DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	6-27-08

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000679	[X] Prepare reply for the Director's signature DATE DUE 7-7-08
2. DATE SIGNED BY DIRECTOR Cleared 7/8/08 Letter attached.	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] 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.			

LINDSEY O. GRAHAM
SOUTH CAROLINA

290 RUSSELL SENATE OFFICE BUILDING
WASHINGTON, DC 20510
(202) 224-5972

UNITED STATES SENATE

June 24, 2008

Ms. Emma Forkner
Director
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

RE: Mr. Arnold Pitoniak
SSN: 245-90-1494

Dear Ms. Forkner:

Enclosed is a copy of correspondence I have received from the above named constituent. I believe you will find it self-explanatory.

Your reviewing this material and providing any assistance or information possible under the governing statutes and regulations will be greatly appreciated. Thank you for your attention in this matter. I look forward to hearing from you soon.

Sincerely,

Lindsey O. Graham
United States Senator

LOG/lt

Enclosure

Please reply to: Senator Lindsey Graham
530 Johnnie Dodds Boulevard, Suite 202
Mt Pleasant, South Carolina 29464

RECEIVED
JUN 27 2008

AUTHORIZATION FORM

Department of Health & Human Services
OFFICE OF THE DIRECTOR

I hereby authorize United States Senator Lindsey O. Graham to receive any information from agencies pertaining to my request below. This authorization is in accordance with the provisions of the Privacy Act of 1974.

(PLEASE TYPE OR PRINT BELOW.)

Name: MR. ARNOLD E. PITONIAK Phone: 843.297.6864

Now: 101 Woodhaven Dr. Bldg C. Apt #144 Hilton Head Island, S.C. 29929

Address: The Oaks at Broad River Landing alternate 843.297.4099 Marilyn A. Stewart
75 RIVERCHASE BLVD. #726.

City: Beaufort State: South Carolina Zip: 29906-0991

Social Security Number: 245.90.1494 VA Number: _____

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 this form or an additional piece of paper.)

I HAVE FILED A FORM DHHS FORM 910 (September 2007) Medicaid application AS OF MARCH 13TH. 2008 with instructions by a MS. TERRY MANIGAULT; the application for the SOUTH CAROLINA MEDICAID PROGRAM I COMPLETED ON MARCH 8TH. 2008. WE SENT AS REQUESTED ALL DOCUMENTS REQUESTED, our bank statement for (3) months, our medicare card, a copy of our Social Security card & a copy of our SC Driver's License with picture identification. Now as of today, Friday, April 11th 2008 the conversation between Terry Manigault was rude, uncalled for, put her office phone # of 843.470.4635. Department of Health & Human Services. PO. Box 1255 Beaufort S.C. 29901

Signature: [signature] Date: FRIDAY, APRIL 11TH 2008

Please return form to: U.S. Senator Lindsey O. Graham
530 Johnnie Dodds Boulevard, Suite 202
Mt. Pleasant, South Carolina 29464

Now we are getty treated unlike a United States Resident let alone any other South Carolina resident.

APP

June 18th 2008
Mr. Arnold E. Pidniak
101 Woodhaven Drive
Bldg. C. Apt. #144
Hilton Head Island, S.C.
29928
Mobile 843. 297.6864

United States Senator Lindsey O. Graham:
Attn.: Leslie
530 Johnnie Dodds Boulevard, Suite 202
Mt. Pleasant, South Carolina 29464

Dear Leslie,

Per our initial conversation on the 11th of April 2008 & again yesterday, the 17th of June 2008; I am hereby amending & providing information on my case for & the enclosed copies of my "Medicaid" application.

The issue at hand seems fairly in essence simple; however, on several calls & again in two (2) Medicaid Eligibility Checklist letters requesting the very exact same information that I initially sent from the get go on our submission mailed in & with US postage to a Ms. Terri Manigault, the Eligibility Specialist • Worker on

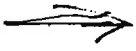
AP

the 13th of March.

IN addition, included with the application was three (3) months of bank statements; a copy of ~~my~~ Medicare card; ~~my~~ social security card & a copy of ~~my~~ South Carolina driver's license showing a current license. The initial conversation with a Ms. Terri Maniquault was to obtain verification as to exactly what is needed since I currently receive SS disability & pay for Medicare Part A Hospital & Part B Medical INSURANCE.

