DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Supra	8-14-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000074	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Lynch cleared 3/29/13, letter attached	[X] Prepare reply for appropriate signature DATE DUE 8-21-13 [ ] FOIA DATE DUE _____ [ ] 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.			

J. Roland Smith
District No. 84 - Aiken County
183 Edgar Street
Warrenville, SC 29851

Committees:
Ways and Means, 3rd V.C.
Transportation and Regulatory Subcommittee, Chairman
Revenue Policy
Invitations & Memorial Resolutions

House of Representatives
State of South Carolina

522B Blatt Building
P.O. Box 11867
Columbia, SC 29211

Tel. (803) 734-3115

August 9, 2013

Mr. Anthony Keck, Director
SC Department of Health and Human Services
2600 Bull Street
Columbia, SC 29201

Re: Devin Jones, SSN: 251-99-1925; DOB: September 30, 1996
Medicaid No. 1885282201; Case No. 10025537

Dear Mr. Keck:

I have been contacted by Ms. Calla Rhoden who resides at 34 Saddle Horse Road, Warrenville, SC 29851; telephone 803.593.4042. Ms. Rhoden is requesting assistance with her efforts to continue receiving Medicaid benefits for her son. I have enclosed documentation that will further explain the case.

If I can be of further assistance, please feel free to contact me.

Sincerely,

J. Roland Smith

JRS/ss/aug8-13-8

Enclosure

South Carolina Department of Health and Human Services

MEDICAL SUPPORT REFERRAL FOR LOW INCOME FAMILIES (LIF) CASES

Must be completed in ink — **Agency Use Only**

Family Number	Medicaid ID Number	County	Date Referred to Child Support Enforcement
10042537	18833822201	42	

If Good Cause has been determined, attach the verification and documentation to the DHHS Form 2700 and file in the case record.

CUSTODIAL PARENT (CP) INFORMATION

Name: *(Last, First, MI)*	Social Security No:	Sex:	Date of Birth:	Relationship to Children:	Race:
Rhoden Calla	214-86-9179	☐ M ☑ F	5/1463	Mother	☑ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other:

Street Address: 34 Saddle Horse Rd City: Aiken State: SC Zip Code: 29851

Mailing Address: City: State: Zip Code:

Name/Address of Your Employer: "None" Shift: Home Telephone No: (803) 593-5067 Work Telephone No: (803) 634-2288

Do you have an attorney actively engaged in child support action? ☐ Yes ☐ No *(If Yes, attach release.)*

Current Marital Status: ☐ Married ☑ Divorced ☐ Common Law ☐ Other _____ Spouse's Name: _____

Place of Marriage: _____ Marriage Date: / / Divorce Date: / /

LIST NAMES OF CHILDREN TO BE SUPPORTED BY ABSENT PARENT

Child's Name	Child's Sex	Child's Medicaid ID No	Child's SS Number	Child's Birth Date	Child's Birthplace	Paternity Legally Verified?
Devin Jones	☑ M ☐ F		251-99-1935	9/30/96		☐ Yes ☐ No
	☐ M ☐ F			/ /		☐ Yes ☐ No
	☐ M ☐ F			/ /		☐ Yes ☐ No
	☐ M ☐ F			/ /		☐ Yes ☐ No

Relationship of children's parents at time of birth: ☐ Married ☐ Divorced ☐ Common Law ☐ Other _____

If Married, Date of Marriage: / / Place of Marriage *(City/State)*:

ABSENT PARENT INFORMATION

(Information is crucial to locate activity. Fill out completely and accurately.)

Father Info

Name *(Last, First, MI)*	Alias/Nickname:	Social Security No:

Mailing Address:	City:	State:	Zip Code:	Is address current? ☐ Yes ☐ No	If No, date last lived there: / /
Street Address:	City:	State:	Zip Code:	Is address current? ☐ Yes ☐ No	If No, date last lived there: / /
Previous Address:	City:	State:	Zip Code:	Home Telephone No: ( )	Work Telephone No: ( )

Date of Birth: / /	Birthplace:	Driver's License No:	Expiration Date: / /	Current Marital Status:

Sex: ☐ M ☐ F	Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other:	Weight: lbs	Height: ft in	Hair Color:	Eye Color:	Identifying Marks:

Last Known Employer's Address/Telephone No: ( )	Date Last Worked: / /	Monthly Salary: $

Father's Name & Address/Telephone No: ( )

Mother's Name & Address/Telephone No: ( )

Name/Address of Last School Attended:

Police Record? ☐ Yes ☐ No	Date of Arrest: / /	Place: *(City/State)*	Offense:	Location of Incarceration:	Release Date: / /

Usual Occupation:	Served in Armed Forces: ☐ Yes ☐ No	Branch:	Entry Date: / /	Discharge Date: / /

SUPPORT INFORMATION

Do you receive child support? ☐ Yes ☐ No

Are payments made to you or through the courts ? If other, explain: To me *or* Through the courts *(Circle the correct answer.)*

Child's Name	Amount	Voluntary?	Court-ordered?	How often paid?	Date last payment was received?	Amount overdue?
Devin	$	☐ Yes ☐ No	☐ Yes ☐ No		/ /	$
	$	☐ Yes ☐ No	☐ Yes ☐ No		/ /	$
	$	☐ Yes ☐ No	☐ Yes ☐ No		/ /	$
	$	☐ Yes ☐ No	☐ Yes ☐ No		/ /	$

If Court-ordered, Docket Number: _____

Name/Address of Court:

☐ If any answer above is unknown, the information is truly not known and I have no way of finding out the information.

