DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Supra	4-10-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER '10'392	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Kast, Lynch Closed, see attached e-mail	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] 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:
Ethics, Chairman
Ways and Means

House of Representatives

State of South Carolina

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

Tel. (803) 734-3114

March 21, 2012

Anthony E. Keck
Director, SC Dept. of Health & Human Services
P.O. Box 8206
Columbia, SC 29851

Dear Director Keck:

I am writing this letter on behalf of Ms. Mary Holley Franklin. I wrote you recently regarding Ms. Franklin, but I have recently received a letter from her doctor that I wanted to pass along to you. I am also enclosing the previous information I sent you regarding Ms. Franklin.

If you have any questions or need any further information, please do not hesitate to contact me.

Sincerely,

J. Roland Smith

J. Roland Smith

Hold until Jenny calls office for an update. bf
3/23/12
4/10/12
Will e-mail a response.
Spoke to Rep Smith's Office

Carolina Musculoskeletal Institute, PA
410 University Parkway, Suite 1000
Aiken, SC 29801
(803) 644-4264 • Fax (803) 649-0543
www.CMI.md

CMI Orthopedics
CLARK D. MOORE, M.D.
DOUGLAS E. HOLFORD, M.D.
TIMOTHY J. SHANNON, M.D.
TY W. CARTER, M.D.
R. VAUGHAN MASSIE, M.D.
ADAM C. SCHAAF, M.D.

CMI Imaging
DAVID D. GOLTRA JR, M.D.

CMI Pain Management
RUSSELL K. DANIEL, M.D

CMI Neurology
MICHELLE M. LYON, M.D.

CMI Rheumatology & Osteoporosis
EDWIN MARTINEZ de ANDINO, M.D.

CMI Podiatry
MACKIE J. WALKER, D.P.M.
ANGELA H. MOLNAR, D.P.M.

March 15, 2012

RE: Mary H. Franklin
DOB: 2/10/22

To Whom It May Concern:

I am the orthopedic surgeon treating Ms. Mary Franklin for her right hip. The patient underwent surgery on her right hip on January 18, 2012. The patient is 90 years old and is minimally ambulatory and is wheelchair bound. Due to the patient's age and physical condition, she is unable to continue residing in an assisted living facility. She is need of assistance with ADL's and needs to be in a skilled nursing facility.

Any assistance that you can give to this patient would be greatly appreciated. If I can be of any further assistance please do not hesitate to contact me.

Sincerely,

Adam C. Schaaf, M.D.
arw

House of Representatives
State of South Carolina

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

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

Tel. 803-734-3114

Committees:
Ethics, Chairman
Ways and Means

March 12, 2012

The Honorable Anthony E. Keck, Director
SC Department of Health and Human Services
P. O. Box 8206
Columbia, SC 29202

Dear Mr. Keck:

I am writing this letter on behalf of Ms. Mary Holey Franklin, who currently resides at 550 East Gate Drive, Aiken, SC 29801. Her mailing address is P. O. Box 527, Warrenville, SC 29851. Ms. Franklin's Guardian ad Litem is Mr. Thomas R. Reames and her daughter, Ms. Cheryl Franklin Reames, of the same address. Ms. Reames' telephone number is 803-663-3220, and her cell phone number is 803-507-4491.

Ms. Franklin broke her hip and is no longer able to live in an assisted living home, and her family is unable to take care of her. Ms. Franklin has applied for Medicaid in order to pay the nursing home bill. As you can see from the enclosed paperwork, her records show her personal finances seem to be in order, which qualifies her for assistance. I am waiting on the letter from her doctor's office, which proclaims she needs to be in a nursing home.

Ms. Franklin lived in an assisted living home before her hip replacement but now she cannot afford it. She has used all her money in an attempt to take care of herself and it appears there are no remaining assets.

