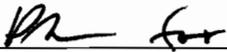
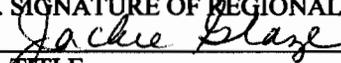


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|---|--|---|---------------------|
| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | | 1. TRANSMITTAL NUMBER: 2012-004 | 2. STATE Florida |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | | 4. PROPOSED EFFECTIVE DATE March 30, 2012 | |
| 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: 1902 (q) of the Act | | 7. FEDERAL BUDGET IMPACT: (in thousands) FY 2011-12 - \$304 FY 2012-13 - \$619 | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 15 to Attachment 2.6-A Page 1 | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Supplement 15 to Attachment 2.6-A Page 1 | |
| 10. SUBJECT OF AMENDMENT: Variations on the Personal Needs Allowance | | | |
| 11. GOVERNOR'S REVIEW (<i>Check One</i>): | | | |
| <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | | <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Reviewed by the Deputy Secretary for Medicaid who is the Governor's designee. | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:  | | 16. RETURN TO: Mr. Justin M. Senior Acting Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308 Attention: Robin Ingram | |
| 13. TYPED NAME: Mr. Justin M. Senior | | | |
| 14. TITLE: Acting Deputy Secretary for Medicaid | | | |
| 15. DATE SUBMITTED: 3/30/12 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: 03/30/12 | | 18. DATE APPROVED: 06/21/12 | |
| PLAN APPROVED - ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/12 | | 20. SIGNATURE OF REGIONAL OFFICIAL:  | |
| 21. TYPED NAME: Jackie Glaze | | 22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns | |
| 23. REMARKS: | | | |