DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	9-28-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000170	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Cleared 10/5/07, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 10-9-07
	[ ] 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.			

Archie Cleveland Sr.
684 Root Branch Road
Pineville SC, 29468
343-567-4614

Leg: Jacobs. app. Mgr

September 27, 2007

Dear Representative Joe Jefferson,

My name is Archie Cleveland Sr. I am 58 years old. I am writing you for help in my situation. I have been working at Georgia Pacific for 33 years as the sole provider for my family.

I was diagnosed with Leukemia in June 2006. My insurance, Cigna, was through Georgia Pacific. My policy was terminated on August 31, 2007. I am not eligible for Medicare or Medicaid. I am currently receiving Social Security disability ($1457.00).

My disability through Georgia Pacific, MetLife, was paying income to me on short term. After 8 months I was eligible for long term disability. I only get $100.00 from MetLife, because they said I was over paid on my short term disability.

Georgia Pacific sold out to another company Rosenberg. I no longer have a job. The only insurance I am eligible for is Cobra through Georgia Pacific. This insurance will cost me $824.00 a month.

I paid my taxes since I was 18 years old. Now I can't work, I need help, and can't get it. Will you please help.

Thank you

Archie Cleveland

Archie Cleveland Sr.

Department of Health and Human Services
P. O. Box 13748
Charleston SC 29422-0000

PRESORTED
FIRST CLASS MAIL
U.S. POSTAGE
PAID 1 OZ.
PERMIT NO. 50

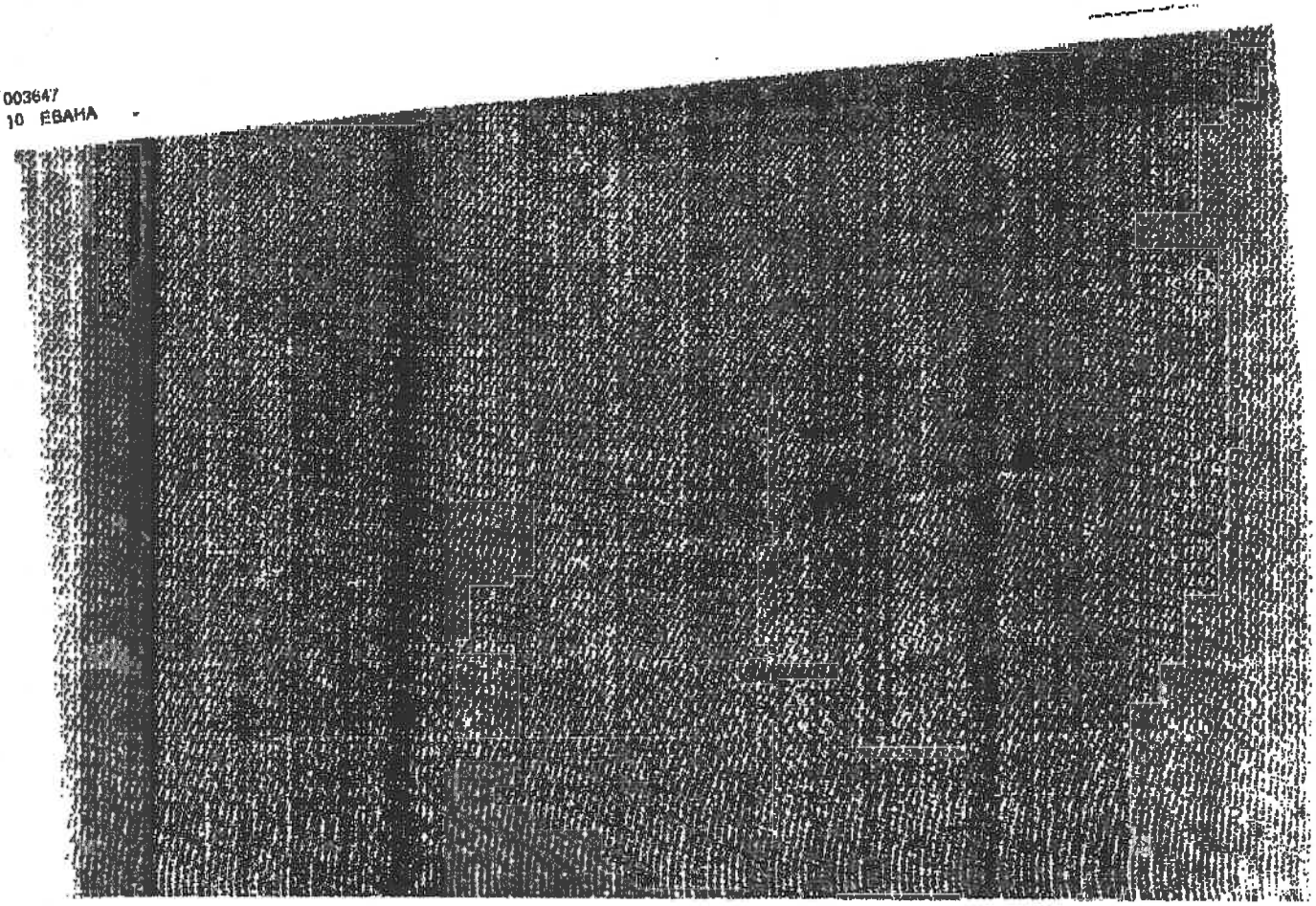
PRESORTED FIRST-CLASS

RETURN SERVICE REQUESTED

Important Information About Health Care Coverage

ARCHIE CLEVELAND
684 ROOT BRANCH RD
PINEVILLE SC 29468-3159

003647
10 EBAHA



09/27/2007 04:00PM

Medicaid Letter of Action

From: CHARLESTON COUNTY DHHS
P. O. Box 13748
Charleston SC 29422-0000

To: ARCHIE CLEVELAND
684 ROOT BRANCH ROAD
PINEVILLE SC 29468

Date: 09/17/2007
Worker Name:
ELIZABETH BAHADORI
Telephone: 843 797-8282
BG #: 09770872
HH #: 101214163
10 EBAHA

Recipient Name:
ARCHIE CLEVELAND
SHIRLEY CLEVELAND

Recipient ID:
0780781246
0780781247

Your application has been denied for: AGED, BLIND, DISABLED (ABD)

Reason for denial:
Your income is more than policy allows.
You did not provide proof of citizenship.

Denied for the month(s) of: 09/2007

Manual/policy reference supporting this action: 303.01.03
102.04.01

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 Hearing from the Department of Health and Human Services

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

To Get Help with Your Hearing

- You may hire an attorney to help you
