HEALTH CARE FINANCING ADMINISTRATION	4	OMB NO. 0938-0193
TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 09-003	2. STATE Florida
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO DECIONAL ADMINISTRATOR	A DRODOGED REPROTENTED ATTO	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE March 1, 2009	
5. TYPE OF PLAN MATERIAL (Check One):		
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)		
6. FEDERAL STATUTE/REGULATION CITATION: 1902 (a) of the Act	7. FEDERAL BUDGET IMPACT: IN THOUSANDS 2008-09 (\$1252) 2009-10 (\$1543)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERS	SEDED PLAN SECTION
Attachment 4.19-B, Exhibit I, Version XIX	OR ATTACHMENT (If Applicable):	
TRALEBY EST CRELENCING ACTIVISTICATION	Attachment 4.19-B, Exhibit I, Version XVIII FORM APPROVED	
TRANSPORTAGE AND NOTICE OF APERCYCLO?	LERANGED LA TOTAL OF THE PARTY	
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MINISTER AND ALL COMPANY OF THE PARTY OF THE		
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10. SUBJECT OF AMENDMENT:		
Florida Title XIX Outpatient Hospital Reimbursement Plan		
DEALTH CARE PRANTER: ADD INSTRACTION	June 1 4509	
CHECKSTATES IN THE AUTHORITY AND FRANCES OF STREET	THE PARTY OF THE P	
11. GOVERNOR'S REVIEW (Check One):		
☐ OTHER, AS SPECIFIED:		
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED		
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	PRINCIPLE CONTROL Transported for the	a se se "Kito"
A PERFECT AND A LATTER DESIGNATION	TV set Child a Would Town	BECHNANDS.
12 SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: Mr. Carlton D. Snipes	
(alfor Kymely	Deputy Secretary for Medicaid	
13. TYPED NAME:	Agency for Health Care Administra	ation
Mr. Carlton D. Snipes	2727 Mahan Drive, Mail Stop #8	
14. TITLE: Deputy Secretary for Medicaid	Tallahassee, FL 32308	
	1 A 1479	
3/20/09	Attention: Robin Ingram	
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED: 03/24/09	18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20-SIGNATURE OF REGIONAL OF	FICIAL:
03/1/09	Corrag Limby for	
21. TYPED NAME:	22. TITLE: Associate Regional Administ	rato
Jackie Glaze	Division of Medicaid & Chil-	
23. REMARKS: 175 - act amount of the control of the		
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