| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES | 1. TRANSMITTAL NUMBER 09-11 | 2. STATE: ILLINOIS | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--|
| | 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 December 2, 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 1902(r)(2), 1931 | 7. FEDERAL BUDGET IMPACT a. FFY 2010 \$ 1,000,000 b. FFY 2011 \$ 0 | | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 8a to Attachment 2.6-A, pp. 2, 2a Supplement 12 to Attachment 2.6-A, p. 4 | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 8a to Attachment 2.6-A, pp. 2 Supplement 12 to Attachment 2.6-A, p. 4 | | |
| 10. SUBJECT OF AMENDMENT Exclusion of temporary employment earnings from the decennial census using 1902(r)(2) and 1931 | | | |
| 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 | | | |
| 12. SIGNATURE OF AGENCY OFFICIAL: Barry & Maran | 16. RETURN TO ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES 201 SOUTH GRAND AVENUE, 3 rd Floor SPRINGFIELD, IL. 62763-0002 ATTENTION: Debbie Watkins, Chief Bureau of Medical Eligibility Policy | | |
| 13. TYPED NAME Barry S. Maram | | | |
| 14. TITLE DIRECTOR | | | |
| 15. DATE SUBMITTED December 30, 2009 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: 12-30-09 | 18. DATE APPROVED: | MAR 1 9 20 <u>10</u> | |
| PLAN APPROVED - ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 12-2-09 20. SIGNATURE OF REGIONAL OFFICIAL: | | | |
| 21. TYPED NAME Verlon Johnson | 22. TITLE: Associate Rec | gional U | |
| 23. REMARKS: | Administrator | | |
| FORM CMS-179 (07-92) Instructions on Back | | | |