DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Bowling	1-23-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000479	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Cleared 2/26/07, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 2-1-07 [ ] 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

Fax Transmittal Sheet

Log - Bowling "Approp. Sign."

TO: Robert Kerr

FROM: Emily McCann

DATE: 1/22

COMMENTS: Re: Sospeter Adongo

Thanks!

2 PAGE(S) TO FOLLOW

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

508 HAMPTON STREET
SUITE 202
COLUMBIA, SC 29201
(803) 933-0112

401 WEST EVANS STREET
SUITE 226B
FLORENCE, SC 29501
(843) 669-1505

101 EAST WASHINGTON STREET
SUITE 220
GREENVILLE, SC 29601
(864) 250-1417

530 JOHNNIE DODDS BOULEVARD
SUITE 202
MOUNT PLEASANT, SC 29464
(843) 849-3887

140 EAST MAIN STREET
SUITE 110
ROCK HILL, SC 29730
(803) 366-2828

135 EAGLES NEST DRIVE
SUITE B
SENECA, SC 29678
(864) 886-3330

LINDSEY O. GRAHAM
SOUTH CAROLINA

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

UNITED STATES SENATE

January 22, 2007

Mr. Robert Kerr
Director
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

Dear Mr. Kerr:

The attached letter concerns an issue outside my official jurisdiction. Therefore, as a courtesy to my constituent, I am sending this correspondence to your attention.

Thank you for your attention to this matter. I ask that you please respond directly to the individual.

Sincerely,

Lindsey O. Graham
United States Senator

LOG/ecm

Enclosure

508 HAMPTON STREET
SUITE 202
COLUMBIA, SC 29201
(803) 933-0112

401 WEST EVANS STREET
SUITE 226B
FLORENCE, SC 29501
(843) 669-1505

101 EAST WASHINGTON STREET
SUITE 220
GREENVILLE, SC 29601
(864) 250-1417

530 JOHNNIE DODDS BOULEVARD
SUITE 202
MOUNT PLEASANT, SC 29464
(843) 849-3887

140 EAST MAIN STREET
SUITE 110
ROCK HILL, SC 29730
(803) 366-2828

136 EAGLE'S NEST DRIVE
SUITE B
SENECA, SC 29678
(864) 888-3330

JAN 19 NAF

January 5, 2007

JAN 22 2007

Sospeter Adongo
320 South Beltline Boulevard, #33e
Columbia, SC 29205

Senator Lindsey Graham,
United States Senate,
Washington, DC 20510

Dear Senator Graham:

RE: MEDICAID ISSUE

I hope that this letter finds you in good health as you continue to serve our State. I writing to you today to request assistance with a Medicaid issue. I would like to thank you again for assisting my family two years ago with a work authorization issue. Your inquiry into that matter had led to a prompt response by the Department of Homeland Security.

Here is a brief background on the Medicaid issue: On 06/02/2004 our daughter was delivered at Palmetto Baptist Hospital in Columbia, South Carolina. At the time my wife's application for Medicaid was being processed at Richland County DHHS. We later received Medicaid approval letters for her and our daughter. Both were dated 09/13/2004 and the details are as follows:

Recipient Name	Recipient ID#	Effective Date
Heidi Tuss Adongo	9780096552	06/01/2004
Sylvia A. Adongo	7780330395	06/01/2004

We promptly called Palmetto Baptist Hospital and gave them the information. However, according to the hospital, the accounts have not yet been paid to this date. The charges incurred on that date have been placed for collection by Palmetto Baptist Hospital through RECEIVABLES MANAGEMENT CORPORATION (Phone# 803-776-2030) under my Credit Report. We have made numerous contacts with both the hospital and the collection agency to no success. Our calls are not being returned. Last February I wrote to the Medicaid Department in Atlanta and received no response.

I write to you again today believing that an inquiry into this issue by your office may help us get some response from the Medicaid Office.

Thank you again for your assistance. May God bless your good work.

Sincerely,

Sospeter O. Adongo

Sospeter Adongo.

