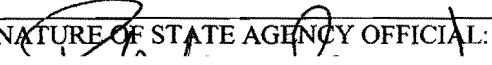
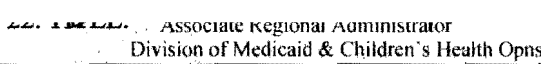


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| 13 TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | | 1. TRANSMITTAL NUMBER: 2010-013 | 2. STATE Florida |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | | 4. PROPOSED EFFECTIVE DATE October 1, 2010 | |
| 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 440.50, 440.100, 440.130 | | 7. FEDERAL BUDGET IMPACT: (in thousands) No Fiscal Impact | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Page 5, 24, 32 Attachment 3.1-B, Page 6, 24, 31 | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A, Page 5, 24, 32 Attachment 3.1-B, Page 6, 24, 31 | |
| 10. SUBJECT OF AMENDMENT: Telemedicine | | | |
| 11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Reviewed by the Deputy Secretary for Medicaid <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL who is the Governor's designee. | | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:  | | 16. RETURN TO: Ms. Roberta K. Bradford Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308 Attention: Robin Ingram | |
| 13. TYPED NAME: Ms. Roberta K. Bradford | | | |
| 14. TITLE: Deputy Secretary for Medicaid | | | |
| 15. DATE SUBMITTED: 12/16/10 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: | | 18. DATE APPROVED: 03-16-11 | |
| PLAN APPROVED - ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 10-01-10 | | 20. SIGNATURE OF REGIONAL OFFICIAL:  Associate Regional Administrator Division of Medicaid & Children's Health Opns | |
| 21. TYPED NAME: Jackie Glaze | | | |
| 23. REMARKS: Approved with following changes as authorized by State Agency on email dated 02/25/11: Block # 8 <u>changed to read</u> : Atch 3.1-A page 11a and Atch 3.1-B page 11 (new) Block # 9 <u>changed to read</u> : Atch 3.1-A page 11a and Atch 3.1-B page 11 (new) | | | |