DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

Gov # 308475

TO	DATE
Ries'	7-6-06

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 060038	[X] Prepare reply for the Director's signature DATE DUE 7-13-06
2. DATE SIGNED BY DIRECTOR Cleared 7/17/06, 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.			

State of South Carolina

Office of the Governor

MARK SANFORD
GOVERNOR

OFFICE OF EXECUTIVE
POLICY AND PROGRAMS

Bren - Ms. Hensley sending more info to me. I'll get off fax -

FAX TRANSMITTAL COVER

RECEIVED
JUL 06 2006
Department of Health & Human Services
OFFICE OF THE DIRECTOR

DATE:	7/6/06
FAX TO:	Jan Polatty
FAX #:	898-4515
FROM:	Sue Cooper

Total number of pages: 5
(including this cover sheet)

If you have any problems receiving this document, please contact:

Jan,
Per our t/c on today's dtd. Enclosed is correspondence ~~from~~ from Lynn Hensley regarding Medicaid eligibility. Thanks!
Sue
734-9873

Office of Constituent Services
Post Office Box 12267
Columbia, SC 29211
TELEPHONE: (803) 734-5049 • FAX: (803) 734-0799

308475

From: <shensley17@sc.rr.com>
To: <governor@gov.sc.gov>
Date: Thu, Jun 22, 2006 4:09 PM
Subject: Governor Request Information form

lynn 3 555 437-15-8641
hensley
240 weyburn street
myrtle beach
sc
29579
8439036688
shensley17@sc.rr.com
Thursday, June 22, 2006

R

JUN 2 3 2006

Referred to HHCS
Answered

RECEIVED
JUL 06 2006
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Governor Sanford,

Hello Governor, hope that time finds you well. It is your old writing buddy, Lynn Nacol Hensley. I am still having troubles with getting my Medicaid insurance, and I can't understand why.

I sent my information in over a month ago, and just sent a fax to the worker I have, and she wasn't even going to let me know whether or not I was approved, until I had reminded her that I was waiting for a decision.

In my opinion, she is sitting in her big comfortable chair, maybe swiveling around a few times, not giving a damn about sick people; she is just trying to make her salary.

Last time I wrote you, I said that I was thinking of contacting the media, regarding the ridiculous treatment I have received from Medicaid. I decided against it at that time, and decided to try again on my own to reapply and continue whatever process I needed to.

This has gotten to be a great burden in my life. I don't know how much fight I have left, but I have to go down swinging, if I go down.

I have pleaded my case to this worker over and over again, and I get denial, after denial, after denial. I am working part time, because my health is deteriorating slowly, and I can barely walk most days. I haven't had my blood pressure medicine in over 5 months, nor my depression medicine, or any of my medicines for that matter.

My husband and I have separated, it's just me and 2 girls, and I am working part time @ $6 an hour. When I was working more, I still made a bare minimum income; still under what the worker told me was the limit. I have been noticing blood clots whenever I blow my nose for the past two weeks, which tells me my pressure is up. I don't want to get up in the morning, which tells me that the depression is setting in deep. When I do get up, I can barely walk because of my knee and back pains. I used to be a really fun, energetic person, now I can barely walk around my own house. I don't feel as though I can hold on much longer, I think that I will have a stroke any time now. I just want my children to know, when they are older that I fought for what I felt I deserved. They will have a record of it from all the letters I have written to people.

I really don't know if you can help or not, you have tried before, but to no avail, since I am still having this problem. I hope that God has mercy on DHHS & Jacqueline Lombard, who wrote me off like a bad meal. Never did anything to try to see that I got the coverage I so desperately need, just wrote me off.

I do hope that you win the upcoming election. I hope that the people, especially my people realize that you have provided TRUE equal opportunity to our community. When it comes to politics, they must realize that you don't vote your party all the time...you don't vote for the man whose skin matches yours...you vote for the best man for the job, and let that person's record of accomplishment speak for itself. Good Luck and Best Wishes

Thank you for your time,

L. Nacol Hensley

Low Income Families (LIF)

The Low Income Families program is for parents and children who meet Family Independence (FI) financial eligibility criteria, but who do not receive a cash payment. A family with little or no income could be eligible for Medicaid under this group as long as the parent is not under a work sanction and the family meets eligibility criteria.

