

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: SPA 09-015	2. STATE Florida
		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 April 1, 2009	
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: 1932 (B) (2) of the Act		7. FEDERAL BUDGET IMPACT: a. FFY: 2008-09 \$594 b. FFY: 2009-10 \$1188	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Page 21		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A, Page 21	
10. SUBJECT OF AMENDMENT: exempting patients 21 years of age or older from the 45 day per fiscal year limit when services are related to the treatment of Tuberculosis provided by a public health hospital, currently known as A.G. Holley Hospital.			
11. GOVERNOR'S REVIEW (Check One):			
<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:	
13. TYPED NAME: Mr. Carlton D. Snipes		Mr. Carlton D. Snipes Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308	
14. TITLE: Deputy Secretary for Medicaid		Attention: Robin Ingram	
15. DATE SUBMITTED: 6/30/09			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 06/30/09		18. DATE APPROVED: 09/25/09	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 04/01/09		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Mary Kaye Justis, RN, MBA		22. TITLE: Acting Associate Regional Administrator Division of Medicaid & Children's Health Opns	
23. REMARKS: Approved with the following change as authorized by State Agency on email dated September 3, 2009: Block #7b FFY: 2009-10 1,188,000; changed to read: Block 7b FFY 2009-10 1,079,000			