P:\My DocumentsExt\Personal\Palmetto Baptist Hospital.doc [3]

```
EDHMS54 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 01/23/07
 MEDSPROD                      RECIPIENT INFORMATION               ACTION:
                  MEMBER PERIOD START: 05/02/06  END:              PAGE: 0001
 NAME: ADONGO HEIDI T                              HH NAME: ADONGO HEIDI T
 RCP NUMBER: 9780096552      HH NUMBER: 100931895  ACTION TYPE: MAINTENANCE
 SSN: 517-76-4678  VC: V   APL STATUS:             ACTION DATE: 09/10/04
 PRIMARY INDIVIDUAL:       APL CO: 40    WORKER ID: GALLE    LOCATION: 001
 320 SOUTH BELTLINE BOULEVARD            SSCN:               RRN:
 APT. 33/E                               RACE: 01   SEX: F   MARITAL STATUS: M
                                         TPL INSURANCE: N    RELATION: SELF
 COLUMBIA                  SC 29205-     DOB: 06/27/1977     DOD:
 CORRECT RCP NUMBER: _____               LIV ARRANGEMENT: HOME INCOME TRUST:
                                         PROVIDER:

     BG       BEG         END                  BENEFITS QMB RETRO  % OF POV   CHIP
S  NUMBER    ELIG        ELIG     PCAT QCAT     TYPE     IND  IND    LEVEL    NUMBER
_ 68690248 01/01/2005 08/01/2006 55   30    LIMITED    N    N        .00
_ 38552817 06/01/2004 01/01/2005 87   30    FULL       N    Y       1.30


 UPDATED: USER ID: GALLE     DATE: 07/21/04  SYSTEM ID: TTR1004  DATE: 07/23/04
ME900063 RECIPIENT RECORD FOUND
 PF2->HH BG  PF3->HH MBR DTL  PF4->REFH  PF5->ELD02  PF6->RETURN  PF7->PREV
 PF8->NEXT  PF9->HH NOTES  PF15->RCP SEARCH  PF17->ELD00  PF18->HH MBR BGS
```

```
1EDHMS54 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 01/23/07
 MEDSPROD                      RECIPIENT INFORMATION                ACTION:
                    MEMBER PERIOD START: 05/02/06  END:             PAGE: 0001
 NAME: ADONGO SLYVIA A                                HH NAME: ADONGO HEIDI T
 RCP NUMBER: 7780330395      HH NUMBER: 100931895     ACTION TYPE: MAINTENANCE
 SSN:    -  -       VC:      APL STATUS:              ACTION DATE: 09/10/04
 PRIMARY INDIVIDUAL:         APL CO: 40    WORKER ID: GALLE    LOCATION: 001
 320 SOUTH BELTLINE BOULEVARD              SSCN:               RRN:
 APT. 33/E                                 RACE: 01   SEX: F   MARITAL STATUS:
                                           TPL INSURANCE: N    RELATION: CHILD
 COLUMBIA                    SC 29205-     DOB: 06/02/2004     DOD:
 CORRECT RCP NUMBER: _____                 LIV ARRANGEMENT: HOME INCOME TRUST:
                                           PROVIDER:

      BG       BEG         END                  BENEFITS QMB RETRO  % OF POV   CHIP
S  NUMBER     ELIG        ELIG     PCAT QCAT  TYPE     IND  IND    LEVEL     NUMBER
_ 28554267 06/01/2004 07/01/2005 12   30   FULL      N    Y         .00

 UPDATED: USER ID: GALLE      DATE: 07/21/04  SYSTEM ID: TTR1001  DATE:
ME900063 RECIPIENT RECORD FOUND
 PF2->HH BG  PF3->HH MBR DTL  PF4->REFH  PF5->ELD02  PF6->RETURN  PF7->PREV
 PF8->NEXT  PF9->HH NOTES  PF15->RCP SEARCH  PF17->ELD00  PF18->HH MBR BGS
```

#479

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

February 26, 2007

Mr. Sospeter Adongo
320 South Beltline Boulevard, #33E
Columbia, South Carolina 29205

Dear Mr. Adongo:

Thank you for the letter to Senator Lindsey Graham regarding Medicaid. The Department of Health and Human Services has been asked to provide a response.

Ms. Jennifer Campbell, Team Leader in the Division of Physician Services, has researched your concerns regarding unpaid medical bills. Though we welcome the opportunity to assist you, due to Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines, we need authorization to discuss personal health information with anyone other than the beneficiary enrolled in the South Carolina Medicaid program.

I have enclosed "SCDHHS Authorization to Disclose Health Information" forms for each beneficiary mentioned in your letter. Please have the completed forms returned to the following address:

South Carolina Department of Health and Human Services
Division of Physician Services
Attention: Jennifer Campbell
Post Office Box 8206
Columbia, SC 29202-8206

If you have any additional questions, please do not hesitate to contact Ms. Jennifer Campbell Team Leader in the Division of Physician Services, at (803) 898-2660.

Sincerely,

Melanie "Bz" Giese, RN
Bureau Director

MG/wd

Medical Services
P. O. Box 8206• Columbia, South Carolina 29202-8206
(803) 898-2868 • Fax (803) 255-8353

SCDHHS AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

Record #: _____ Client SS #: _____

I _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Provider/Plan/Agency)

from the records of the above named client to: _____
(Recipient Name/Address/Phone/Fax)

_____

_____

for the specific purpose(s):_____

_____

Specific information to be disclosed: _____

_____

_____

I understand that this authorization will expire on the following date, event or condition: _____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that refusal to sign this authorization will not condition or limit my access to treatment, payment, enrollment or eligibility for benefits available to me.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

****

NOTE: This Authorization was revoked on _____	_____
(Date)	*(Signature of Staff)*

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Client) *(Date)* *(Signature of Witness)* *(Date)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Staff) *(Date)* *(Signature of Witness)* *(Date)*