pen + Ink changes authorized by the state on 4/1/09.

FORM HCFA-179 (07-92)