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: 2011-001

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, 2011

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:
42 CFR 440.167

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

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A Page 9
Attachment 3.1-A Page 12
Attachment 3.1-A Page 2b.2
Attachment 4.19-B Page 3
Attachment 4.10-B Page 3c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A Page 9
Attachment 3.1-A Page 12
Attachment 3.1-A Page 2b.2
Attachment 4.19-B Page 3
Attachment 4.10-B Page 3c

10. SUBJECT OF AMENDMENT: Prescribed Pediatric Extended Care

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:
Justin M. Senior

13. TYPED NAME:
Justin M. Senior

14. TITLE:
Acting Deputy Secretary for Medicaid

15. DATE SUBMITTED: 10/20/11

16. RETURN TO:
Mr. Justin M. Senior
Acting 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: 10/21/11

18. DATE APPROVED: 1/17/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/1/11

20. SIGNATURE OF REGIONAL OFFICIAL:
Tina Roberts for Jackie Glaze

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 8 and 9 as authorized by State Agency on email dated: 1-18-12

**Block# 8 changed to read:** Attachment 3.1-A pages 9, 12 and 12a; Attachment 3.1-B pages 12, 8 and 12a; Attachment 4.19-B pages 3 and 3c

**Block#9 changed to read:** Attachment 3.1-A pages 9, 12 and 12a; Attachment 3.1-B pages 12, 8 and 12a (new); Attachment 4.19-B pages 3 and 3c (new)