Eligibility

- Have gross income at or below 185% of the Family Independence (FI) need standard, currently $1,491 for a family of four (4).
- Have countable net income at or below the appropriate needs standard for the family's size, currently $806 monthly for a family of four (4).
- Have a dependent child living in the home.

(2)

Non-Financial Requirements

- State residency
- Identity
- Citizenship
- Social security number
- Specified degree of relationship
- Assign rights to and cooperate in seeking medical support

Benefits

Individuals who are eligible will receive all Medicaid covered services.

Effective Date

Coverage for this group is effective September 1, 1998

Get an Application

Applications may be obtained from the Department of Health and Human Services or from out-stationed locations such as the County Health Departments, federally qualified rural health centers, most hospitals and the county Department of Social Services. Applications for Medicaid may be filed in person or by mail.

10/01/03

Low Income Families (LIF)
October 1, 2005

Family Size	Gross Income Limit	Net Income Limit
1	$736	$398
2	$986	$534
3	$1,239	$670
4	$1,491	$806
5	$1,742	$943
6	$1,992	$1,077
7	$2,244	$1,213
8	$2,495	$1,349

Note: For family sizes over 8, add $135.00 for each extra person to the net income limit for 8.
To calculate the gross income limit, multiply the net income limit by 185%.

SOUTH BEACH RESORT
MYRTLE BEACH LLC.
EARNINGS STATEMENT

711586411	437-15-****	LYNN N. HENSLEY
Jun 12, 2006	Jun 18, 2006	177223

TYPE	RATE	HOURS	CURRENT	TYPE	CURRENT	YTD	TYPE	CURRENT	YTD	TYPE	CURRENT	YTD
HR2 COMML HR1 SPIFR	$6.00	11.50	$69.00	FICA Med SS Federal SC	$1.00 $4.28	$19.07 $81.54 $6.78						
		11.50	$69.00		$5.28							
			$1,290.19			$1,182.80						$63.7

SOUTH BEACH RESORT
MYRTLE BEACH LLC.
EARNINGS STATEMENT

EMPLOYEE NUMBER	SOC SEC NO	EMPLOYEE NAME
711586411	437-15-****	LYNN N. HENSLEY
PERIOD BEGINNING	PERIOD ENDING	CHECK NUMBER
Jun 19, 2006	Jun 25, 2006	179748

TYPE	RATE	HOURS	CURRENT	TYPE	CURRENT	YTD	TYPE	CURRENT	YTD	TYPE	CURRENT	YTD
HR2 COMML HR1 SPIFR	$6.00	17.50	$105.00	FICA Med SS Federal SC	$1.52 $6.51 $0.12	$20.59 $88.05 $6.90						
		17.50	$105.00		$8.15							
			$1,395.19			$1,279.65						$96.8.

07/06/2006 04:13PM

COASTAL ORTHOPAEDIC ASSOCIATES
2376 CYPRESS CIRCLE 300
CONWAY SC 29526

78176

STATEMENT

ADDRESS SERVICE REQUESTED

(843) 347-7222
OFFICE PHONE NUMBER

06/05/06
CLOSING DATE

78176
YOUR ACCOUNT NUMBER

01
PAGE NO.

☐ CHECK HERE For Credit Card Payment
SHOW AMOUNT PAID HERE $_____

291.00
PATIENT BALANCE

MRS LYNN N HENSLEY
240 WEYBURN STREET
MYRTLE BEACH, SC 29579

COASTAL ORTHOPAEDIC ASSOCIATES
2376 CYPRESS CIRCLE 300
CONWAY, SC 29526-8995

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

PLEASE RETURN THIS PORTION WITH PAYMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS
011106		INJ/ASP. MAJOR JOINT/BURSA	LYNN	156.00	
011106		ESTAB. PT. OFFICE VISIT	LYNN	94.00	
011106		RENALOG	LYNN	48.00	
053006		** MEDICAID (KMX INS. FILED ON 01/13/06	LYNN		
		VOC. REHAB. PAYMENT			-15.00