- You may 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

ELD007 - Revison Date 07/2004 - 10 EBAHA

Social Security Administration
Retirement, Survivors and Disability Insurance
Notice of Award

Southeastern Program Service Center
2001 Twelfth Avenue, North
Birmingham, Alabama 35285-0001
Date: December 9, 2006
Claim Number: 247-92-6787HA

[illegible]

ARCHIE C CLEVELAND
684 ROOT BRANCH RD
PINEVILLE, SC 29468-3159

You are entitled to monthly disability benefits beginning January 2007.

The Date You Became Disabled

We found that you became disabled under our rules on July 18, 2006. This is different from the date given on the application.

Also, you have to be disabled for 5 full calendar months in a row before you can be entitled to benefits. For these reasons, your first month of entitlement to benefits is January 2007.

What We Will Pay And When

- You will receive $1,457.00 for January 2007 around February 21, 2007.
- After that you will receive $1,457.00 on or about the third Wednesday of each month.

The day we make payments on this record is based on your date of birth.

Other Social Security Benefits

The benefit described in this letter is the only one you can receive from Social Security. If you think that you might qualify for another kind of Social Security benefit in the future, you will have to file another application.

Your Responsibilities

You are due disability benefits because you are expected to be disabled under our rules for at least 5 full calendar months. Therefore, you should let us know if your health improves or you are able to return to work.

Enclosure(s):
Pub 05-10153
Pub 05-10058

CONEXIS
P.O. Box 226101
Dallas, TX 75222-6101

Date: 8/29/2007
Form: CLC02-CXDEN
Doc ID: 15115715
Account #: 0107952958

To ARCHIE C CLEVELAND and Covered Dependents
684 ROOT BRANCH RD
PINEVILLE SC 29468-3159

Election Form and Plan Alternatives

Applicant Name: ARCHIE C CLEVELAND (Account Number: 0107952958)

Employer/Plan Sponsor: Georgia-Pacific Corporation
Election Deadline: 11/2/2007

Date of Notice: 8/29/2007
Date of Coverage Loss: 8/31/2007
Coverage Start Date if Electing: 9/1/2007

Qualifying Event Reason: Reduction of Hours/Other Loss of Eligibility

To Employee and any Covered Dependents of: ARCHIE C CLEVELAND

Please use this document to notify us of your decision to continue coverage under the above referenced employer's group health plan(s) as further described in the enclosed Notice of Right to Elect Continuation Coverage form. If there is a family member who was covered on the day before the Qualifying Event that resides at a different address, you must notify CONEXIS immediately so that a separate notice can be provided. If you need further information about continuation coverage, please contact CONEXIS toll free at 1-877-722-2667.

CONEXIS has been retained by the above named employer to notify you of your group health plan benefits continuation rights. Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you, your covered spouse and/or your covered dependents are entitled to continue your group health benefits coverage under the employer or plan sponsor named above beyond the date coverage would normally end. Please read all of the enclosed information on COBRA Rights. Please understand that if cancellation of COBRA continuation coverage occurs it is without possibility of reinstatement.

If you wish to elect coverage, your completed election form must be postmarked by the United States Postal Service (USPS) on or before 11/2/2007 and received by CONEXIS. Please visit our website at www.CONEXIS.org. If you wish to elect online, you will need your social security number and your birthdate to log in to the Employees & Continuants section Your initial premium payment(s) must be USPS postmarked no later than 45 days of the postmark date of your election and received by CONEXIS. To avoid cancellation, your initial payment must include premiums due from the date of coverage loss through the end of the month prior to the month in which your payment is USPS postmarked. Subsequent payments are due on the first of each month and will be returned if not USPS postmarked within 30 days of this due date. Claims may not be paid until your account is current. For example, a June 1 election, based on an April 30 loss of coverage and Qualifying Event, would require a first premium payment no later than July 15 for the months of May and June. The July premium payment would be due no later than July 31. Incomplete election forms will be returned.

You should receive a monthly invoice within 2 weeks of the date we receive your election. Premiums are due regardless of your receipt of the monthly invoice, so please contact CONEXIS at 1-877-722-2667 if you do not receive them. The check must be sent to CONEXIS at the address below. Payment is considered timely if USPS postmarked on or before the applicable grace period expiration date and received by CONEXIS.

Please mail forms and make checks payable to CONEXIS, P.O. Box 226101 Dallas, TX 75222

Applicant Name: ARCHIE C CLEVELAND
Employer/Plan Sponsor: Georgia-Pacific Corporation

Election Deadline: 11/2/2007
Account Number: 7952958

Section A. Plan Alternatives

Place an "X" in the box adjacent to the monthly cost of the coverage(s) you are selecting. Circle the dependents that you wish to cover. Please note that you may not obtain coverage above that which was in effect on your Date of Coverage Loss.

Available Coverages	Employee + Spouse	Employee Only	Spouse Only				Circle dependents you wish to cover
(b)GP HMO Plan CIGNA Network2 HJ07 2007*	☐ $ 824.16	☐ $ 393.72	☐ $ 393.72				a b c d e f g h i j
GP Dental Plan - $50 Deductible D001 2007	☐ $ 75.48	☐ $ 37.74	☐ $ 37.74				a b c d e f g h i j

Section B. Applicant's Authorization and Agreement

Your first premium payment **must be postmarked no later than 45 days** after the postmark date of your completed election. By my signature below, I elect to continue the coverage(s) checked in Section A.

Applicants Signature: _____ Date: _____

Section C. Dependent Information

Dependent Coverage:

Code	Dependent Name	Relationship	Birth Date	Gender
a	CLEVELAND, SHIRLEY	Spouse	10/19/1946	F

DM241 2M03502

09/27/2007 04:00PM

log 0170

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

October 5, 2007

Mr. Archie Cleveland, Sr.
684 Root Branch Road
Pineville, South Carolina 29468

Dear Mr. Cleveland:

Representative Joe Jefferson asked our agency to respond to your recent letter to his office concerning Medicaid eligibility and your healthcare needs.

Medicaid eligibility is based on federal and state requirements. To qualify for Medicaid, an individual must meet certain financial guidelines and categorical requirements. Unfortunately, your recent application for coverage under Medicaid's Aged Blind or Disabled program was denied because your current monthly income exceeds the allowable limit for a couple.