So therefore, we completed the initial application with requested information. The first letter we receive indicates more of the same information is requested. We received this letter some (30) days later. Thereafter what I would call an unacceptable attitude over the telephone to a Ms. Terri Maniquault in the SC Department of Health & Human Services, telephone 843. 470.4635 with a facsimile of 843.470.4653, We complied by sending a letter of explanation along with the same documentation.

Then I received another letter dated the. May 14th 2008.



I have experienced the trials and tribulations of dealing with principals and various agencies both private and public. Especially in dealing with my medical disorder that gave rise to now deceased Senator Thurond who prevailed in my behalf in 1996 after initial diagnosis in 1994 for the grant of SSI Now changed to a "permanent" "disability" status.

So I'm prevailing about a direct answer with the respect & dignity a United States citizen should receive since family & generations before me paid well into this system for this system to work & work well not against creating frustration. on behalf of the earnest efforts of Arnold E. Pitonik to. Arnold E. Pitonik's Needs.

Per the advice of the Washington, D.C. office, the Columbia, S.C. office & Now in the Mount Pleasant, S.C. office of Senator Lindsey O. Graham that this office could be of assistance in rectifying this situation.

With this being said on these Previous three(3) pages, I am asking

Appr

for the full Power of this office with this application & provide an expedited answer since I clearly qualify for MEDICAID & the need was yesterday & is NOW.

IN advance, I thank you for the review of this lengthy letter & the positive response on & in my behalf.

Sincerely,
ARNOLD E. PITONIAK

Arnold E. Poniak APE

cc: Marilyn Ann Stewart
Mobile 843.297.6864

APE

South Carolina Department of Health and Human Services

REQUIRED DOCUMENTATION TO ACCOMPANY YOUR APPLICATION

By providing as much information as possible when you apply, DHHS may be able to process your application in a shorter time period. Listed below is a checklist of required documentation. Some forms require different documentation than others. Be sure to provide the proper documentation for the application you are submitting. If you are not sure what you need to provide, please call our toll-free number for assistance: 1-888-549-0820. In addition, your eligibility worker will be able to tell you if more information is needed.

SOUTH CAROLINA (MEDICAID) PROGRAM APPLICATION – FM 910

1. If you are not eligible for Medicare Part A or B, you must provide verification of Citizenship and Identity. You must provide original documents.

2. Proof of Gross Income Received by Family Members

   - ☐ Copies of pay stubs for the **last 4 weeks** or a letter from your employer that shows your last 4 weeks of GROSS pay.
   - ☑ A copy of the letter you received telling you the gross amount of any benefits received through Social Security, Unemployment, Veterans' Administration, Workers' Compensation, etc.
   - ☐ Proof of all other income for the last 4 weeks, including child support.
   - ☑ If self-employed, attach a copy of your most recent federal income tax form including all schedules.

3. Verification of Any Assets You List on the Application

4. All Medical Insurance Cards

5. If Under Age 65 and not currently receiving Social Security disability benefits, DHHS Form 3218 ME and DHHS Form 921 *(To locate these forms, go to: DHHS Home page, Resource Library, Forms.)*

6. Proof of Child Care or Adult Day Care Expenses - Statement from day care or receipt

Mail the completed, signed application and other required forms and information to your County DHHS Medicaid Office. (To obtain the location and/or mailing address for your County DHHS Medicaid Office or to find out what county you are located in, go to: DHHS Home page, Office Locations.)

APE

Alert Mailed Envelope ... Thursday March 13th 2008 ... SC ... 0678708 ...

South Carolina Department of Health and Human Services
Application for the South Carolina Medicaid Program
This application is developed specifically for Aged, Blind, or Disabled Adults.

Note: *You only need to tell us the Social Security Number and answer the questions about being a US Citizen for the people for whom you want full Medicaid benefits. However, if you give us your Social Security Number, even if you are not applying for benefits, it may help us process your application faster. We only use Social Security Numbers to help us verify income.*

APE

- A citizen applying for Medicaid must provide original documents to prove US citizenship and identity
- A non-citizen applying for Medicaid must provide Bureau of Citizenship and Immigration Services (BCIS) documents to support his/her legal entry into the US.
- A non-citizen applying for Emergency Services Only is not required to provide these documents or a Social Security Number.

