
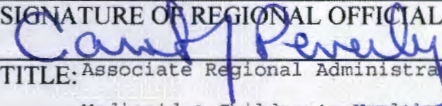


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 13-09	2. STATE Oregon
FOR: Centers for Medicare and Medicaid Services		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Medical Assistance	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE 7/1/2013	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>):			
<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 (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 1915(j) Social Security Act		7. FEDERAL BUDGET IMPACT: a. FFY 2013 \$ 0 b. FFY 2014 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Section 3, Page 19d Attachment 3.1-A, Page 11 Supplement 3 to Attachment 3.1-A, page 1- 20 ²² (P&I)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 3.1-A, Page 11 Supplement 3 to Attachment 3.1-A, page 1-14	
10. SUBJECT OF AMENDMENT: This transmittal is being submitted to amend 1915(j) eligibility criteria.			
11. GOVERNOR'S REVIEW (<i>Check One</i>):			
<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 <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Division of Medical Assistance Programs Oregon Health Authority 500 Summer Street NE E-35 Salem, OR 97301 ATTN: Jesse Anderson, State Plan Manager	
13. TYPED NAME Judy Mohr Peterson			
14. TITLE: Director, Division of Medical Assistance Programs			
15. DATE SUBMITTED: 6/27/2013			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: June 27, 2013		18. DATE APPROVED: September 24, 2013	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2013		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Carol J.C. Peverly		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS:			