

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: 10-010	2. STATE Kentucky
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION		
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                       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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  Same

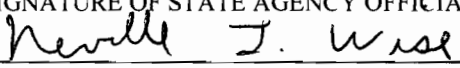
10. SUBJECT OF AMENDMENT  
This State Plan Amendment will demonstrate compliance with the new requirements of Section 1903(r) of the Act by certifying that KY does have an eligibility determination system that provides data matching through the Public Assistance Reporting Information System (PARIS), 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                       OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

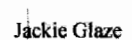
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO:  Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621
13. TYPED NAME: Neville Wise	
14. TITLE: Acting Commissioner, Department for Medicaid Services	
15. DATE SUBMITTED: October 18, 2010	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: 10/19/10	18. DATE APPROVED: 12/17/10
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**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.