YOU MAY PAY BY MASTER CARD OR VISA

STATEMENT CLOSING DATE: 06/05/06 PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 78176

CURRENT	30-60 DAYS	60-90 DAYS	> 90 DAYS	TOTAL	PATIENT BALANCE PAY THIS AMOUNT
			291.00	291.00	291.00

SEND INQUIRIES TO:
COASTAL ORTHOPAEDIC ASSOCIATES
2376 CYPRESS CIRCLE 300
CONWAY SC 29526
(843) 347-7222

#38
(#308475)
Gov#

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

July 17, 2006

Ms. Lynn Hensley
240 Weyburn Street
Myrtle Beach, South Carolina 29579

Dear Ms Hensley:

Governor Mark Sanford asked our agency to respond to your recent correspondence concerning your eligibility for Medicaid. We understand your concerns and welcome the opportunity to assist you.

Our records indicate that you applied for Medicaid under the Low Income Families (LIF) program on April 5, 2006. Your application was denied because your countable monthly income exceeded the income limit of $670 for a family of three. We understand that your income has changed and you believe that you are now eligible for the LIF program. Please complete and return the enclosed application to the Horry County Medicaid Office at 1601 11th Avenue, Conway, South Carolina 29528. Their telephone number is 843-381-8260.

We hope this information is helpful. If you experience any problems with the application process, please contact Ms. Valerie Hollis at 803-898-3103.

Sincerely,

Gary Ries
Deputy Director

GR/joe

enclosure

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

LEGISLATIVE LOG #	0038
LEGISLATOR/INQUIRER	Governor Sanford #306475
CONSTITUENT	Lynn Hensley
SSN	437-15-8641
BC ASSIGNED LOG	Jacobs
DATE REC'D BY AGENCY	7/6/2006
DATE DRAFT DUE GR	7/12/2006
LOG LETTER DUE DATE	7/13/2006
DATE REFERRED TO BC	7/7/2006

Brief Description of Issue/Problem	Date	Staff Person	Phone #	Action Taken
	7/7/2006	Jan	8-2502	Jacobs box
	7/10/2006	Denise	8-2505	Jill gave me the log & Mark is handling.
	7/11/2006	Denise	8-2505	Mark asked Valerie to give him the history on this case. Ref. 0898 from FY 05-06 as we have communicated with her before.
	7/13/2006	Valerie	8-3103	I contacted Ms. Hensley. She said that her income has changed. She does not want to apply for ABD ash she believes that her income is now low encugh for LIF. I told her that I would mail her an application. I prepared draft and gave to Mark for review
	7/13/2006	Mark		To Alicia
	7/14/2006	Jan	8--2502	Reviewed - Folder to Gary

CHECKLIST

Family Size	
Income/Resources	

Other Resources:

Communicare	
FQHCs	
Free Medical Clinics	
Medicare	
MIAP	
Prescription Drug Programs	
Social Security	
Together Rx	

Programs:

ABD (32)	
Foster Children (31,60)	
General Hospital (14)	
HCBWS (15)	
LIF (59)	
MBCCP (71)	
Nursing Home (10)	
OSS (85,86)	
PHC (88)	
Pregnant Women & Infants (12,87)	
QMB (90)	
SILVERxCARD (92)	
SLMB (48,52)	
SSI (80)	
TEFRA (57)	
Transitional (11)	
Working Disabled (40)	

Instructions:

Jan creates new worksheet for each log by copying template into workbook & changing name of worksheet to proper log #.
Each user finds log # on bottom tab & enters "date/action taken" in shaded cells. (Once entered, user must exit document.)
If question about current status of a log letter, contact previous user.
Jan & Linda will update upon each log's return and, as a log is closed, they will cut and paste each worksheet into the archive file.
Path: GROUPS/Constituent Services/Log Letters & Transmittals/Aides for Creating-Tracking/Trackers-Tools/Excel Log Tracker