Another option for healthcare assistance is Medicaid's Community Long Term Care (CLTC) program. CLTC can provide assistance to individuals requiring institutional care who choose to receive care in their home. Eligibility for this program is based on a higher maximum monthly income and some resource restrictions. If your health situation worsens, please contact the Charleston CLTC office at (843) 529-0142 to determine if you may be eligible for this program.

In an effort to assist with your healthcare needs, we mailed you materials on several other programs that can provide assistance to South Carolina residents with their medical and prescription medication needs. We hope this information is helpful to you.

Sincerely,

Alicia Jacobs

Alicia Jacobs
Interim Deputy Director

AJ/odl

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

109 0170

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

October 5, 2007

The Honorable Joseph H. Jefferson
South Carolina House of Representatives
1375 Colonel Maham Drive
Pineville, South Carolina 29468

Dear Representative Jefferson:

Thank you for referring Mr. Archie Cleveland, Sr., to our agency regarding Medicaid eligibility and healthcare assistance.

A member of our staff has been in direct contact with Mr. Cleveland regarding Medicaid eligibility and the rules and regulations governing the program. We also provided Mr. Cleveland with information on other programs and organizations that can assist residents in South Carolina with their healthcare services, prescription medications, and inpatient hospitalization expenses.

We appreciate 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/jodl

Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202-8206
Phone (803) 898-2504 • Fax (803) 255-8235

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	9-28-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000170	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR 10/05/07	[X] Prepare reply for appropriate signature DATE DUE 10-9-07
	[ ] 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.	10/4/07		
2.			
3.			
4.			

Archie Cleveland Sr.
684 Root Branch Road
Pineville SC, 29468
343-567-4614

Log: Jacobs. app. Sept

September 27, 2007

Dear Representative Joe Jefferson,

My name is Archie Cleveland Sr. I am 58 years old. I am writing you for help in my situation. I have been working at Georgia Pacific for 33 years as the sole provider for my family.

I was diagnosed with Leukemia in June 2006. My insurance, Cigna, was through Georgia Pacific. My policy was terminated on August 31, 2007. I am not eligible for Medicare or Medicaid. I am currently receiving Social Security disability ($1457.00).

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Georgia Pacific sold out to another company Rosenberg. I no longer have a job. The only insurance I am eligible for is Cobra through Georgia Pacific. This insurance will cost me $824.00 a month.

I paid my taxes since I was 18 years old. Now I can't work, I need help, and can't get it. Will you please help.

Thank you

Archie Cleveland

Archie Cleveland Sr.

Medicaid Letter of Action

From: CHARLESTON COUNTY DHHS
P. O. Box 13748
Charleston SC 29422-0000

To: ARCHIE CLEVELAND
684 ROOT BRANCH ROAD
PINEVILLE SC 29468

Date: 09/17/2007
Worker Name:
ELIZABETH BAHADORI
Telephone: 843 797-8282
BG #: 09770872
HH #: 101214163
10 EBAHA

Recipient Name:

ARCHIE CLEVELAND
SHIRLEY CLEVELAND

Recipient ID:
0780781246
0780781247

Your application has been denied for: AGED, BLIND, DISABLED (ABD)

Reason for denial:

Your income is more than policy allows.
You did not provide proof of citizenship.

Denied for the month(s) of: 09/2007

Manual/policy reference supporting this action: 303.01.03
102.04.01

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.

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

To Get Help with Your Hearing

- You may hire an attorney to help you
- You may 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

Social Security Administration
Retirement, Survivors and Disability Insurance
Notice of Award

Southeastern Program Service Center
2001 Twelfth Avenue, North
Birmingham, Alabama 35285-0001
Date: December 9, 2006
Claim Number: 247-92-6787HA

000172 MCBM73 N3 3.380

ARCHIE C CLEVELAND
684 ROOT BRANCH RD
PINEVILLE, SC 29468-3159

You are entitled to monthly disability benefits beginning January 2007.

The Date You Became Disabled

We found that you became disabled under our rules on July 18, 2006. This is different from the date given on the application.

