DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

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

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: **09-003**

2. STATE: **California**

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
**September 30, 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 1940(a) of the Social Security Act (42 U.S.C. Section 1396w(a))**

7. FEDERAL BUDGET IMPACT:
a. FFY 2009/10 $900,000
b. FFY ongoing $900,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
**Supplement 16 to Attachment 2.6-A**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
**None**

10. SUBJECT OF AMENDMENT:
**Asset Verification Through Access to Information Held by Financial Institutions**

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:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
**Toby Douglas**

14. TITLE:
**Chief Deputy Director of Health Care Programs**

15. DATE SUBMITTED:
March 24, 2009

16. RETURN TO:
**Department of Health Care Services**
**Attn: State Plan Coordinator**
**1501 Capitol Ave, Suite 71-4063, MS 4607**
**P.O. Box 997417**
**Sacramento, CA 95899-7417**

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:
March 24, 2009

18. DATE APPROVED:
APR 16 2009

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
September 30, 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Gloria Nagle

22. TITLE:
Associate Regional Administrator, DMHCO

23. REMARKS:

FORM CMS-179 (07-92)