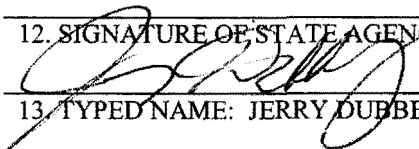
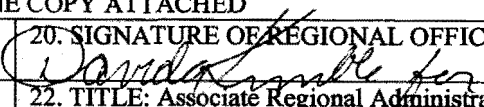


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 13-001	2. STATE GEORGIA
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2013	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):			
<input type="checkbox"/> NEW STATE PLAN                      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: 430.12(b)		7. FEDERAL BUDGET IMPACT: FFY 2013 \$0 FFY 2014 \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  89		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  89	
10. SUBJECT OF AMENDMENT: State Governor's Review			
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: Single State Agency Comments Attached	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:  Department of Community Health Division of Medicaid 2 Peachtree Street, NW, 36 <sup>th</sup> Floor Atlanta, Georgia 30303-3159	
13. TYPED NAME: JERRY DUBBERLY			
14. TITLE: CHIEF, DIVISION OF MEDICAID			
15. DATE SUBMITTED:			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 02/22/13		18. DATE APPROVED: 03/04/13	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/13		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Opns	
23. REMARKS:			