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Enclosure(s):
Pub 05-10153
Pub 05-10058

CONEXIS
P.O. Box 226101
Dallas, TX 75222-6101

Date: 8/29/2007
Form: CLC02-CXDEN
Doc ID: 15115715
Account #: 0107952958

To ARCHIE C CLEVELAND and Covered Dependents
684 ROOT BRANCH RD
PINEVILLE SC 29468-3159

Election Form and Plan Alternatives

Applicant Name: ARCHIE C CLEVELAND (Account Number: 0107952958)

Employer/Plan Sponsor: Georgia-Pacific Corporation
Election Deadline: 11/2/2007

Date of Notice: 8/29/2007
Date of Coverage Loss: 8/31/2007
Coverage Start Date if Electing: 9/1/2007

Qualifying Event Reason: Reduction of Hours/Other Loss of Eligibility

To Employee and any Covered Dependents of: ARCHIE C CLEVELAND

Please use this document to notify us of your decision to continue coverage under the above referenced employer's group health plan(s) as further described in the enclosed Notice of Right to Elect Continuation Coverage form. If there is a family member who was covered on the day before the Qualifying Event that resides at a different address, you must notify CONEXIS immediately so that a separate notice can be provided. If you need further information about continuation coverage, please contact CONEXIS toll free at 1-877-722-2667.

CONEXIS has been retained by the above named employer to notify you of your group health plan benefits continuation rights. Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you, your covered spouse and/or your covered dependents are entitled to continue your group health benefits coverage under the employer or plan sponsor named above beyond the date coverage would normally end. Please read all of the enclosed information on COBRA Rights. Please understand that if cancellation of COBRA continuation coverage occurs it is without possibility of reinstatement.

If you wish to elect coverage, your completed election form must be postmarked by the United States Postal Service (USPS) on or before 11/2/2007 and received by CONEXIS. Please visit our website at www.CONEXIS.org. If you wish to elect online, you will need your social security number and your birthdate to log in to the Employees & Continuants section Your initial premium payment(s) must be USPS postmarked no later than 45 days of the postmark date of your election and received by CONEXIS. To avoid cancellation, your initial payment must include premiums due from the date of coverage loss through the end of the month prior to the month in which your payment is USPS postmarked. Subsequent payments are due on the first of each month and will be returned if not USPS postmarked within 30 days of this due date. Claims may not be paid until your account is current. For example, a June 1 election, based on an April 30 loss of coverage and Qualifying Event, would require a first premium payment no later than July 15 for the months of May and June. The July premium payment would be due no later than July 31. Incomplete election forms will be returned.

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Please mail forms and make checks payable to CONEXIS, P.O. Box 226101 Dallas, TX 75222

Applicant Name: ARCHIE C CLEVELAND
Employer/Plan Sponsor: Georgia-Pacific Corporation

Election Deadline: 11/2/2007
Account Number: 7952958

Section A. Plan Alternatives

Place an "X" in the box adjacent to the monthly cost of the coverage(s) you are selecting. Circle the dependents that you wish to cover. Please note that you may not obtain coverage above that which was in effect on your Date of Coverage Loss.

Available Coverages	Employee + Spouse	Employee Only	Spouse Only				Circle dependents you wish to cover
(b)GP HMO Plan CIGNA Network2 H107 2007*	☐ $ 824.16	☐ $ 393.72	☐ $ 393.72				a b c d e f g h i j
GP Dental Plan - $50 Deductible D001 2007	☐ $ 75.48	☐ $ 37.74	☐ $ 37.74				a b c d e f g h i j

Section B., Applicant's Authorization and Agreement

Your first premium payment **must be postmarked no later than 45 days** after the postmark date of your completed election. By my signature below, I elect to continue the coverage(s) checked in Section A.

Applicants Signature: _____ Date: _____

Section C. Dependent Information

Dependent Coverage:

Code	Dependent Name	Relationship	Birth Date	Gender
a	CLEVELAND, SHIRLEY	Spouse	10/19/1946	F

00824120836302

09/27/2007 04:00PM

Closed? ☐

Constituent ID 1030 Date Closed

Source Blue Log

Log No. 0170 Due Date 10/ 9/2007

Print this Form

Constituent Notes

SSN 247-92-6787

MEDICAID ID 0780781246

HIPAA Authorization

Reason for Referral Other

First Name Archie MI Last Name Cleveland

Constituent Phone(s) (843) 567-4614 ( ) -

Constituent Phone Extension

Staff ID 5 Staff First Name Robert Staff Last Name Liming

Point of Contact

Authorized Rep

Rep Phone ( ) -

Relationship

Legislator/ Other Rep. Jefferson

Entry Date 9/28/2007

Last Update 10/ 1/2007

Last Update User LIMINGR

Apply Cancel Close

Constituent# 1030

	Notes ID	Entry Date	Last Update	Notes
▶	1666	10/3/2007	10/3/2007	Changes made and gave to Mark for review. LYNCHJEN 10/3/2007 3:47:06 PM
	1609	10/1/2007	10/1/2007	Reviewed correspondence, checked MEDS and see application never went to VR because the applicant was well over income. some $556 in excess. Reading his ltr also shows his COBRA would be only $393 and not $800. He also qualifies for SSA and will start Medicare in January 2009, so could keep insurance under COBRA until Medicare, although it would be very costly. LIMINGR 10/1/2007 11:14:31 AM
	1606	9/28/2007	9/28/2007	Letter given to Bob to handle. LYNCHJEN 9/28/2007 3:06:14 PM

Medicaid Programs / Other Resources Check List

Log # 0170 Legislator/Inquirer: Joe Jefferson

Constituent: Archie Cleveland, Sr. SS#: 247-92-6787
Tel: 813-567-4614

PROBLEM / ISSUE	FAMILY SIZE	INCOME/ RESOURCE	MEDICAID PROGRAMS		OTHER RESOURCES	
has Lukemia and now on SSA disab: hdy well over income ABD, says can't afford to COBRA from former employer before his Medicare kicks in at end of 2008	2	1,407	ABD	☐	Communicare	☐
	STAFF PERSON		Foster Children	☐	FQHC	☐
	Bob Liming		HCBWS	☐	Free Medical Clinics	☐
			LIF	☐	Medicare	☐
			MAO	☐	MiAP	☐
			MBCCP	☐	Prescription Drug Programs	☐
			Optional Supplement	☐	Social Security	☐
			PHC	☐	TogetherRX	☐
			Pregnant Women/Infants	☐		
			SILVERxCARD	☐		
			SLMB	☐		
			SSI	☐		
			TEFRA	☐		
			Working Disabled	☐		

DATE	ACTIONS TAKEN TO HELP
9/28/07	Get file, read and review
10/1/07	MEDS schaos ABD denial due to income 9/H card failure to document citizenship
10/2/07	In his letter Mr. Cleveland says insurance will cost him $824, but that is rate for a couple, his alone would be $393 and could cover until Medicare begins
10/3/07	Mail handout + charitable sheets; also memo Since Mr. Cleveland has my name + telephone #

```
1EDHMS68 P          S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 09/28/07
 MEDSPROD                  HOUSEHOLD SUMMARY INFORMATION              PAGE: 0001
 HH NAME: CLEVELAND ARCHIE                                  ACTION TYPE: MAINTENANCE
 HH NUMBER: 101214163      APL STATUS:                      ACTION DATE: 09/12/07
 RCP/SSN/BG: _____         LAST APL: 09/04/07   HH COUNTY: 10 CHARLESTON
 RES ADDR      HOME PHONE: 843-567-4614  MAIL ADDR     WORK PHONE:     -    -
                                         684 ROOT BRANCH ROAD
                                SC      -   PINEVILLE                 SC 29468-
 S RCP NUMBER PI NAME                        SSN          LATEST ELG PERIOD AGE
 _ 0780781246 * ARCHIE CLEVELAND             247-92-6787          -          58
   WRKR ID:          NAME:                       SPNSR:      BG:          CNTY:
 s 0780781247   SHIRLEY CLEVELAND             251-80-6403          -          60
   WRKR ID:          NAME:                       SPNSR:      BG:          CNTY:

ME900049 HOUSEHOLD RECORD FOUND
PF2->PI   PF5->HH MBR DTL   PF7->PREV  PF8->NEXT   PF9->HH APLS   PF11->HH MBRS
PF12->HH BGS  PF14->RCP INFO   PF17->ELD00  PF18->HH MBR BGS   PF19->REPL CARD
```

