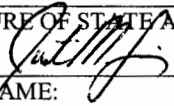
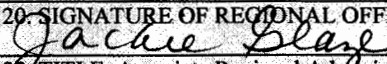


ANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 2013-013	2. STATE Florida
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE September 11, 2013	
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: 1915i		7. FEDERAL BUDGET IMPACT: (in thousands) FFY 2012-2013 \$690 FFY 2013-2014 \$3,322	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 5 to Attachment 3.1-A Supplement 5 to Attachment 3.1-A adding pages 44 + 45 Attachment 4.19-B pages 44 + 45 to be included in Supplement 5 to Attachment 3.1-A		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 5 to Attachment 3.1-A Attachment 4.19-B pages 44+ 45 to be included in Supplement 5 to Attachment 3.1-A	
10. SUBJECT OF AMENDMENT: Revised 1915i			
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: 8/30/13			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 08-30-13		18. DATE APPROVED: 10-25-13	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 09-11-13		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-mail dated 09/19/13: Block # 7 Changed to read: FFY 2012-2013 \$151,290.00			