1. **Tell us about yourself.**

Date received by DHHS:

Name (First, Middle Initial, Last): ARNOLD E. PITRWIAK

Social Security Number: (not required for emergency services) 245.90.1494

Date of Birth: 05.29.1963

Address where you get mail (include apartment number): 75 RIVERCHASE BLVD. APT. #726 **City:** BEAUFORT **State:** S.C. **Zip Code:** 29906 **County:** BEAUFORT

Home Address (if not the same as your mailing address): **City:** **State:** **Zip Code:**

Telephone Number: (843) 297 6864

Your Full Name at Birth: This helps us verify citizenship: ARNOLD EDWARD PITONIAK

Your Mother's Full Name at her Birth: PAMELA KAY CRAVEN

County/State where you were born: FORSYTH, NORTH CAROLINA

Do you want Medicaid for yourself? ☑ Yes ☐ No

Sex: ☐ Female ☑ Male

Marital Status: ☑ Single ☐ Widowed ☐ Married ☐ Separated ☐ Divorced

Are you currently attending school? ☐ Yes ☑ No — If yes, what grade? ____

Check all that apply: ☑ US Citizen ☑ Disabled ☐ Pregnant ☐ Emergency Services Only

What language do you use most? ☑ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Sign Language ☐ Vietnamese ☐ Other ____

Medicare Number, if applicable: 245901494A

Race: ☑ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Cuban ☐ Refugee Entrant ☐ Puerto Rican ☐ Hispanic ☐ Asian American/Oriental ☐ Other

If an Authorized Representative is completing this application, please complete the following:

Name:

Address:

Phone Number:

Relationship:

2. Tell us about the people who live with you A Social Security Number is not required if applying for Emergency Services Only.

Name: (First, Middle Initial, Last)		Social Security Number:		Full Name at Birth:		Mother's Full Name at her Birth:
Is this person applying for Medicaid? ☐ Yes ☐ No	Check all that apply: ☐ US Citizen ☐ Disabled ☐ Pregnant ☐ Emergency Services Only	Sex: ☐ Female ☐ Male Date of Birth:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	How is this person related to the person on page 1? ☐ Child ☐ Spouse ☐ Other: ______	Currently attending school? ☐ Yes ☐ No If yes, what grade? ______	County/State where you were born:
Medicare Number, if applicable:		Race: ☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other				

Name: (First, Middle Initial, Last)		Social Security Number:		Full Name at Birth:		Mother's Full Name at her Birth:
Is this person applying for Medicaid? ☐ Yes ☐ No	Check all that apply: ☐ US Citizen ☐ Disabled ☐ Pregnant ☐ Emergency Services Only	Sex: ☐ Female ☐ Male Date of Birth:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	How is this person related to the person on page 1? ☐ Child ☐ Spouse ☐ Other: ______	Currently attending school? ☐ Yes ☐ No If yes, what grade? ______	County/State where you were born:
Medicare Number, if applicable:		Race: ☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other				

Name: (First, Middle Initial, Last)		Social Security Number:		Full Name at Birth:		Mother's Full Name at her Birth:
Is this person applying for Medicaid? ☐ Yes ☐ No	Check all that apply: ☐ US Citizen ☐ Disabled ☐ Pregnant ☐ Emergency Services Only	Sex: ☐ Female ☐ Male Date of Birth:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	How is this person related to the person on page 1? ☐ Child ☐ Spouse ☐ Other: ______	Currently attending school? ☐ Yes ☐ No If yes, what grade? ______	County/State where you were born:
Medicare Number, if applicable:		Race: ☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other				

3. Retroactive

Did you or anyone who lives with you receive medical services in the past 3 months?

Who? ~~Yes~~, I DID. ARNOLD E. PITONIAK Which month(s)? ALL THREE MONTHS, December, January & February

In order for us to determine eligibility for these month(s), you are required to provide proof of income and resources for each month listed.

4. Tell us how much income your family has.
Enter GROSS pay before taxes and deductions, not take home pay. Enter zero ("0") if you are not working. **You must send us proof of income for the past 4 weeks.**

Your Income from Employment	**Other Parent's/Spouse's Income from Employment** *(if living in the home)*
Name of person employed ARNOLD E. PITONIAK	Name of person employed
Employer's Name N/A.	Employer's Name
Employer's Address N/A.	Employer's Address
Employer's Phone Number (including area code) 843. 297. 6864	Employer's Phone Number (including area code)
Gross amount earned per pay period before taxes? $ Social Security	Gross amount earned per pay period before taxes? $
How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☑ Monthly	How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly
Still employed? ☐ *Yes* ☑ *No* *If no, where did you work last?* ATLN. CORP.	*Still employed?* ☐ *Yes* ☐ *No* *If no, where did you work last?*
When did you stop working there? Still a consultant at Times.	When did you stop working there?

