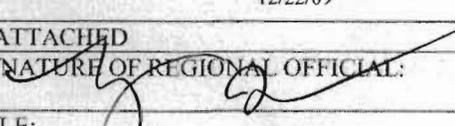


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 2009-023	2. STATE Florida
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE December 1, 2009	
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: 42 CFR 435.112, 1902(a)(52), 1902(e)(1), and 1925 of the Act		7. FEDERAL BUDGET IMPACT: (in thousands) a. FFY 2009-10: \$2.73 b. FFY 2010-11: \$3.31	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 12 to Attachment 2.6-A Page 4		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ): NEW	
10. SUBJECT OF AMENDMENT: Transitional Medical Assistance			
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. Phil E. Williams Interim 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. Phil E. Williams			
14. TITLE: Interim Deputy Secretary for Medicaid			
15. DATE SUBMITTED: 12/9/09			
17. DATE RECEIVED: 12/09/09			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 12/09/09		18. DATE APPROVED: 12/22/09	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 12/01/09		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:			