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: SPA #10-15	2. STATE Kansas
	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 October 1, 2010	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Section 1137 of the Act and 42 CFR 435.940 through 435.960	7. FEDERAL BUDGET IMPACT: a. FFY 2011 $ 0 b. FFY 2012 $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.32-A, Page 2 (New)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Public Assistance Reporting Information System (PARIS)

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
X OTHER, AS SPECIFIED:
Andy Allison, PhD. is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL: Barbara E Langner	16. RETURN TO: Andy Allison, PhD. Kansas Health Policy Authority Landon State Office Building 900 SW Jackson, Room 900-N Topeka, KS 66612-1220
13. TYPED NAME: for Andy Allison, PhD.	
14. TITLE: Executive Director of the Kansas Health Policy Authority	
15. DATE SUBMITTED: October 12, 2010	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: October 12, 2010	18. DATE APPROVED: January 7, 2011
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2010	20. SIGNATURE OF REGIONAL OFFICIAL: James G. Scott
21. TYPED NAME: James G. Scott	22. TITLE: Associate Regional Administrator for Medicaid and Children's Health Operations
23. REMARKS:	

FORM HCFA-179 (07-92)