Is anyone self-employed? ☐ Yes ☐ No If yes, please name Self-Employment Business and/or Partnership

You must send copies of all the most recently filed Federal income tax forms with all schedules.

Other Income	**Amount**	**Which family member gets this income?**	**How often is this income received?**
Child Support	$		
Alimony	$		
Social Security Income	$ 1,036.00/100	I DO. ARNOLD E. PITONIAK	ON OR BEFORE THE 3RD OF EACH MONTH.
Unemployment Benefits	$		
Veterans Benefits	$		
Workers Compensation/Long Term or Short Term Disability	$		
Money from Friends/Relatives	$		
Retirement/Pensions/Annuities	$		
Other Income *(Please Explain)*	$		

5. If your family does not have any source of income, explain in the space below how your household bills are being paid.

Through Social security disability income & gifts & loans

6. Does anyone in your family own the following? You must send proof of Assets/Resources with this application.

Asset/Resource	Yes	No	Company name, address, and phone #; Account/Policy number; and/or Description	Who does it belong to?	What is the value?	How much is owed?
Cash on Hand	✓		TWENTY-ONE DOLLARS PLUS COINS. #21.00 (6/11)	ARNOLD E PITONIAK	$ Approximate 30.00	
Checking Account(s)	✓		HA-MUSICA LLC 39-0401-7005 ARNOLD E. PITONIAK	Company & ARNOLD E. PITONIAK	$ 413.10	
Savings Account(s)					$	
Certificate(s) of Deposit					$	
Annuities/Trusts/Stocks/ Bonds	✓		PRIVATE STOCK	ARN. CORP. & ARNOLD E. PITONIAK	$ Difficult to value	
Home Property (location/description)					$	$
Other Property (location/description)	✓		Furniture, Clothing, journals, accessories, Art, other misc. items / Storage Bin Facility 75 Riverchase Blvd. Apt #126 Storage Bin Loc. #1	ARN CORP. & ARNOLD E. PITONIAK	$ 400.00-500.00	$
Life/Burial insurance	✓		LIFE INSURANCE POLICY 26 Bluetail SC 29406	ARN CORP. & ARNOLD E. PITONIAK	$ 10,000.00	$
Burial Contracts					$	$
Burial Plots					$	$
Vehicles (make, model, year)					$	$
Retirement Account					$	$
Other (please be specific)					$	$

7. Do you pay someone to take care of your child(ren) under 12 and/or a dependent adult while you work or attend school?

☐ Yes ☒ No _____ Number of children under age 12 and/or dependent adults for whom you pay for care. **You must provide proof of this payment.**

8. Tell us about any health or medical insurance covering anyone for whom you are applying. Please send us a copy of the card(s), front and back. Include Medicaid in another state. Even if you already have health insurance, you can still qualify for Medicaid.

Insurance Company	Policy Number	Policyholder's Name	Policyholder's ID	Persons Covered	What type of coverage is this?
MEDICARE	245401494A	ARNOLD E PITONIAK		ARNOLD E PITONIAK	HOSPITAL & MEDICAL

IMPORTANT

Check below to tell us what you attached.

- **Sending this information in with the application will help us to process your application faster.**
- **You must read and sign this form on the last page to complete your application.**

☐ Proof Of Income

- ☐ Copies of pay stubs for the **last 4 weeks for any adult person listed**; *or* a letter from employer that shows last 4 weeks of GROSS pay.
- ☑ A copy of the letter telling the gross amount of any benefits received (Social Security, Unemployment, VA, Workers' Compensation, etc.)
- ☐ Proof of all other income for the last 4 weeks, including child support.

NOTE: You may be required to apply for additional potential benefits, such as unemployment or Social Security Benefits.

☐ Proof of Assets/Resources listed in application.

☐ Proof of income/resources for the past 3 months if you have received medical services.

☑ Most recent income tax forms including all schedules, if you are self employed.

☐ Proof of due date from doctor, nurse, or Health Department for each pregnant woman.

☐ Verification of the childcare/dependent adult expenses (statement from daycare, receipt, etc.)

☐ Bureau of Citizenship and Immigration Services (BCIS) documents for each non-citizen applying for full Medicaid. Does not apply to Emergency Services Only.

☑ Original Documents of citizenship and identity for each US citizen applying for Medicaid. (If you have provided this information before, you do not have to provide it again.)