☐ I give the above information as truthful and correct to the best of my knowledge for the purpose of receiving Medicaid and will be used in court against the absent parent

Signature of Custodial Parent/Applicant	Date: / /	Signature of Medicaid Eligibility Worker:	Date: / /

Please answer question 17 ONLY if you are pregnant or applying for children in the home.

17. Does the equity value of all your assets add up to more than $30,000? Do not count the value of the home you live in or up to $20,000 of equity value per vehicle for each licensed driver.

☐ **Yes, my assets are over $30,000** ☐ **No, my assets are less than $30,000**

Assets are things that you own, such as cars, boats, trailers, non-homestead property, checking and savings accounts, cash, and CDs. Equity value is how much something is worth minus any money owed on it. (For example, a vehicle that is valued at $5000, and $2000 is still owed on it, has an equity value of $3000.)

Please answer questions 18 and 19 ONLY if you are applying for a disabled child OR if you or your spouse are blind, disabled, or aged 65 or older AND are applying for Medicaid

18. Look at the list below. Check the box for anything on the list that you, your spouse, or other person in your home may own. For anything that you check, please tell us about it on the lines below.

When we start working on your application, you may be asked to send in proof of the assets you tell us about.

☐ Bank Checking Account
☐ Safe Deposit Box (Include a list of the contents)
☐ Stocks, Bonds, or Mutual Funds
☐ 401K, IRA or other Retirement Account
☐ DirectExpress Debit Card for SSA, SSI or other benefits
☐ Bank Savings Account
☐ Car, Truck, Van
☐ Motorcycle, Boat, Camper
☐ Pre Need Burial Contract
☐ Other (Please be specific):
☐ Certificate of Deposit
☐ Annuity (If Yes, provide a copy)
☐ Farm Machinery or Business Equipment
☐ Cemetery Burial Space
☐ Trust Fund or Trust Account
☐ Cash on Hand
☐ Life Insurance
☐ Money Set Aside for Burial

Owned By	Tell us about the asset Include the location, such as the name of bank or funeral home, and any account numbers or other information used to identify the asset	Current Value or Balance

19. Do you or your spouse own any property? *If you answer **YES** to any of the following questions, please tell us about the property on the next page.*

Home (house, buildings and land where you live) ☐ Yes ☐ No
Land (not connected to the home) ☐ Yes ☐ No
Other House or Building (not your home) ☐ Yes ☐ No
Vacation Home or Time Share Property ☐ Yes ☐ No

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

VOLUNTARY CHILD SUPPORT/CONTRIBUTIONS FORM

To: _____	**Name of Applicant/Beneficiary:** Calla Rhoden
Address: _____	**Address of Applicant/Beneficiary:** 34 Saddle Horse Road Aiken, SC 29851
_____	**Budget Group Number:** 100255537

THE ABOVE-NAMED APPLICANT/BENEFICIARY HAS REPORTED THAT (S)HE RECEIVED CASH CONTRIBUTIONS OR CHILD SUPPORT FROM YOU. PLEASE COMPLETE THE ITEMS CHECKED BELOW AND RETURN THIS FORM TO:
Region II **DEPARTMENT OF HEALTH AND HUMAN SERVICES**

ADDRESS: PO Box 2748 Aiken, SC 29802

MEDICAID ELIGIBILITY WORKER'S NAME: Region II Worker **DATE:** 07/03/2013

I. CONTRIBUTIONS

☐ 1. Do you give any money directly to _____ ? ☐Yes☐No

☐ 2. For what purpose is the money given? _____

☐ 3. How much did you give? Month _____ Amount _____ Month _____ Amount _____
Month _____ Amount _____ Month _____ Amount _____

☐ 4. Is this money a gift? ☐Yes ☐No Is this money a loan? ☐Yes ☐No

☐ 5. If a loan, when do you expect to be repaid?

