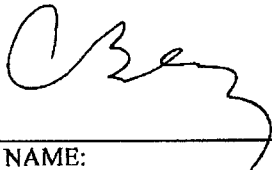



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 11-09	2. STATE Minnesota
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE October 1, 2011	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR §431.806 & 431.812(f)		7. FEDERAL BUDGET IMPACT: a. FFY \$0 b. FFY \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: p. 35		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): p. 35	
10. SUBJECT OF AMENDMENT: MEQC election in PERM eligibility review year			
11. GOVERNOR'S REVIEW (Check One):			
<input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		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: June 24, 2011			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 06-24-11		18. DATE APPROVED: AUG 11 2011	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10-01-11		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Verlon Johnson		22. TITLE: Associate Regional Administrator	