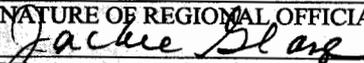


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 2012-012	2. STATE Florida
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE December 6, 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: 42 CFR 440		7. FEDERAL BUDGET IMPACT: (in thousands) FFY 2012-2013 No Fiscal Impact	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Section 3.1-A page 50 Section 3.1-A page 51 Section 3.1-B page 47 Section 3.1-B page 48 Section 4.19-B page 25 Section 4.19-B page 28 Section 4.19-B page 36		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Section 3.1-A page 50 Section 3.1-A page 51 Section 3.1-B page 47 Section 3.1-B page 48 Section 4.19-B page 25 Section 4.19-B page 28 Section 4.19-B page 36	
10. SUBJECT OF AMENDMENT: Federally Qualified Health Centers			
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 Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308 Attention: April Cook	
13. TYPED NAME: Mr. Justin M. Senior			
14. TITLE: Deputy Secretary for Medicaid			
15. DATE SUBMITTED: 12/12/12			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 12/12/12		18. DATE APPROVED: 03/11/13	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 12/06/12		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns	
23. REMARKS:			