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: 11-03	2. STATE Minnesota
	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 January 1, 2011	

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: §1917(c)	7. FEDERAL BUDGET IMPACT: a. FFY '11 $ (143,000) b. FFY '12 $ (622,000)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 9 to Attachment 2.6-A, pp. 1 - 9	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 9 to Attachment 2.6-A, pp. 1 - 9

10. SUBJECT OF AMENDMENT:
Eliminating a Penalty Period for Transfer of Assets

11. GOVERNOR'S REVIEW *(Check One)*:
x GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: Aberg	16. RETURN TO: Ann Berg Minnesota Department of Human Services 540 Cedar Street, PO Box 64983 St. Paul, MN 55164-0983
13. TYPED NAME: Ann Berg	
14. TITLE: Deputy Medicaid Director	
15. DATE SUBMITTED: February 24, 2011	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 02-24-11	18. DATE APPROVED: SEP 23 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 01-01-11	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Verlon Johnson	22. TITLE: Associate Regional Administrator

FORM HCFA-179 (07-92)