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: 10-010

2. STATE: Kentucky

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
10/1/2010

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:
42 CFR 435.940 through 4359.960
Section 1903(r) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 - Budget Neutral
b. FFY 2011 - Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Page 79, Section 4.32(c)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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

10. SUBJECT OF AMENDMENT
This State Plan Amendment will demonstrate compliance with the new requirements of Section 1903(r) of the Act by certifying that KY does have an eligibility determination system that provides data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other states.

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: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Neville J. Wise

13. TYPED NAME: Neville Wise

14. TITLE: Acting Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: October 18, 2010

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 10/19/10

18. DATE APPROVED: 12/17/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/10

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Jackie Glaze

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

23. REMARKS:

Approved with following changes as authorized by State Agency on email dated 11/16/10:

Block # 8 Changed to read: 42 CFR 435.940 through 435.960 Section 1903 (r) of the Act.

FORM HCFA-179 (07-92)