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	I. TRANSMITTAL NUMBER: 11-001	2. STATE Kentucky
FOR: HEALTH CARE FINANCING ADMINISTRATION	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 01/01/2011	
5. TYPE OF PLAN MATERIAL (Check One):	The state of the s	
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CO	NSIDERED AS NEW PLAN	K AMENDMENT
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AME	ENDMENT (Separate Transmittal for each	amendment)
5. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(80) of P.L. 111-148 (Section 6505)	7. FEDERAL BUDGET IMPACT: a. FFY 2011 - Budget Neutral b. FFY 2012 - Budget Neutral	
R. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERS OR ATTACHMENT (If Applicable):	
Section 4, Page 80 (New)	None	APPROVED
TRANSPORTAL SERVICE OF APPROVAL OF	1. TRANSMITTAL NUMBER:	Ashart Centasky
10. SUBJECT OF AMENDMENT This State Plan Amendment is being submitted pursuant to SMD letter 10-0 services provided under the State plan or under a waiver to any financial ins	26 confirming that the State shall not provi titution or entity located outside of the Uni	de any payments for items ted 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	
2. SIGNATURE OF STATE AGENCY OFFICIAL:	16, RETURN TO:	CASUSTERNAL CONTRACTOR
I3. TYPED NAME: Neville Wise	Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621	
14. TITLE: Acting Commissioner, Department for Medicaid Services		
15. DATE SUBMITTED: January 18, 2011		
FOR REGIONAL O		
7. DATE RECEIVED:	18. DATE APPROVED: 01/31/11	在一个 自己的
PLAN APPROVED – ON		(1)
9. EFFECTIVE DATE OF APPROVED MATERIAL; 01/01/11	20. SIGNATURE OF REGIONAL OF	
1. TYPED NAME: Jackie Glaze	22. TITLE: A Sociate Regional Administrator Division of Medicaid & Children	s Health Opis
23. REMARKS:	English Carry Commence	
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Scotlaged From SV Conserved to the State of	None	
77. EXPENSES OF THE PROPERTY O	TO DATE AT SANGED TO THE	
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ORM HCFA-179 (07-92)	176—11-178 (2018) Reprint Made (2018) Substitution (2018) Charles (2018) (2018) (2018) (2018) (2018) (2018)	[2][[2][[2][[2][[2][[2][[2][[2][[2][[2]