II. CHILD SUPPORT

☑ 1. Are you the parent of Devin Jones ? ☐Yes☐No

☑ 2. Are you giving any money for support of Devin Jones ? ☐Yes☐No
If yes, how much and how often? _____

☑ 3. Are you giving support money on a regular basis? ☐Yes☐No

☑ 4. How long have you been giving support money? _____

☑ 5. How do you pay this money? (Check One) ☐By Cash ☐By Check ☐ Other _____

☑ 6. To whom do you pay this money? (Check One) ☐a. Applicant/Beneficiary ☐b. Clerk of Court
☐ c. Department of Social Services ☐ d. Other Who? _____

☑ 7. How much did you give?
Month 06/2013 Amount _____
Month 05/2013 Amount _____
Month 04/2013 Amount _____

DO YOU HAVE ANY PROOF OF PAYMENT, SUCH AS RECEIPTS OR CANCELLED CHECKS?
☐Yes ☐No
IF SO, PLEASE ENCLOSE THEM. THEY WILL BE COPIED AND RETURNED TO YOU PROMPTLY

☑ 8. Do you have medical/hospital insurance on Devin Jones ? ☐Yes☐No
If yes, tell us the company's name _____

☑ 9. Do you have a Driver's License? ☐ Yes ☐ No If yes, print your DL number _____

☑ 10. What is your Social Security Number? _____; Date of Birth: _____

☑ 11. Where do you work? Name of Company: _____
Company's Address: _____
Company's Telephone No.: _____

Your Signature:	Your Telephone Number:	Date:

DHHS Form 1216 ME (Sept 2006)

South Carolina Department of Health and Human Services
MEDICAID ELIGIBILITY CHECKLIST

Applicant's Name: Calla Rhoden Date: 7/3/2013

Budget Group Number: 100255537 Social Security Number: _____

To determine Medicaid eligibility, the Department of Health and Human Services **will** need the **items** ☑ **checked for** the applicant, spouse, and children under age 22:

- ☐ Power of Attorney, Guardianship, or Conservator Papers
- ☐ Verification of ☐ Citizenship ☐ Identity Original Documents Required.
- ☐ Social Security numbers for persons requesting Medicaid
- ☐ Proof of gross income received by _____
- ☐ Proof of pregnancy and due date
- ☐ All bank or other financial account statements for _____

  _____
- ☐ Copies of trust agreements
- ☐ Pre-need burial contracts
- ☐ Proof of amount owed on real and personal property
- ☐ Year, make, and model of all motor vehicles
- ☐ All life insurance policies
- ☐ All medical insurance policies or cards and proof of premiums
- ☐ _____ must apply with the Social Security Administration for disability benefits. After the application has been filed, complete the DHHS Form 3204 ME, Disability Referral, and return to _____
- ☐ Disability Form(s)
  - ☐ DHHS 3218 ME, Adult Disability Report ☐ DHHS 3218-D ME, Child Under Age 19 Disability Report
  - ☐ DHHS 3266 ME, Adult Disability Review ☐ DHHS 3266-D ME, Child Under Age 19 Disability Review
  - ☐ DHHS 921, Authorization to Disclose Health Information
- ☐ Proof of child care expenses
- ☒ DHHS Form 2700ME
- ☒ Other: Provide proof of child support for 5/27/13 - 6/27/13

  _____
- ☒ Other: Complete # 17 of the application

  _____

Please provide this information by 7/31/2013. **If you have any questions or you need additional time to secure requested information,** please call your worker listed below. Thank you for your cooperation.

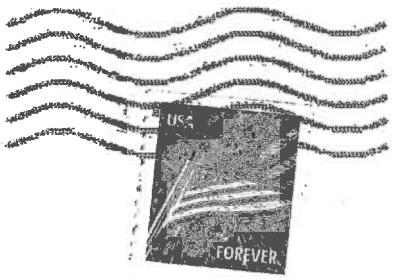
Worker: Region II Worker Telephone: 803-643-1938

Address: PO Box 2748 Fax: 803-643-1911

Akien, SC 29802

Representative J. Roland Smith
Member, SC House of Representatives
183 Edgar Street
Warrenville, SC 29851

COLUMBIA SC 290
10 AUG 2013 PM 1 L



RECEIVED
AUG 13 2013
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Mr. Anthony Keck, Director
SC Department of Health and Human Services
1801 [redacted]
Main Street
Columbia, SC 29201

[redacted]

Log 74

South Carolina Department of Health & Human Services

Anthony E. Keck • Director
Nikki Haley • Governor

August 29, 2013

The Honorable J. Roland Smith
Member, SC House of Representatives
183 Edgar Street
Warrenville, South Carolina 29851

Dear Representative Smith:

Thank you for contacting our Agency regarding Medicaid eligibility on behalf of Ms. Calla Rhoden's son, Devin Jones.

Ms. Carolyn Roach in our Office of Member Relations has been in contact with Ms. Rhoden regarding Medicaid eligibility for Devin. If Ms. Rhoden has questions regarding the Medicaid Program she has been informed to contact Ms. Roach who will be happy to assist her. 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,

John R. Supra Jr.

JRS:J

Office of Information Management.
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2505 • Fax (803) 898-8235