Other documents can be used to provide proof. If you are not sure what to send, call our toll-free line at 1-888-549-0820 for help.

The South Carolina Department of Social Services' Child Support Enforcement Division (CSED) provides services to establish paternity and child support, modify child support orders, and enforce support orders. Services are available to Medicaid beneficiaries without charge. I understand that if I check "no" and ask for child support services later, I will have to pay a $25 fee. I want to voluntarily apply for these services: Yes No

APK

Rights and Responsibilities

1. I know that my children under age 19 who are eligible for Partners for Health Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Medicaid Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Medicaid Card(s).

   a. I know that, in accordance with the federal rules governing the Medicaid Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.

   b. I know that, in accordance with the federal rules governing the Medicaid Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about my family and me with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medicaid programs, and the TANF and Food Stamp agency (DSS, in this state). Immigration status will be verified with the Department of Homeland Security (DHS).

   c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.

   d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.

3. I know that my Social Security Number, which I am required to provide, under §1137(a)(1) of the Social Security Act [42 U.S.C. 1320b-7(a)(1)], may be used or released in connection with the exceptions in Item 2, above.

4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

5. I know that the Medicaid program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Medicaid has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.

6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Medicaid coverage.

7. I understand that I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.

8. I know that I may request a hearing if I believe an error has been made in processing my application.

☐ **I have read the Rights and Responsibilities, or they have been read to me.** *(If possible, both the Applicant and Authorized Representative should sign.)*

Applicant's Signature: _____ Date: March 8TH 2008

Signature of Authorized Representative: _____ Date: _____

MR. ARNOLD E. PITONIAK
c/o MOTEL 6
830 William Hilton Parkway. Room # 422
HILTON HEAD ISLAND, S.C. 29928

APRIL 30TH 2008

MS. TERRI MANIGAULT
ELIGIBILITY SPECIALIST
P. O. BOX 1255
BEAUFORT
SOUTH CAROLINA
29901
Telephone 843.470.4635
Facsimile 843.470.4653

Dear Ms. Manigault,

Per our conversation on Friday, April 11TH 2008 following the submission of our initial application for Medicaid mailed on approximately Wednesday, March 12TH 2008 according to our records, I am now replying to the letter I received just recently due to being in a different city from the address mailed to on the envelope.

We are further enclosing copies of our only bank account now lodged with REGIONS Bank for the MONTHS FEBRUARY & MARCH of this year 2008.

AP

Furthermore, an explanation of the answer provided on page 4 of DHHS Form 910 for listing "private stock" is hereby provided:

We own, Arnold E. Pitoniak, privately owned stock in several currently NON-operating entities thereby this stock is currently only worth the paper it has been issued at this point. The companies are no longer in business or operating as a viable enterprise.

The companies are as such:

1. UNITED AMERICAN COMPANIES, INC. a Colorado Corporation
2. HISPANAMERICA CORP. a Delaware Corporation
3. ARN CORP.; its registered office is in the State of Delaware.

9711 Centerville Road
Suite 400
Wilmington
County of New Castle
Delaware 19808

The following can verify this information:

1. MARILYN ANN STEWART #843.297.4098
   Healthcare Power of Attorney
2. MARK A. CRAVEN #~~336~~.991.7920
   Former majority stockholder, officer & director of United American Companies, Inc. & HispanAmerica Corp.
3. Kenneth J. Walker #336.350.1849
   Former Stockholder, Chief Operating Officer of United American Companies, INC. & HISPANAmerica Corp.

SAPE

IN addition, I have been told by Ms. Paula Kay Craven, my Mother, that the Nominal insurance policy purchased on my life has been cancelled. I believe this can be verified by herself @ 843. 540.3553 and the agent, Marianne Robinson @ #843.863.1034 and/or at 843.224.8145 or 843.696.9827.

I believe I have complied with the items requested by yourself via the telephone & in the March 26th letter, your 2008. The letter is generated from your department's form DHHS Form 1233, the South Carolina Department of Health and Human Services MEDICAID ELIGIBILITY CHECKLIST.

Should you have any questions, I am reachable on #843.297.6864 or through my durable power of attorney & friend, Marilyn Ann Stewart & her direct line is # 843.297.4098.

Thank you for your attention in expediting this application.

Sincerely,

[signature] APE

MR.

