DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICIAD SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 09-11-MA

2. STATE: New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: June 19, 2007

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 440.130

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 $0.
b. FFY 2010 $0.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Addendum to Attachment 3.1-A Page 13(d).9
Addendum to Attachment 3.1-A Page 13(d).9a to Page 13(d).9e
** SEE REMARKS
Attachment 4.19-B Page 24.7

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same
New Pages
Same

10. SUBJECT OF AMENDMENT:
Community Mental Health Rehabilitation Services – Minimum Periodicity of Face-to-Face Visits

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
☒ OTHER, AS SPECIFIED:
Not required, pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Jennifer Velez

14. TITLE: Commissioner,
Department of Human Services

15. DATE SUBMITTED: December 1, 2009

16. RETURN TO:
Valerie J. Harr Director
Division of Medical Assistance and Health Services
P.O. Box 712, Mail Code #26
Trenton, NJ 08625-0712

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: APR 0 8 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUN 1 9 2007

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: **Michael Melendez**

22. TITLE: ~~Acting Associate Regional Administrator~~ **Division of Medicaid and State Operations**

23. REMARKS:

The revised page Attachment 3.1-A, page 13(d).9 submitted on 4/1/11 has replaced the corresponding page that was originally submitted on December 1, 2009.
Originally submitted page 4.19-B, page 24.7 was replaced with revised page submitted via State email of 3/8/11.