

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR**

ACTION REFERRAL

TO <i>Hutto</i>	DATE <i>12-11-14</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000137	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Kost, Lynch Cleared 12/19/14, letter attached.</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>12-19-14</i>
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

LINDSEY O. GRAHAM
SOUTH CAROLINA



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WASHINGTON, DC 20510
(202) 224-5972

UNITED STATES SENATE Fax Transmittal Sheet

RECEIVED

DEC 11 2014

Department of Health & Human Services
OFFICE OF THE DIRECTOR

TO: DHHS 848 4515

FROM: Sgt Jalka

DATE: 12/10

COMMENTS: Amson

[Signature]

2 PAGE(S) TO FOLLOW

IF THERE IS ANY PROBLEM RECEIVING THIS FAX, PLEASE
CALL (803) 933-0112.

Confidentiality: This message is intended solely for the use of the addressee and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the person responsible for delivering it to the recipient, you are put on notice that any dissemination, distributing or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by phone and return the original message at the address via U.S. Postal Service.
Thank you.

508 HAMPTON STREET
SUITE 202
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(803) 933-0112

401 WEBB EVANS STREET
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(843) 668-1505

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UNITED STATES SENATE AUTHORIZATION FORM

By providing the information below and signing this form, I hereby authorize the appropriate agency to furnish the office of U.S. Senator Lindsey Graham information pertaining to my claim or request. This authorization is in accordance with the Privacy Act of 1974.

Name: MICHAEL LESLEY HINSON Phone: 803-760-0545

Address: 101 SALUDA PT. DR. APT 821

City: LEXINGTON State: S.C. Zip: 29072

Social Security Number: 247-27-8585 VA Number (if applicable): SOME 15 SSN

In the space below, briefly describe the problems that you are experiencing and explain exactly what you would like Senator Graham to do on your behalf. Without this information, it will be impossible for Senator Graham to adequately assist you. (If you need more space, please use the back of the form).

APPLIED FOR MEDICAID ON 10/31/14. CHECKED SEVERAL TIMES WITH MEDICAID IN LEXINGTON TO SEE IF I QUALIFY. EACH TIME I WAS TOLD THAT MEDICAID HAS NOT EVEN STARTED ON MY APPLICATION YET DUE TO NEW SYSTEM THAT THEY ARE USING. AS A DISABLED VET, WITH CHRONIC SYSTEMIC CONDITIONS, I FEEL THAT THIS NEGLECT FOR ME AND OTHERS THAT NEED MEDICAL HELP.

Signed: Michael Lesley Hinson Date: 12/2/14

NOTE: Those requesting assistance from Senator Graham should note that if they are represented by an attorney, that attorney must contact the Senator's office by letter or telephone before action can proceed. This is to eliminate any confusion and it is in the best interest of the client.

If represented by an attorney, please give attorney's name _____

Please return form to:
U.S. Senator Lindsey O. Graham
508 Hampton Street, Suite 202
Columbia, South Carolina 29201
Phone: (803) 933-0112
Fax: (803) 933-0957

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Log # 137



Nikki Haley GOVERNOR
Christian L. Sours INTERIM DIRECTOR
P.O. Box 8206 Columbia, SC 29202
www.scdhhs.gov

December 19, 2014

Mr. Michael Lesley Hinson
101 Saluda Point Drive, Apartment 821
Lexington, SC 29072

Dear Mr. Hinson:

Senator Lindsey Graham contacted our agency on your behalf regarding your application for Medicaid benefits.

Medicaid eligibility is based on federal and state requirements. To qualify for Medicaid, an individual must meet certain financial guidelines and categorical requirements. An individual under the age of 65 must be determined disabled. The Medicaid program uses the same disability guidelines as the Social Security Administration when determining disability. This determination is made by Vocational Rehabilitation Disability Determination Service (VRDDS).

Our records indicate that you applied for Medicaid under the Aged, Blind or Disabled (ABD) program on October 27, 2014. On December 9, 2014, you returned the requested paperwork in order for VRDDS to make a disability determination. The disability determination will take a minimum of ninety (90) days. We must await VRDDS decision, before we can determine your Medicaid eligibility. Once a determination is made you will be notified.

If you have questions regarding the Medicaid program, you may contact Ms. Carolyn Roach in Member Relations and she will be happy to assist you. Ms. Roach can be reached at (803) 898-3967.

We appreciate your continued interest and support of the South Carolina Healthy Connections Medicaid program. If I may be of further assistance on this or any other matter, please let me know.

Sincerely,

Elizabeth B. Hutto, Deputy Director
Eligibility, Enrollment & Member Services

BH:j

