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**M. Tryon Face, M.Ed.
Rehabilitation Consultant
554 Hope Ferry Road
Lexington, SC 29072
803-808-0219
Fax 803-808-0519**

DATE: October 26, 2014
FAX #: 803-734-5167
ATTN: Governor Nikki Haley
FROM: Tryon Face
RE: Lillian R. Face

Please see the attached letter to Healthy Connections (SC Medicaid) regarding my soon to be 94 year old mother. The way this agency has handled this is very troubling. I just wanted you to be aware of how us "common folks" out here are treated. Thank you. Tryon Face

**M. Tryon Face, M.Ed.
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Lexington, SC 29072
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Via Facsimile
October 26, 2014

Healthy Connections
Department of Health and Human Services
SCDHSS Region 2
PO Box 100101
Columbia, SC 29202

Re: Lillian R. Face
DOB: 11/9/20

To whom it may concern:

This is in follow up to the letter I received from your agency on October 25, 2014 requesting additional information regarding the Medicaid application that I completed for mother, Lillian Face, on April 15, 2014. The following are issues and concerns that I have regarding that request:

1. In addition to the information that I submitted on May 8th I will do my best to obtain the financial information you requested and have that information to your agency tomorrow.
2. To say that I was surprised to receive this request is a polite way to state my reaction. I filed the application on April 15th and submitted information your agency requested on May 8, 2014. This is the first written document that I have received in five and one-half months! I have made multiple calls and was told that everything had been submitted and the representatives to whom I spoke were surprised I had received no response.
3. Your letter requested what category of Medicaid we are requesting. It is nursing home care and that should be well documented. Ms. Ann Williamson with Healthy Connections evaluated my mother on Tuesday, October 21st and stated that she met the qualifications for nursing home care. A letter of certification to that effect was received yesterday as well.
4. My mother is approaching 94 years of age. She has lived on a fixed income of primarily Social Security for years with no additional funds available. She has \$44 in her checking account after I have paid her monthly bills. That is all the money she has in the world!! She is bedridden at home due to a combination of age, Crohn's disease, Alzheimer's and heart disease. We are doing our best to take care of her at home which we are no longer able to do. That is why we have requested assistance from your agency. We do not want to place her in a nursing home, but see no alternative at this point.
5. We need to seek nursing home placement as soon as possible. To receive this request for follow up information five and one half months later in the process is difficult to comprehend. To

receive a request regarding what category of Medicaid we are seeking and one of your own representatives has been to see my mother the day before is just plain difficult to understand!

6. Your letter to me was dated October 22, 2014? Was this the first time someone had reviewed our application?
7. Assuming I can obtain the additional bank statements when can we expect a decision so we can hopefully begin looking for a nursing home bed? An additional contact number for me is my cell phone which is 803-807-8822.

Sincerely,

A handwritten signature in black ink that reads "M. Tryon Face". The signature is written in a cursive, slightly slanted style.

M. Tryon Face

CC: Honorable Nikki R. Haley
Honorable Timothy E. Scott
Honorable Lindsey O. Graham

MEDICAID CHECKLIST FOR NURSING HOME ASSISTANCE, GENERAL HOSPITAL, HOME AND COMMUNITY BASED WAIVER SERVICE

Applicant/Beneficiary: LILLIAN R. FACE Date: 10/22/2014

Authorized Representative: M. TRYON FACE

Application Date: 04-15-2014

We are currently working on your application/review for Medicaid long-term care services. To complete the eligibility process, some additional information will be needed concerning you, and if married, your spouse. **Please see the items ☒ checked below:**

- ☐ Complete the Attached Review Form
- ☐ Power of Attorney, Guardianship, or Conservator Papers
- ☐ Verification of ☐ Citizenship ☐ Identity ☐ Original Documents Required.
- ☐ The income limit for institutional care is \$ _____ for _____. The applicant's income is over this amount. To possibly qualify for Medicaid assistance for long-term care services, an income trust must be established. You will find the forms needed to complete this process attached.
- ☐ Proof of gross income received by _____. This may be a copy of an itemized check-stub, award letter, PRINTOUT, or statement on letterhead from the company or agency.
- ☒ For all accounts, copies of **entire** bank statements, not account summaries, for April 2014, March 2014, April 2013, April 2012, April 2011, April 2010, April 2009, and the following month(s): **FOR CHECKING ACCT -628-0, I NEED THE STATEMENT FOR 04-2010. I HAVE ALL THE OTHERS BUT ONE FOR 2010. THERE WAS ANOTHER ACCOUNT, MONEY MARKET ACCT #452-152-590-9 THERE WAS 2 STATEMENTS IN HER FILE FOR 2012 AND 2011. WE NEED STATEMENTS FOR APRIL 2009, APRIL 2010, APRIL 2013 AND APRIL 2014. IF THE ACCOUNT IS CLOSED WE STILL NEED THE STATEMENTS FOR THE MONTHS INDICATED (UNLESS IS CLOSED PRIOR TO THE DATE REQUESTED) AS WELL AS VERIFICATION THAT THE ACCOUNT IS CLOSED, DATE CLOSED, CLOSING BALANCE AND RECEIPTS/DOCUMENTATION OF HOW THE MONEY WAS SPENT.**
- ☐ Designate or establish a bank account for income to flow through. Return verification of this account.
- ☐ Proof of assets sold, transferred, or given away on or after April 2009 to the present. _____
- ☐ Verification you have applied for _____ benefits on the applicant's behalf.
- ☐ Burial Assets: Copies of the applicant/spouse's ☐ Pre-need burial contract(s) ☐ burial plot deed(s) or other verification of ownership such as a statement on letterhead. If the contract or plot is not paid for, we also need verification of the payoff amount.
- ☐ Copies of all life insurance policies owned by the applicant/spouse. If the policy is not on hand, a letter from the agent showing the policy number, name of owner, face value, and current cash value of the policy can be provided. If this is not possible, give the name and address of the insurance company, and the policy number for each policy. The owner of the policy needs to sign and date DHHS Form 1280 ME, Verification of Insurance Value, to let us verify current cash values directly from the insurance company.
- ☐ Copy of annuity for _____
- ☐ Please sign and return the form(s) indicated:
 - ☐ DHHS 943, Release of Information ☐ DHHS 1212 ME, Verification of Veterans Information
 - ☐ DHHS 1766-A, Burial Exclusion ☐ DHHS 1253 ME, Request for Financial Investigation
 - ☐ DHHS 1280 ME, Verification of Insurance Value ☐ DHHS 1296 ER, Estate Recovery Notification
 - ☐ DHHS 1282, Authorized Representatives Acknowledgement of Responsibilities

☐ All medical insurance policies or cards and proof of premiums

☒ Other: WHAT CATEGORY OF MEDICAID ARE YOU SEEKING FOR YOUR MOTHER AT THIS TIME-IN-HOME CARE OR NURSING HOME CARE? IF IT IS NURSING HOME, IS SHE IN A FACILITY? IF SO, NEED THE NAME AND DATE ENTERED.

☐ Other: _____

Please provide this information by 11-06-2014. If you have any questions or you need additional time to secure requested information, please call your worker listed below. Thank you for your cooperation.

Worker: SCDHSS REGION 2 Telephone: 1.888.549.0820

Address: PO BOX 100101, COLUMBIA, SC 29202 Fax: 803.710.7310