Jan.
We had problems printing the screen from the tracker. Will you please print for us.
Thanks
Valerie

Note: Please refer to the "tracker" for notes. I do not want to hold this up but cannot get the tracker notes to print. Denise is out tomorrow so we will try to address next week.

```
MEDELD01 P          S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 07/13/06
 MEDSPROD                    MEDICAID ELIGIBILITY DECISION            ACTION:
                      DATES-FROM: 04 / 2006 THRU: __ / ____           PAGE: 2 OF 3
 HH NAME:   LYNN N HENSLEY                                    HH NUMBER: 100177623
 BG NUMBER: 98992905          CATEGORY: LIF                ACTION TYPE: MAINTENANCE
 BG: D  BGP: D      WKR: JLOMB    JACQUELI LOMBARD           ACTION DATE: 04/21/06
    COUNTABLE BG MEMBERS:  3
    COUNTABLE INCOME:        789.04      COUNTABLE RESOURCES:          0.00
        INCOME LIMIT:        670.00      RESOURCE LIMIT:               0.00
              POV-LVL:         +.57 %     HLTH INS PREM:               0.00
    RECURRING INC:     0.00   TOTAL ALLOC:     0.00   OSS AWARD:      0.00
 MEETS NON-FINANCIAL?    (Y/N): Y        ACT ON DECISION COMPLETE? (Y/N): Y
 MEETS INCOME?           (Y/N): N        DECISION ACCEPTED DATE:    04/21/06
 MEETS RESOURCES?        (Y/N): Y        NEXT REVIEW DATE:          04/21/07
 MEETS OTHER CONDITIONS? (Y/N): Y        ANTICIPATED CLOSURE DATE:  ________
 REASON(S) FOR DENIAL/CLOSURE/CHANGE:
 051 Your income is more than policy allows.

 ELIGIBILITY DECISION APPEALED? (Y/N) _    CONTINUE BENEFITS?      (Y/N): _
 APPEAL REQUEST DATE: ________             COUNTY DECISION UPHELD? (Y/N): _
 UPDATED: USER ID: JLOMB     DATE: 04/21/06  SYSTEM ID: ELD3000  DATE: 04/21/06
ME900115 BUDGET GROUP PERIOD INFORMATION FOUND
      PF1->HELP  PF3->NEXT SCR  PF6->RETURN  PF10->MENU  PF13->FIELD HELP
 PF15->MAKE DECISION PF16->BG DET PF21->HIST- PF22->HIST+ PF24->ACT ON DECISION
```

```
4EDELD01 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES   DATE: 07/11/06
 MEDSPROD                 MEDICAID ELIGIBILITY DECISION            ACTION:
                       DATES-FROM: 01 / 2004 THRU: __ / ____       PAGE: 2 OF 3
 HH NAME:   LYNN N HENSLEY                                  HH NUMBER: 100177623
 BG NUMBER: 58248210          CATEGORY: TM                ACTION TYPE: MAINTENANCE
 BG: C  BGP: C      WKR: JANDE    JACQUELY ANDERSON        ACTION DATE: 12/19/05
    COUNTABLE BG MEMBERS:  3
    COUNTABLE INCOME:        842.65      COUNTABLE RESOURCES:          0.00
        INCOME LIMIT:       2353.00      RESOURCE LIMIT:               0.00
             POV-LVL:         +.00 %      HLTH INS PREM:                0.00
    RECURRING INC:      0.00    TOTAL ALLOC:      0.00   OSS AWARD:      0.00
 MEETS NON-FINANCIAL?    (Y/N): Y        ACT ON DECISION COMPLETE? (Y/N): Y
 MEETS INCOME?           (Y/N): Y        DECISION ACCEPTED DATE:    12/19/05
 MEETS RESOURCES?        (Y/N): Y        NEXT REVIEW DATE:          12/31/05
 MEETS OTHER CONDITIONS? (Y/N): Y        ANTICIPATED CLOSURE DATE:  12/31/05
 REASON(S) FOR DENIAL/CLOSURE/CHANGE:
 093 Your Medicaid eligibility period has ended.

___ ____________________________________________________________________________
 ELIGIBILITY DECISION APPEALED? (Y/N) _      CONTINUE BENEFITS?      (Y/N): _
 APPEAL REQUEST DATE: ________               COUNTY DECISION UPHELD? (Y/N): _
 UPDATED: USER ID: YRICH     DATE: 12/19/05  SYSTEM ID: ELD3000  DATE: 12/19/05
ME900115 BUDGET GROUP PERIOD INFORMATION FOUND
      PF1->HELP  PF3->NEXT SCR  PF6->RETURN  PF10->MENU  PF13->FIELD HELP
 PF15->MAKE DECISION PF16->BG DET PF21->HIST- PF22->HIST+ PF24->ACT ON DECISION
```