I would appreciate any assistance you could provide for Ms. Franklin. If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

J. Roland Smith

JRS/dkh/2012march12-2

Enclosure

cc: Ms. Cheryl Franklin Reames, P. O. Box 527, Warrenville, SC 29851

160956272

P. Simmons
642-3668

South Carolina Department of Health and Human Services
MEDICAID APPLICATION FOR

MEDICAID

☑ Nursing Home ☐ Waiver Services ☐ General Hospital

JAN 27 2012

County Name: Aiken Case Number: _____ Date Received: _____

ELIGIBILITY

The following information is needed so that a determination of eligibility for Medicaid can be made. All information given is subject to verification and you may be asked to answer additional questions and provide documentation. At the end of this form, you will be asked to sign a statement that you understand the questions and that you have answered all the questions fully and completely, to the best of your knowledge, and that you have not given any false information. Please answer all questions unless otherwise instructed.

1. **Answer these questions if you are making this application for someone else.**

Your Name: Sheryl Franklin Reames Relationship to Applicant: Daughter

Your Address: Po Box 527 Home Phone Number: 803-663-3220
Warrenville SC 29851 Work Phone Number: 803-507-4491

Do you or anyone else have any of the following for the applicant? ☒ Yes ☐ No ☐ Don't Know

☐ Conservatorship ☐ Guardianship ☒ Power of Attorney

If yes, please give us a copy of the legal papers and the name of the person if someone other than you.

Name: Thomas R. Reames

2. **Who is the person needing assistance (applicant)?**

Mary (First) Holley (Middle) Franklin (Last)

☒ Aged *(Age 65 and older)* ☐ Disabled ☐ Blind

Home Address	Mailing Address *(if different)*	Home Phone Number
550 East Gate DR. Aiken SC	Po Box 527 Warrenville SC 29851	803-663-3220
		Work Phone Number

Where is the applicant physically located now? At the above Home Address.

If in a medical facility, what was the date of admission? 1-21-2012

Please give the following information about the applicant:

Date of Birth (Mo/Day/Year)	Sex	SC Resident (Yes or No)	US Citizen (Yes or No)	Marital Status	Social Security Number	Social Security or Railroad Retirement Claim Number
02/10/1922	F	Yes	Yes	Widowed	247-22-8743	

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

Full name at birth:	Place of birth: (County and state where hospital or home in which he/she was born is/was located)
Mary S. Holley or Mary Stephen Holley	Aiken South Carolina

3. **Give the following information about the applicant's spouse and children in the home under age 21. Also list any children in the home over age 21 with a disability.**

Name	Relationship	Birthday (Mo/Day/Yr)	Sex	Race	SC Resident (Yes or No)	Marital Status	Social Security Number (Optional)	Social Security or Railroad Retirement Claim Number (Optional)
	Spouse							

4. Is the applicant/spouse/minor child(ren) receiving or applying for income from any of the following?

(√) Check "Receiving" or "Applied For" *(Yes or No)*	Receiving		Applied For	
	Yes	No	Yes	No
Supplemental Security Income (SSI)		✓		
Social Security Benefits (Retirement, Survivors, Disability Insurance)	✓			
Veteran's Administration Benefits (VA)	✓			
South Carolina State Retirement		✓		
Civil Service		✓		
Other Pension or Retirement Income	✓			
Child Support or Alimony		✓		
Interest, Dividends, Trust, Annuity Income, or Insurance		✓		
Rental Income		✓		
Money from Loans, Promissory Note, or Mortgage		✓		
Money from Relatives, Friends, or Boarders		✓		
Payment Made to a Medical Facility on Applicant's Behalf		✓		
Workman's Compensation		✓		
Unemployment Compensation		✓		
Work/Training/Self-Employment		✓		

If you answered yes to any of the above, complete the following:

Income Source	Who Is the Money For	Amount	How Often Received
Social Security	Mary H. Franklin	995.30	Monthly
VA	Mary H. Franklin	1,094.00	Monthly
Retirement	" " "	60.05	Monthly

5. **Does the applicant, spouse, or children receive any money or checks that we have not asked about?** ☐ Yes ☒ No

If yes, explain: _____

6. **Is the applicant a veteran?** ☐ Yes ☒ No VA Claim Number: _____

Is the applicant's spouse a veteran? ☒ Yes ☐ No VA Claim Number: XC12554981

7. **If the applicant is disabled, is it due to an accident?** ☐ Yes ☐ No ☒ Not Disabled

If yes, when and where did the accident occur? _____

Was there, or will there be, any compensation to the applicant? ☐ Yes ☒ No *If yes, explain:* _____

8. **Does the applicant or spouse have any of the following?**

Item	Yes	No	Item	Yes	No
Bank Checking Account	✓		Car, Truck, Van		✓
Bank Savings Account		✓	Motorcycle, Boat, Camper		✓
Certificate of Deposit		✓	Holder of a Mortgage or Promissory Note		✓
Trust Fund or Trust Account		✓	Cash on Hand		✓
Safe Deposit Box		✓	Annuity (If Yes, provide a copy)		✓
Stocks, Bonds, or Mutual Funds		✓	Other (Identify):		
401K, IRA or other Retirement Account		✓			
Farm Machinery or Business Equipment		✓			

If yes, complete the following about each:

Owned By	Type of Account - or - Type of Asset	Account Number - or - Asset Description	Current Value or Balance	Name and Address of Institution
Mary H. Franklin, Sheryl F. Reames + Thomas R. Reames	Checking	5660510711	312.73	SRP Federal Credit Union

9. **Does anyone have a bank account, or any other asset, for the applicant or spouse?** ☐ Yes ☒ No

If yes, at what bank or location, and in whose name(s)? _____

_____

10. **Does the applicant or spouse own any property?**

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

If yes, complete the following:

What is the address/location of the property?	What is the address/location of the property?
_____	_____
_____	_____
_____	_____
_____	_____
Owner's Name: _____	Owner's Name: _____
Homestead? ☐ Yes ☐ No	
Intend to Return Home? ☐ Yes ☐ No	

11. **Does the applicant or spouse share ownership in any property?** ☐ Yes ☒ No

Does the applicant or spouse own lifetime rights to any property? ☐ Yes ☒ No

If yes, where is the property located and whose name is it in?

12. **Does the applicant or spouse own any life, accidental death or burial insurance?** *(This includes any policies purchased for someone else.)* ☒ Yes ☐ No

Owner of Policy	Person Insured	Name of Company	Policy Number	Face Value
Mary H. Franklin	Mary H. Franklin	Security Life of Denver	8415447170	1,000.00

13. **Has the applicant or spouse made plans for burial and own the following?**

Asset	Yes	No	Description and Location of Asset
Pre Need Burial Contract		✓	
Burial Account		✓	
Money Set Aside for Burial		✓	
Cemetery Burial Lot	✓		Pine Forrest Baptist Church / Aiken SC

Other information:

14. **Is the applicant or spouse covered by any other medical insurance, including Medicare or coverage purchased by someone else?** ☒ Yes ☐ No

If yes, complete the following and provide a copy of the card, policy and/or premium notice:

Person Insured	Name of Company	Policy Number	Type of Policy
Mary H. Franklin	Medicare		
Mary H. Franklin	AARP	018174529-1	Supplemental

15. Did the applicant receive medical services in the previous three (3) months? ☒ Yes ☐ No
If yes, complete the following:

Date of Service	Provider of Services (Doctor, Hospital, Drug Store, etc.)
01/18/2012	Aiken Regional Medical Center (DR. Schaaf)

16. Were the applicant's financial situation and living arrangements the same in the previous three months as it is now?
☐ Yes ☒ No *If no, explain how they were different:* She could live in Assisted living before Hip Replacement, & now She has used all of her money cant afford it. She

17. Does anyone for whom you are applying have a plastic South Carolina Healthy Connections (Medicaid) card?
☐ Yes ☒ No *If yes, list their names here:* _____

18. Where has the applicant lived in the past five (5) years?

City	County	State	From	To
Aiken	Aiken	SC	2-1-10	1-16-12
Warrenville	Aiken	SC		

19. If ever married, give the following information about the applicant's spouse(s). *(List the most recent first.)*

Name: Walter Elmer Franklin JR.		Phone Number:
Address:	☐ Living ☐ In a medical facility ☐ Married living together ☐ Married living apart ☐ Married separated ☐ Divorced	☒ Deceased Date of Death: 4-22-2003 County and state where estate was probated: Aiken SC
If Separated, how long:	If Divorced, date and place divorce filed:	
Name:		Phone Number:
Address:	☐ Living ☐ In a medical facility ☐ Married separated ☐ Divorced	☐ Deceased Date of Death: _____ County and state where estate was probated:
If Separated, how long:	If Divorced, date and place divorce filed:	

20. Give the following information about the applicant's mother and father, if known.

Mother:	☐ Living
Mother's Full Maiden Name: Florine Rhodes Holley	
Address: Phone Number:	☒ Deceased Date of Death: 1970 or 1971 County and State where estate was probated: Aiken SC
Father: Stephen Holley	☐ Living
Address: Phone Number:	☒ Deceased Date of Death: 1933 County and State where estate was probated: Aiken SC

21. Complete the following:

Where did the applicant work the longest?	Where did the applicant last work?
Company Name and Address: Clearwater Finishing Plant	Company Name and Address: ←
Dates of Employment: From: Unknown To: Unknown Does applicant receive a pension? ☒ Yes ☐ No	Dates of Employment: From: _____ To: _____ Does applicant receive a pension? ☐ Yes ☐ No

22. Has the applicant or spouse closed any bank accounts on or after February 8, 2006?

☐ Yes ☒ No *If yes, at what bank and in whose name(s)?*

A. _____ B. _____

Date Closed: _____ Closing Balance: _____ Date Closed: _____ Closing Balance: _____

23. Has the applicant or spouse sold or given as a gift, any cash, property, vehicle, boat or other resource to any person any time on or after February 8, 2006? ☒ Yes ☐ No

Item Sold or Given Away	Person to Whom it was Sold or Given	Date Given or Sold	Amount Received
House + 1 1/2 Acre land	Kellie R. Adkinson	4-27-2011	$ 5.00

24. If married and entering a nursing home, does the applicant want to give (allocate) part or all of income to spouse remaining at home? ☐ Yes ☒ No

25. Tell us what language you use most:

☒ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Korean ☐ Vietnamese ☐ Sign Language

☐ Other _____

26. If you do not know the answers to all questions, is there another person who can give more information?

Name: NO Telephone: _____

Address: _____

ESTATE RECOVERY *(BE SURE TO GET A COPY OF THE ESTATE RECOVERY BROCHURE.)*

As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:

- A person of any age who was a patient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care, or
- A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.

Please complete and sign. I have read my Rights and Responsibilities on the next page. ☒ Yes ☐ No

Applicant/Beneficiary's Signature:		Date: 1-25-2012
Responsible Person's *(or Authorized Representative's)* Signature: Cheryl T. Reames	Title/Relationship: Daughter	Date: 1-25-2012
Witness: *(Signature by mark of "X" requires2 witnesses)*	Complete Address:	Date:
Witness:	Complete Address:	Date:

If you have decided not to continue with your application, complete the following:
I have decided not to continue with my request, and my signature below means that I want to withdraw my application for Medicaid.

Signature:	Date:

Referrals Discussed:
- ☐ Supplemental Security Income Program
- ☐ Adult Services
- ☐ Other: _____

Forms Given to Client:
- ☐ Civil Rights Pamphlet
- ☐ Medicaid Handbook
- ☐ Other: _____
- ☐ Estate Recovery
- ☐ Fair Hearing & Appeals

DHHS Worker's Signature:	Date:

For DHHS Use Only

Burial Exclusion for: _____

Pre Need Burial Contract
Name of Funeral Home: _____ ☐ Irrevocable ☐ Revocable

Burial Space Items: $ _____ Burial Fund Items: $ _____ Date of Contract: _____

Burial Fund Exclusion List the Asset(s) Designated for Burial and the Value:

_____

_____

Total Amount Designated: $ _____ Excluded: $ _____ Non Excluded: $ _____

I UNDERSTAND THAT IF ANY EXCLUDED BURIAL FUNDS ARE USED FOR ANY PURPOSE EXCEPT BURIAL, AN AMOUNT EQUAL TO THE AMOUNT USED FOR SOME OTHER PURPOSE WILL BE COUNTED AS INCOME IN DETERMINING ELIGIBILITY FOR ASSISTANCE.

SIGNATURE: _____ DATE: _____

RIGHTS AND RESPONSIBILITIES

1. I know that my children under age 19 who are eligible for 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.

9. I know that DHHS must be named as a primary remainder beneficiary for any annuity owned by a Medicaid beneficiary receiving long term care services, regardless of irrevocability or other treatment of the annuity.

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

Hasler
03/22/2012
US POSTAGE
FIRST-CLASS MAIL
$00.65⁰
ZIP 29201
011D12601984

Anthony E. Keck
Director, SC Dept. of Health & Human Services
P.O. Box 8206
Columbia, SC 29851

Brenda James - Mary Franklin - Representative Smith (update)

From: Jennifer Lynch
To: Brenda James
Date: 4/16/2012 10:08 AM
Subject: Mary Franklin - Representative Smith (update)

The letter we received from Rep. Smith included an application, which was forwarded to the local Medicaid office for processing. The worker spoke with Ms. Reames, the AR, and let her know that it was received and would be processed. I updated Representative Smith with this information, told him we'd be keeping Ms. Reames updated directly, but that he could call at anytime, if needed. Below is the latest, as of last week:

From the eligibility worker: I spoke to Deena Williamson from Anchor Health/Rehab. That's the facility where Mary Franklin is residing. Deena stated that the client is still being covered under her Medicare days as well as her private insurance. Per Deena client will have to exhaust all of her Medicare days before she can be switch over to Medicaid. Once she uses up her Medicare days ,client will need a level of care determination from Community Long Term Care. Once the level of care is completed the nursing home will forwarded their paperwork to the Medicaid office for Medicaid processing.

Yes, I did speak with Ms. Reames. I explained to her about the Medicare days and the reason the Medicaid application is still pending. Ms. Reames thanked me for explaining everything to her and that she was very appreciative of everything we are doing for her mother. Thanks.

Jenny Lynch,
Legislative Affairs and Communications
SC Department of Health and Human Services
(803) 898-3965
(803) 351-5673 Cell
(803) 255-8235 Fax

Brenda James

From: Teeshla Curtis
Sent: Monday, May 21, 2012 9:21 AM
To: Brenda James
Subject: FW: Log 392

This a note confirming Log 392 is closed.
Teeshla

From: Jennifer Lynch [mailto:LYNCHJEN@scdhhs.gov]
Sent: Friday, May 18, 2012 10:19 AM
To: Teeshla Curtis
Subject: Re: Log 392

I have this one as closed. We didn't do a response. Since it was an application I forwarded it to the county office to process. They have been working directly with the AR and I've provided phone updates to Rep. Smith's office. Once a decision is made, I will make a final follow-up. I believe a decision will be made soon. They were waiting on her Medicare days to run out...

Jenny Lynch,
Legislative Affairs and Communications
SC Department of Health and Human Services
(803) 898-3965
(803) 351-5673 Cell
(803) 255-8235 Fax

>>> Teeshla Curtis <CURTIST@scdhhs.gov> 5/15/2012 3:18 PM >>>
Jenny,

Just checking the status of Log 392 – Mary Holley Franklin.

Teeshla Curtis

Administrative Coordinator
Office of Information Management
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, South Carolina 29202
(803) 898-2502