TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	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 *(Check One)*:

☐ NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: 89

10. SUBJECT OF AMENDMENT:
State Governor's Review

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: Single State Agency Comments Attached

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: JERRY DUBBERLY	Department of Community Health Division of Medicaid 2 Peachtree Street, NW, 36th Floor Atlanta, Georgia 30303-3159
14. TITLE: CHIEF, DIVISION OF MEDICAID	
15. DATE SUBMITTED:	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 02/22/13	18. DATE APPROVED: 03/04/13
PLAN APPROVED – ONE COPY ATTACHED	
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: