DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 8

2. STATE: CO

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
July 1, 2001

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:
1902(a)(10)(A)(ii) and 1905(a) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ $0.00
b. FFY 2002 $ $0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 2.2-A
Page 9c

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Eligibility for individuals who are eligible for, but not receiving cash assistance.

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Richard C. Allen

14. TITLE:
Director, Office of Medical Assistance

15. DATE SUBMITTED:
August 13, 2001

16. RETURN TO:
Colorado Department of Health Care Policy and Financing
1575 Sherman St., Denver, Colorado
80203-1714
ATTN: Karen Snell

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 25, 2001

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Spencer K. Ericson

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: Hand-carried September 25, 2001

FORM HCFA-179 (07-92)

Instructions on Back

State: Colorado

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy

42 CFR 435.210 1902(a)(10)(A)(ii) and 1905(a) of the Act

☐ 1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

☐ The plan covers all individuals as described above.

☐ The plan covers only the following group or groups of individuals:

___ Aged
___ Blind
___ Disabled
___ Caretaker relatives
___ Pregnant women

42 CFR 435.211

☒ 2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

Agency that determines eligibility for coverage. County Dept. of Social Services / Social Security