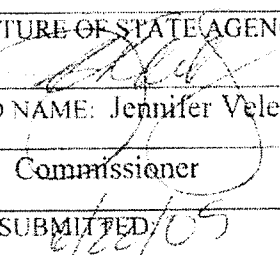
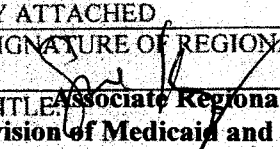


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-04-MA	2. STATE New Jersey
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2009	
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: Section 1903(v) of the Social Security Act		7. FEDERAL BUDGET IMPACT: a. FFY 2009: \$6.9 million b. FFY 2010: \$12.7 million	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 2.6-A, Page 3d ** SEE REMARKS		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): NEW	
10. SUBJECT OF AMENDMENT: Eligibility conditions and requirements for Medical Assistance for pregnant women and children lawfully admitted for permanent residence in the United States for less than five years and otherwise eligible for medical assistance (CHIPRA section 214)			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Not required, pursuant to 7.4 of the Plan <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Director John R. Guhl Division of Medical Assistance and Health Services P.O. Box 712, Mail Code #26 Trenton, NJ 08625-0712	
13. TYPED NAME: Jennifer Velez			
14. TITLE: Commissioner			
15. DATE SUBMITTED: 6/22/09			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: MAY 21 2010	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2009		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Sue Kelly		22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations	
23. REMARKS: Originally submitted plan pages have been replaced with revised pages on 03/30/2010. Pages were submitted in response to CMS RAI via State's e-mail. Originally submitted CMS 179 has been replaced with revised CMS 179 via State's e-mail of 05/05/2010.			