South Carolina Department of Health and Human Services
MEDICAID ELIGIBILITY CHECKLIST

Applicant's Name: Arnold E Pitoniak Date: 3/26/2008

Budget Group Number: 80030656 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 21:

- ☐ 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 February & March 2008 and Stock _____
- ☐ Copies of trust agreements
- ☐ Pre-need burial contracts
- ☐ Proof of amount owed on real and personal property
- ☐ Proof of assets sold, transferred, or given away during the past _____ months
- ☐ Year, make, and model of all motor vehicles
- ☑ All life insurance policies
- ☐ All medical insurance policies or cards and proof of premiums
- ☐ DHHS Form 3218ME or 3218D-ME
- ☐ Proof of child care expenses
- ☐ DHHS Form 2700ME
- ☐ Other: _____

Please provide this information by 4/7/2008. If you have any questions, please call your worker listed below for additional information. Thank you for your cooperation.

Worker: Terri Manigault Telephone: 843.470.4635fax843.470.4653

Address: P.O.Box 1255

Beaufort, SC 29901

South Carolina Department of Health and Human Services
MEDICAID ELIGIBILITY CHECKLIST

Applicant's Name: Arnold E Pitoniak Date: 5/14/2008

Budget Group Number: 80030656 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 21:

- ☐ 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 Stock
- ☐ Copies of trust agreements
- ☐ Pre-need burial contracts
- ☐ Proof of amount owed on real and personal property
- ☐ Proof of assets sold, transferred, or given away during the past _____ months
- ☐ Year, make, and model of all motor vehicles
- ☑ All life insurance policies
- ☐ All medical insurance policies or cards and proof of premiums
- ☐ DHHS Form 3218ME or 3218D-ME
- ☐ Proof of child care expenses
- ☐ DHHS Form 2700ME
- ☐ Other: _____

Please provide this information by 6/4/2008. If you have any questions, please call your worker listed below for additional information. Thank you for your cooperation.

Worker: Ms. Terri Manigault Telephone: 843.470.4635fax843.470.4653

Address: P.O.Box 1255

Beaufort, SC 29901

Log 679

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

July 8, 2008

The Honorable Lindsey Graham
United States Senate
530 Johnnie Dodds Boulevard, Suite 202
Mount Pleasant, South Carolina 29464

Dear Senator Graham:

Thank you for contacting our agency on behalf of Mr. Arnold Pitoniak regarding Medicaid eligibility and his healthcare needs.

A member of our staff has been in direct contact with Mr. Pitoniak to address his questions and concerns regarding Medicaid eligibility and the rules and regulations governing the program. We also mailed him information on other programs and organizations that can assist residents in South Carolina with their healthcare services, prescriptions, inpatient hospitalization and daily living needs.

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

Sincerely,

Emma Forkner
Director

EF/jcol

Reg 679

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

July 8, 2008

Mr. Arnold E. Pitoniak
101 Woodhaven Drive
Building C, Apt. # 144
Hilton Head Island, South Carolina 29928

Dear Mr. Pitoniak:

Senator Lindsey Graham contacted our agency on your behalf regarding problems you encountered when submitting your Medicaid application. We apologize for any inconvenience this process may have caused you. Good customer service is important to us, and I regret any difficulty or misunderstandings you experienced in submitting your application and during the eligibility determination process.

Your application for the Aged, Blind or Disabled program was denied in error on June 16, 2008 because we did not receive the information necessary to process your application. Your application should have been denied because your monthly income exceeds the allowable limit of $867 for an individual. Enclosed is a copy of the correct denial notice. If you have additional questions, please contact Ms. Catherine James, Medicaid eligibility supervisor, at (843) 470-4627.

An alternate health insurance option through AugeoBenefits offers a variety of health insurance plans from top-rated insurance carriers. You may wish to look over the enclosed brochure and contact them at 1-866-273-5613 or visit their website at www.augeobenefits.com/sc to see if they can assist you. We also enclosed information on other programs and organizations that can assist residents in South Carolina with their healthcare services, prescriptions, inpatient hospitalization and daily living needs.

If you have any questions about the Medicaid program, please contact Ms. Jennifer Lynch at (803) 898-3965, and she will be happy to assist you.

Sincerely,

Alicia Jacobs

Alicia Jacobs
Acting Deputy Director

AJ/col
Enclosures

Medicaid Eligibility and Beneficiary Services
P.O. Box 8206 • Columbia, South Carolina 29202-8206
Phone (803) 898-2502 • Fax (803) 255-8235