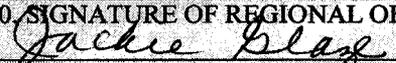


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 2012-021	2. STATE Florida
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE December 13, 2012	
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: 42 CFR 435.725		7. FEDERAL BUDGET IMPACT: (in thousands) FFY 2012-2013 \$ FFY 2013-2014 \$ Please see attached narrative	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 3 to Attachment 2.6-A page 1		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 3 to Attachment 2.6-A page 1	
10. SUBJECT OF AMENDMENT: Treatment of Post Eligibility Income			
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: 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: 12-21-12			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 12-21-12		18. DATE APPROVED: 05-09-13	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 12-13-12		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns	
23. REMARKS: Approved with the following changes to item 7 as authorized by State Agency e-mails dated 02-28-13: Block # 7a Changed to read: FFY 12 -13 \$28,360 and 7b FFY13-14 \$35,794			