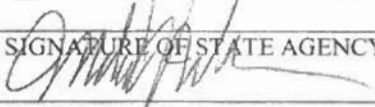
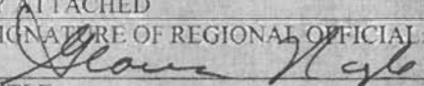


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 10-005	2. STATE NEVADA
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: January 1, 2010	
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: 1860D-14(a)(3)(D); 1902(a)(10)(E)(i)-(iv); P.L. 110-275 1905(p)(1)© of the Social Security Act		7. FEDERAL BUDGET IMPACT: Fiscal Impact Unknown a. FFY 2010 \$0 Due to New Legislation b. FFY 2011 \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <u>Attachment 2.2-A pages 9b, 9b1, 9b2</u> <u>Attachment 2.6-A page 22-23</u>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <u>Attachment 2.2-A pages 9b, 9b1, 9b2</u> <u>Attachment 2.6-A page 22-23</u>	
10. SUBJECT OF AMENDMENT: Increase resource limits for Qualified Medicare Beneficiaries, Qualifying Individuals and Specified Low-Income Medicare beneficiaries. Correction to section to reflect mandatory coverage group: Qualifying Individuals not previously specified.			
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 The Governor's Office does not <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL wish to review the State Plan Amendment.			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Marta Stagliano, Chief, Compliance DHCFP/Medicaid 1100 East William Street, Suite 101 Carson City, NV 89701	
13. TYPED NAME: Michael J. Willden			
14. TITLE: Director, Department of Health and Human Services			
15. DATE SUBMITTED: MAR 31 2010			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: March 31, 2010		18. DATE APPROVED: JUN 17 2010	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2010		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Gloria Nagle, PhD, MPA		22. TITLE: Regional Associate Administrator	
23. REMARKS: Pen and ink changes made to boxes 6 and 7.			