33 June 06

→ Leukemia $1437

Berkley

Send data

684 Root Branch Rd

Pineville, SC

29468

No other income, wife Lol, not disabled advised him re HBCS NH if came to that

```
MEDELD01 P          S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 09/28/07
 MEDSPROD                  MEDICAID ELIGIBILITY DECISION              ACTION:
                    DATES-FROM: 09 / 2007 THRU: __ / ____            PAGE: 2 OF 3
 HH NAME: ARCHIE CLEVELAND                                  HH NUMBER: 101214163
 BGN: 09770872 PCAT: ABD    SPN: 1004 CHAS MUSC             ACT TYPE: MAINTENANCE
 BG: D BGP: D          WKR: EBAHA    ELIZABET BAHADORI       ACT DATE: 09/14/07
    COUNTABLE BG MEMBERS:  1
    COUNTABLE INCOME:        1407.00     COUNTABLE RESOURCES:          0.00
        INCOME LIMIT:         851.00     RESOURCE LIMIT:            4000.00
             POV-LVL:          +1.65 %    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:    09/14/07
 MEETS RESOURCES?        (Y/N): Y     NEXT REVIEW DATE:          09/14/08
 MEETS OTHER CONDITIONS? (Y/N): Y     ANTICIPATED CLOSURE DATE:  ________
 REASON(S) FOR DENIAL/CLOSURE/CHANGE:
 051 Your income is more than policy allows.
 061 You did not provide proof of citizenship.
 ELIGIBILITY DECISION APPEALED? (Y/N) _     CONTINUE BENEFITS?      (Y/N): _
 APPEAL REQUEST DATE: ________              COUNTY DECISION UPHELD? (Y/N): _
 UPDATED: USER ID: EBAHA     DATE: 09/14/07  SYSTEM ID: ELD3000  DATE: 09/14/07
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
```

1EDHMS54 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 09/28/07
MEDSPROD RECIPIENT INFORMATION ACTION:
MEMBER PERIOD START: 09/04/07 END: PAGE: 0001

NAME: CLEVELAND ARCHIE HH NAME: CLEVELAND ARCHIE
RCP NUMBER: 0780781246 HH NUMBER: 101214163 ACTION TYPE: MAINTENANCE
SSN: 247-92-6787 VC: V APL STATUS: ACTION DATE: 09/12/07
PRIMARY INDIVIDUAL: APL CO: 10 WORKER ID: CREES LOCATION: 053
684 ROOT BRANCH ROAD SSCN: 247926787A RRN:
RACE: 02 SEX: M MARITAL STATUS: M
TPL INSURANCE: N RELATION: SELF
PINEVILLE SC 29468- DOB: 07/14/1949 DOD:
CORRECT RCP NUMBER: _____ LIV ARRANGEMENT: HOME INCOME TRUST:
PROVIDER:

S	BG NUMBER	BEG ELIG	END ELIG	PCAT	QCAT	BENEFITS TYPE	QMB IND	RETRO IND	% OF POV LEVEL	SPONSOR

UPDATED: USER ID: EBAHA DATE: 09/14/07 SYSTEM ID: SVE3000 DATE: 09/14/07
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

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MEDELD00 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 09/28/07
 MEDSPROD                  MEDICAID ELIGIBILITY DECISION            ACTION:
                      DATES-FROM: 09 / 2007 THRU: __ / ____         PAGE: 1 OF 3
 HH NAME: ARCHIE CLEVELAND                                  HH NUMBER: 101214163
 BGN: 09770872 PCAT: ABD    QCAT: 50 SPN: 1004 CHAS MUSC    ACT TYPE: MAINTENANCE
 BG: D BGP: D        WKR: EBAHA    ELIZABET BAHADORI         ACT DATE: 09/14/07

 REQUIREMENTS              _ ARCHI C   _ SHIRL C   _          _          _
 APPLYING:                    A           A          ___        ___        ___
 CITIZENSHIP:                 P           F
 RESIDENCY:                   P           P
 SSN:                         P           P
 PREGNANCY:                   N/A         N/A
 AGE:                         F           F
 RELATIONSHIP:                N/A         N/A
 IDENTITY:                    P           P
 DISABLED/BLIND:              P           P
 ASSIGNMENT OF RIGHTS:        P           P
 REFERRAL TO OTHER BENEFITS:  P           P
 LIVING ARRANGEMENTS:         N/A         N/A
 UPDATED: USER ID: EBAHA     DATE: 09/14/07  SYSTEM ID: ELD3000  DATE: 09/14/07
ME900115 BUDGET GROUP PERIOD INFORMATION FOUND
 PF1->HELP PF2->MBR CTZN/ID PF3->NEXT PF5->HH MBR DTL PF6->RET PF13->FIELD HELP
 PF16->BG DET  PF18->RCP INFO  PF19->LEFT  PF20->RIGHT  PF21->HIST-  PF22->HIST+
```