DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2009-021

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
October 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(q)(1) and (2) of the Act

7. FEDERAL BUDGET IMPACT: (in thousands)
No Fiscal Impact

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 2.6-A Supplement 15 Page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 2.6-A Supplement 15 Page 1

10. SUBJECT OF AMENDMENT:
Variations from the Personal Needs Allowance.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Reviewed by the Deputy Secretary for Medicaid who is the Governor's designee.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Mr. Phil E. Williams

14. TITLE:
Interim Deputy Secretary for Medicaid

15. DATE SUBMITTED:
12/16/09

16. RETURN TO:
Mr. Phil E. Williams
Interim Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

Attention: Robin Ingram

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/17/09

18. DATE APPROVED:
07/09/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
09/01/09

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Jackie Glaze

22. TITLE:
Associate Regional Administrator
Division of Medicaid & Children's Health Opns

23. REMARKS:

FORM HCFA-179 (07-92)