4EDHMS49 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 07/11/06
MEDSPROD HOUSEHOLD BUDGET GROUPS

PAGE: 0001

HH NAME: HENSLEY LYNN N ACTION TYPE: MAINTENANCE
HH NUMBER: 100177623 APL STATUS: _____ ACTION DATE: 04/17/06

S	BG NUMBER	CATEGORY	WORKER	CNTY	LOC	NEXT REVIEW	LAST REVIEW	BG STATUS
_	49270599	PHC	MMELT	26	001	06/20/2007		ACTIVE
_	59112593	PHC	JLOMB	26	011	02/03/2007		CLOSED
_	58248210	TM	JANDE	26	005	12/31/2005		CLOSED
_	77808811	INFANT	JGORE	26	001	11/18/2003	01/08/2004	CLOSED
_	22608823	LIF	JGORE	26	001	09/16/2004	07/31/2003	CLOSED
_	49270523	LIF	JLOMB	26	011	06/20/2007		DENIED
_	98992905	LIF	JLOMB	26	011	04/21/2007		DENIED
_	59112576	LIF	WENDJ	26	009	08/09/2006		DENIED
_	39110005	ABD	RENEG	26	001	02/17/2007		DENIED

UPDATED: USER ID: JLOMB DATE: 04/17/06 SYSTEM ID: HMS5000 DATE: 04/17/06
ME904675 HOUSEHOLD BUDGET GROUPS FOUND
PF1->HELP PF3->HH MEMBERS PF5->BG DETERMINATION
PF6->RETURN PF7->PREV PF8->NEXT PF10->PREV MENU PF17->ELD00

CERTIFICATE OF MEDICAID COVERAGE

IMPORTANT: KEEP THIS MEDICAID LETTER IN A SAFE PLACE

This letter gives you information about the Medicaid coverage you had. If you enroll in another health insurance plan, you may need to give them a copy of this letter.

Date of this letter: **12/20/2005**

Name of Group Health Plan: **MEDICAID**
HH#: **100177623** 26 JANDE

Recipient Name: **LYNN N CHARLES**
Recipient Medicaid Number: **2260882301**

COVERAGE PERIODS:

DECEMBER	**2005**	**MARCH**	**2005**
NOVEMBER	**2005**	**FEBUARY**	**2005**
OCTOBER	**2005**	**JANUARY**	**2005**
SEPTEMBER	**2005**	**DECEMBER**	**2004**
AUGUST	**2005**	**NOVEMBER**	**2004**
JULY	**2005**	**OCTOBER**	**2004**
JUNE	**2005**	**SEPTEMBER**	**2004**
MAY	**2005**	**AUGUST**	**2004**
APRIL	**2005**	**JULY**	**2004**

SOUTH CAROLINA MEDICAID SERVICE

INPATIENT HOSPITAL
WELL CHILD CARE
FAMILY PLANNING
LABORATORY AND X-RAY

HOME HEALTH
OUTPATIENT HOSPITAL
VISION CARE
DURABLE MEDICAL EQUIPMENT

AMBULANCE TRANSPORTATION
REHABILITATIVE THERAPIES
PRESCRIPTION DRUGS
LONG TERM CARE/NURSING HOME FACILITIES
RESIDENTIAL TREATMENT FACILITY
HOSPICE
MENTAL HEALTH
ALCOHOL AND OTHER SUBSTANCE ABUSE

