

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 08-07	2. STATE New York
		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, 2008	
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			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: NYCRR Part 360-4 Social Security Act 1902(r)(2)		7. FEDERAL BUDGET IMPACT: a. FFY 2007-08 \$3 Million b. FFY 2008-09 \$3.4 Million	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 1 to Attachment 2.6-A, Page 8 Supplement 2 to Attachment 2.6-A, Page 7 Supplement 6 to Attachment 2.6-A Supplement 8A to Attachment 2.6-A, Pages 3 & 3a ** SEE REMARKS		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 1 to Attachment 2.6-A, Page 8 Supplement 2 to Attachment 2.6-A, Page 7 Supplement 6 to Attachment 2.6-A Supplement 8A to Attachment 2.6-A, Pages 3 & 3a	
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: DEC 01 2009	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2008		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Sue Kelly		22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations	
23. REMARKS: Originally submitted pages were replaced with pages per State's response on July 24, 2009 to CMS's June 24, 2008 RAI. Originally submitted HCFA 179 Form was replaced with revised form per State's e-mail of August 27, 2009.			