



<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 2009-020	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 July 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 447		7. FEDERAL BUDGET IMPACT: No Fiscal Impact a. FFY \$0 b. FFY \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Supplement B		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ): Attachment 4.19-B, Supplement B	
10. SUBJECT OF AMENDMENT: County Health Department Reimbursement Plan Version VII			
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. Carlton D. Snipes 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. Carlton D. Snipes			
14. TITLE: Deputy Secretary for Medicaid			
15. DATE SUBMITTED: 9/29/09			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 09/29/09		18. DATE APPROVED: 08/03/10	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/09		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Opns	
23. REMARKS:			