EVALUATION/COUNSELING/EDUCATION FOR SPECIAL NEEDS
NON-EMERGENCY TRANSPORTATION TO MEDICAL APPOINTMENTS

If you have questions about this letter you can call 1-888-549-0820 or you can write to:
The Department of Health and Human Services
P.O. Box 100147
Columbia, South Carolina 29202-9181

South Carolina Medicaid Program
Notice that Medicaid Coverage Will End

HORRY COUNTY DHHS
P. O. Box 290
Conway SC 29528-0000

LYNN N CHARLES
APT 36-B
608 KENT LANE
MYRTLE BEACH SC 29579

Date: **12/20/2005**
Worker Name:
JACQUELYN ANDERSON
Telephone: **843 234-5054**
BG #: **58248210**
HH #: **100177623**
26 JANDE

Medicaid coverage for the people listed below will end on: **01/01/2006**

Beneficiary name:	Beneficiary Medicaid ID#:
LYNN N. CHARLES	**2260882301**
MICHAIAH L. CHARLES	**2260882302**
KENNEDY HENSLEY	**7780004518**

Reasons: Medicaid coverage will end because:
Your Medicaid eligibility period has ended.

You may get a copy of the manual or policy information that requires your case to be closed from your worker. Manual/policy reference supporting this action:
204.06.02

You may qualify for Medicaid under other programs if there have been changes in your family, health or income since your last application or review. If there have been changes that we do not know about, you should re-apply.

To re-apply you can do one of the following:

- Contact a Medicaid eligibility worker in the county where you live.
- Call 1-888-549-0820 and ask that a Medicaid application be mailed to you. This is a free call.
- Use the computer to get an application from our website at www.dhhs.state.sc.us.

If the reason shown above states that your Medicaid coverage will stop because of "Failure to Return Review Form" AND you have not received a review form or have already returned your review form, please contact your worker right away.

Fair Hearing

If you feel your case has been closed in error, you may ask for a fair hearing before the South Carolina Department of Health and Human Services.

- To ask for a fair hearing, send a request in writing, along with a copy of this letter, within 30 days to your worker.
- You can hire an attorney to help you or you can have someone come to the hearing and speak for you.
- If you request a hearing within 10 days of the date on this letter, you can ask in your request that your Medicaid coverage continue until a final decision is made by the hearing officer. However, if the hearing officer rules that the decision to close your case was correct, you will be required to pay back any Medicaid benefits you received while your case was being reviewed.

MEDICAID REVIEW FORM

FROM: **HORRY COUNTY DHHS**
P. O. Box 290
Conway SC 29528-0000

DATE: **06/06/2005**

BUDGET GROUP: **58248210**

HH#: **100177623**

TO: **LYNN N CHARLES**
APT 36-B
608 KENT LANE
MYRTLE BEACH SC 29579

WORKER NAME:
JACQUELYN ANDERSON

26 JANDE

YOUR MEDICAID WILL END IF THIS LETTER IS NOT COMPLETED AND RETURNED.

Dear Parent/Caretaker/Relative: **LYNN N CHARLES**

You and your children are receiving Medicaid benefits under a program called Transitional Medicaid. It is time for us to see if you are still eligible. We need you to tell us if there have been any changes in your household or income in the past 3 months. Please complete and return this letter to your local DHHS office at the address below within 30 days from the date of this letter.

Questions:

1. How much money did your family earn in the past 3 months?
Please attach proof of income.

2. Has anyone moved in or out of your home in the past 3 months? Yes ___ No ___. If yes, did they move in ___ or did they move out ___? What is their name and relationship to you?

---

3. Do you pay for child care? Yes ___ No ___. If yes, for how many children under 12 do you pay child care? ____. How much do you pay? $ _____ ☐ Weekly ☐ Other _____
Attach proof of amount.

By signing this form, you are saying that the information you gave us is true and correct.

