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: 11-006

2. STATE: Alabama

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
June 1, 2011

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:
42 CFR 431.12(b)

7. FEDERAL BUDGET IMPACT:
a. FFY 11 Cost to Agency $.00
b. FFY 12 Cost to Agency $.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

State Plan Amendment AL-11-006, Preprint page 9, Section 1.4

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

State Plan Amendment AL-11-006, Preprint page 9, Section 1.4

10. SUBJECT OF AMENDMENT: This amendment will allow the Alabama Medicaid Agency to give a written notice to Poarch Creek Indians allowing 30 days to comment from the date of the notice on any matters related to Medicaid and CHIP programs and for consultation on all State Plan Amendments and any other changes that would affect the Tribe prior to all SPA submission to CMS.

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: Governor's designee on file via letter with CMS

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
R. Bob Mullins, Jr., MD

14. TITLE:
Commissioner

15. DATE SUBMITTED: 5-11-11

16. RETURN TO:
R. Bob Mullins, Jr., MD
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, Alabama 36103-5624

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 5-11-11

18. DATE APPROVED: 07/22/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 06-01-11

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Davida Kimble

22. TITLE: Acting Associate Regional Administrator
Division of Medicaid & Children's Health Opns

23. REMARKS: