

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Myers</i>	DATE <i>10-3-07</i>
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DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER <i>000176</i>		<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____	
2. DATE SIGNED BY DIRECTOR		<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____	
<i>*Note: Nec. Action Via e-mail.</i>		<input type="checkbox"/> FOIA DATE DUE _____	
		<input checked="" 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.			

From: "Thread Kim" <Kim.Thread@medela.com>
 To: <polatty@scdhs.gov>
 Date: 10/2/2007 3:46:19 PM
 Subject: Request for information

I am requesting to have a report sent to me on the number of lives that are dual insured with Medicare primary and Medicaid secondary in the state of South Carolina. You can send this report to me at the following address:

Kim Thread

c/o Mededa Healthcare

1101 Corporate Drive

McHenry, IL 60050

Contact phone number: 904-838-6361

*Log: Myers
 (Kevin)
 ne. abur
 via email*

RECEIVED

OCT 03 2007

Department of Health & Human Services
 OFFICE OF THE DIRECTOR

The contents of this message may be privileged and confidential. Therefore, if this message has been received in error, please delete it without reading it. Your receipt of this message is not intended to waive any applicable privilege. Please do not disseminate this message without the permission of the author.



State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

TO:

FROM:

SUBJECT: Cost of Processing Request for Information

The South Carolina Department of Health and Human Services has received and processed your Information request. The cost for processing this information is as follows:

Staff processing time at \$10.00 per hour	_____ Hours	\$ _____
Pages copied at \$.10 per page	_____ Pages	\$ _____
Pages faxed at \$.20 per page	_____ Pages	\$ _____
Shipping and Handling Costs		\$ _____
Other costs associated with the FOIA request:	_____	\$ _____
Total Amount Due SCDHHS:		\$ _____

Please remit the above amount to the following address:

Bureau of Fiscal Affairs
South Carolina Department of Health and Human Services
Post Office Box 8297
Columbia, South Carolina 29202-8397

Please contact _____ should you have any questions.

Signature _____

Date: _____

Finance and Administration
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2503 Fax (803) 255-8235