Signed _____ Date: _____

If you have questions call your county DHHS office at: **843 234-5054**

Please return this letter to:
300 Singleton Ridge Rd.
Conway SC 29526-0000

MEDICAID APPROVAL LETTER

OCWI (CHILDREN)/PHC

HORRY COUNTY DHHS
P. O. Box 290
Conway SC 29528-0000

LYNN N HENSLEY
240 WEYBURN STREET
MYRTLE BEACH SC 29579

Date: 02/03/2006
Worker: WENDY JOHNSON
Telephone: 843 448-8407
BG #: 59112593
HH #: 100177623
26 WENDJ

Your application has been approved. The persons listed below will get Medicaid benefits:

Recipient Name	Recipient ID#	Medicaid Card Effective Date	Retro Date(s)
MICHAIAH L CHARLES	2260882302	01/01/2006	
KENNEDY HENSLEY	7780004518	01/01/2006	

The Medicaid card will be mailed to your current address. If you move, you must tell your County Department of Health and Human Services (DHHS) because the Post Office cannot forward your Medicaid cards. You must present this card to the doctor, hospital, drug store each time you go.

You may have a choice about the way that you receive your Medicaid services. For more information, call toll free 1-888-549-0820.

X As a condition of eligibility when you apply for medical assistance, you are assigning to the state your rights to any medical support or other payments for medical care and you are agreeing to cooperate with the state in obtaining third party payments.

X You may ask for a fair hearing before the Department of Health and Human Services if you believe an error was made in processing your application.

To Request A Fair Hearing From the Department of Health and Human Services

- Ask your Medicaid worker in writing within 30 days of the date on this letter. Attach a copy of this letter to your request.

You must tell your Medicaid worker in 10 days if you have a change in the following:

- Where you live
- Income
- Resources
- Family size (someone moves in or out)
- Any news that would change your case

To Get Help With Your Fair Hearing

- You can hire an attorney to help you
- You can have someone you know come to the hearing and speak for you
- Contact your Medicaid worker in person or by phone to get help in asking for a hearing.

YOU WILL RECEIVE A REVIEW FORM IN THE MAIL EVERY 12 MONTHS (SOMETIMES SOONER). WHEN YOU RECEIVE THE REVIEW FORM, YOU MUST COMPLETE AND RETURN IT OR YOUR MEDICAID WILL STOP.

From: Lynn Charles <nacol2001@yahoo.com>
To: Rosa Patterson <Patterso@dhhs.state.sc.us>
Date: 2/15/06 10:26:45 PM
Subject: Re: Medicaid Eligibility

ma'am, i am just reading your email, as well as getting your voicemail, and i do appreciate your time. MY 3-YEAR OLD HAS PNEUMONIA, AND I HAVE BEEN UP WITH HER ALL LAST NIGHT AND TODAY. I HAVE SUBMITTER A DR'S NOTE AS AN ATTACHMENT, SO THAT YOU CAN SEE I HAVE THIS AS A PROBLEM. i HAVE FILLED OUT ALL THAT I CAN ON THAT PAPERWORK, BUT WAITING FOR THE DOCTOR'S OFFICE TO HAVE TIME TO FILL IT OUT IS ANOTHER STORY. I HAVE A BAD KNEE INJURY, WITH SEVERE ARTHRITIS IN IT, AND IT IS HARD FOR ME TO GET AROUND LIKE I NEED TO. I WAS ATTENDING REHABILITATION/THERAPY, SO THAT HOPEFULLY I CAN WALK BETTER ONE DAY, BUT NOW THAT HAS HAD TO END BECAUSE MY MEDICAID IS CUT OFF. SO I CAN NOT GET AROUND AT YOUR CONVENIENCE OR ANY ONE ELSE'S I GET AROUND AT MINE, I HAVE NO OTHER CHOICE. I HAVE TWO SMALL CHILDREN AS WELL AS BEING A FULL TIME STUDENT AT CCU, SO MY SPARE TIME IS VERY LIMITED. NOW, I WILL TRY AGAIN TO GET THE DOCTOR'S OFFICES TO GIVE ME THE THINGS I NEED, AND I HOPE THAT I CAN JUST DROP IT OFF AT SOMEONE'S OFFICE. IF THIS IS NOT THE CASE, WELL THEN I WILL WRITE THE GOVERNOR AGAIN, OR EVEN THE PRESIDENT, DOESN'T MAKE MUCH DIFFERENCE TO ME, AS LONG AS SOMEONE HELPS ME. GOVERNOR SANFORD IS A GOOD MAN, AND HE ANSWERS ME EVERY TIME I WRITE HIM. SO THAT IS MY SITUATION IN A NUTSHELL.

THANK YOU,

LYNN NACOL HENSLEY

Rosa Patterson <Patterso@dhhs.state.sc.us> wrote:
I work for the SC Department of Health and Human Services (Medicaid) and Governor Sanford asked our agency to assist you with your concerns regarding the closure of your Medicaid case.

Your children's Medicaid has been reinstated under the Partners for Healthy Children program; however, we are awaiting the return of your Medical Support Referral Form and the disability package before a determination can be made regarding your eligibility. If those documents are not received today, your application will be denied. Please forward the requested documents to Ms. Wendy Johnson in our Horry County Medicaid Office at 843-448-8407 as soon as possible.

If you have any questions about this email, please contact me at 803-898-2626.

Thank you.

Confidentiality Note

This message is intended for the use of the person or entity to which it is addressed and may contain information, including health information, that is privileged, confidential, and the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED.

If you have received this in error, please notify us immediately and destroy the related message.

843

Ms. Hensley 424-1552

From: Renee Gray
To: Rosa Patterson
Date: 2/13/06 4:57:11 PM
Subject: Re: Lynn N. Hensley HH #100177623

She has not returned her information to me. If it is not received by Wed. it will be denied.

Thank you

Renee Gray
Horry County DHHS
843-381-8260 x-164

>>> Rosa Patterson 02/13/06 4:32 PM >>>
I have a log letter from the Governor's Office and would like to know the current status of Ms. Henley's LIF and ABD applications. Please provide me with an update.

Thanks.

From: Wendy Johnson
To: Rosa Patterson
Date: 2/13/06 4:53:47 PM
Subject: Re: Lynn N. Hensley HH #100177623

I approved the PHC but Pended the LIF and sent her a 2700 to be ret'd by 02/16/06. I have not rec'd it yet. Renee Gray is working the ABD.
Thank You,
Wendy Johnson

>>> Rosa Patterson 02/13/06 4:32 PM >>>
I have a log letter from the Governor's Office and would like to know the current status of Ms. Henley's LIF and ABD applications. Please provide me with an update.

Thanks.

CERTIFICATE TO RETURN TO SCHOOL/WORK

Name Lynn Charles Hensley has been under my care from 2/14/06 to 2/21/06 and will be able to return on 2/22/06

☐ Restrictions _____

Comments Child sick (pneumonia)

Jill Lidsey, MD Date: 2/15/06

COASTAL PEDIATRICS, P.A.
8030 MYRTLE TRACE DRIVE, CONWAY
843-347-4677 Fax: 843-347-4678

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

2376 Cypress Circle, Suite 300
Conway, South Carolina 29526
(843) 347-7222 FAX: (843) 347-3305

Work and / or School Release

Date 2-9-06 Chart 78176

RE Lynn Hensley

Diagnosis _____

Please be advised that the above named patient:
(+) Was seen in this office on the following dates; 1-11-06
Sebastian Dent

( ) May return to full duty on _____

( ) May not return to work until _____

(+) May return to light duty _____

( ) May not participate in _____

Return Appointment _____

☐ James W. Yates, Jr., M.D. ☐ J. Stewart Haskin, Jr., M.D. ☐ William L. Mills, M.D. ☐ C. Curtis Elliott, M.D.
☐ A. Jay Prestar III, M.D. ☐ Jeffrey C. Wilkins, M.D. ☐ Ross Taylor, M.D.