

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

1. TRANSMITTAL NUMBER:  
09-020

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  
10/01/2009

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 1902(a)(73) SSA

7. FEDERAL BUDGET IMPACT:  
a. FFY 2010 .....\$0K  
b. FFY 2011 .....\$0K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
Page 9. ....

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  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

10. SUBJECT OF AMENDMENT:

Tribal consultation requirements.

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:  


16. RETURN TO:  
Jason A. Helgerson  
State Medicaid Director  
Division of Health Care Access and Accountability  
1 W. Wilson St.  
P.O. Box 309  
Madison, WI 53701-0309

13. TYPED NAME:  
Jason A. Helgerson

14. TITLE:  
State Medicaid Director

15. DATE SUBMITTED:  
December 21, 2009

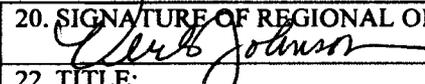
**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:  
December 21, 2009

18. DATE APPROVED:      JUL 29 2010

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
October 1, 2009

20. SIGNATURE OF REGIONAL OFFICIAL:  


21. TYPED NAME:  
Verlon Johnson

22. TITLE:  
Associate Regional Administrator

23. REMARKS: