

State/Territory: District of Columbia

SECTION 7 - GENERAL PROVISIONS

Citation

42 CFR 430.12(c)

7.1 Plan Amendments

The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

State/Territory: District of Columbia

Citation

7.2 Nondiscrimination

45 CFR Parts
80 and 84

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et.seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

Revision: HCFA-PM-91- 4
AUGUST 1991

(BPD)

OMB No. 0938-

State/Territory: District of ColumbiaCitation7.3 Maintenance of AFDC Efforts

1902(c) of
the Act

— The State agency has in effect under its approved
AFDC plan payment levels that are equal to or more than
the AFDC payment levels in effect on May 1, 1988.

Not Applicable

TN No. 02-06
Supersedes
TN No. _____

Approval Date

NOV 27 2002

Effective Date

JAN 01 2002

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No. 0938

State/Territory: District of Columbia

Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

☐ Not applicable. The Governor--

☐ Does not wish to review any plan material.

☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

THE DEPARTMENT OF HEALTH (OFFICE OF MEDICAL ASSISTANCE)
(Designated Single State Agency)

Date: August 29, 2002


(Signature)

Acting Director

(Title)

TN. No.
Supersedes
TN No.

Approval Date

NOV 27 2002

Effective Date

JAN 01 2002

HCFA ID:7982E