

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 2010-011	2. STATE Florida
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		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 October 1, 2010	
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: Section 1902(a)(73) of the Act		7. FEDERAL BUDGET IMPACT: (in thousands) No Fiscal Impact.	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Section 1.4 Tribal Consultation Requirements		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ): Section 1.4 Tribal Consultation Requirements	
10. SUBJECT OF AMENDMENT: Tribal Consultation			
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      Reviewed by the Deputy Secretary for Medicaid <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL      who is the Governor's designee.			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Ms. Roberta K. Bradford Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308 Attention: Robin Ingram	
13. TYPED NAME: Ms. Roberta K. Bradford			
14. TITLE: Deputy Secretary for Medicaid			
15. DATE SUBMITTED: 10/20/10			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: 01-04-11	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10-01-10		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Opns	
23. REMARKS:			