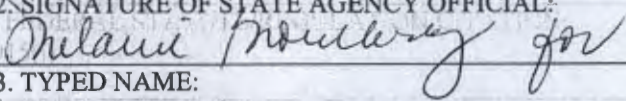
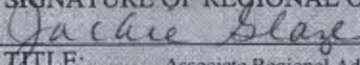


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 2011-016	2. STATE Florida
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE October 1, 2011	
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: 1915(j)		7. FEDERAL BUDGET IMPACT: (in thousands) No Fiscal Impact	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 4 to Attachment 3.1-A Pages 1-6, 8, 10-12, 16, 17, 21 Attachment 4.19-B Page 47		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 4 to Attachment 3.1-A Pages 1-6, 8, 10-12, 16, 17, 21 Attachment 4.19-B Page 47	
10. SUBJECT OF AMENDMENT: 1915(j) Personal Care Services/Consumer Directed Care Plus			
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: Mr. Justin M. Senior 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. Justin M. Senior			
14. TITLE: Deputy Secretary for Medicaid			
15. DATE SUBMITTED: 12/28/11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 12/28/12		18. DATE APPROVED: 03/19/12	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/11		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns	
23. REMARKS:			