

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 07-19	2. STATE New York
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		4. PROPOSED EFFECTIVE DATE April 1, 2007	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Sections 1902(a) and 1902 (r)(2) of the Social Security Act		7. FEDERAL BUDGET IMPACT: a. FFY 2006-07 \$1,500,000 b. FFY 2007-08 \$3,000,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 1 to Attachment 2.6-A, Pages 8 & 9 Supplement 2 to Attachment 2.6-A, Page 7 Supplement 6 to Attachment 2.6-A ** SEE REMARKS		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 1 to Attachment 2.6-A, Pages 8 & 9 Supplement 2 to Attachment 2.6-A, Page 7 Supplement 6 to Attachment 2.6-A	
10. SUBJECT OF AMENDMENT: Medically Needy Income and Resource Standards			
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO: New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237	
13. TYPED NAME: Deborah Bachrach			
14. TITLE: Deputy Commissioner Department of Health			
15. DATE SUBMITTED:			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: JUN 04 2009	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2007		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Sue Kelly		22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations	
23. REMARKS: HCFA 179 form and State Plan pages originally submitted on June 28, 2007, were replaced with revised attached pages submitted via State's e-mail on April 24, 2009. Pen & Ink change to the State's April 24, 2009 letter - State indicated a response to CMS "September 13, 2009" Request for Additional Information". However, it should have been response to CMS "September 13, 2007 letter".			