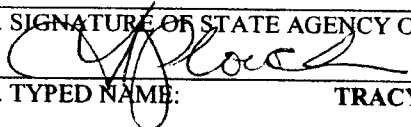



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 08-011	2. STATE OHIO
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		4. PROPOSED EFFECTIVE DATE OCTOBER 4, 2010	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		5. TYPE OF PLAN MATERIAL (<i>Check One</i>):	
<input type="checkbox"/> NEW STATE PLAN AMENDMENT		<input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN	
<input checked="" type="checkbox"/>			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 430.12 42 CFR 440.225		7. FEDERAL BUDGET IMPACT: a. FFY 11 \$ 13496 K b. FFY 12 \$ 13991 K	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: ATTACHMENT 4.19-B, ITEM 13-d-1, PAGES 1 AND 2 ATTACHMENT 4.19-B, ITEM 13-d-2, PAGES 1 AND 2 ATTACHMENT 3.1-A, ITEM 13-d-1, PAGES 1 THROUGH 20 ATTACHMENT 3.1-A, ITEM 13-d-2, PAGES 1 THROUGH 16		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): ATTACHMENT 4.19-B, REFERENCE PREPRINT, PAGES AND 6 OF ATTACHMENT 3.1-A, ITEM 13. PAGES 1 THROUGH 4 ATTACHMENT 4.19-B, REFERENCE PREPRINT, PAGES AND 6 OF ATTACHMENT 3.1-A, ITEM 13. PAGE 1 OF 1 ATTACHMENT 3.1-A, PRE-PRINT PAGES 5 AND 6, ITEM 13. PAGES 1 THROUGH 8 ATTACHMENT 3.1-A, PRE-PRINT PAGES 5 AND 6, ITEM 13. PAGES 1 AND 2	
10. SUBJECT OF AMENDMENT: 13.d.1. REHABILITATIVE SERVICES PROVIDED BY COMMUNITY MENTAL HEALTH FACILITIES and 13.d.2. REHABILITATION SERVICES PROVIDED BY ALCOHOL AND OTHER DRUG TREATMENT PROGRAMS			
11. GOVERNOR'S REVIEW (<i>Check One</i>):		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Governor has delegated signature authority to ODJFS Director. Director has delegated signature authority to Medicaid Director	
<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			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME: TRACY J. PLOUCK		Becky Jackson	
14. TITLE: MEDICAID DIRECTOR		OHP/Bureau of Health Plan Policy	
15. DATE SUBMITTED: 7-14-10		Ohio Department of Job and Family Services	
		P.O. BOX 182709	
		Columbus, Ohio 43218	
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 04-22-08		18. DATE APPROVED: SEP 10 2010	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 4, 2010		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Verlon Johnson		22. TITLE: Associate Regional Administrator	