

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Bailling</i>	DATE <i>8-16-06</i>
DIRECTOR'S USE ONLY	
1. LOG NUMBER <i>000151</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>CC: Singleton</i> <i>Cleared 8/25/06, letter</i> <i>attached</i> ✓	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>8-23-06</i> <input type="checkbox"/> FOIA DATE DUE _____ <input type="checkbox"/> 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.			

AUG. 15, 2006 3:01PM

NO. 541 P. 1/14



RECEIVED

AUG 15 2006

Department of Health & Human Services
OFFICE OF THE DIRECTOR

State of South Carolina

Office of the Governor

MARK SANFORD
Governor

Post Office Box 12267
COLUMBIA 29211

FAX TRANSMITTAL COVER

*Log. Bowling
10:40pm (5 days ago)*

FAX TO:

Jan Polathy @ HHS

cc: Nevada

FAX #:

255-8235

FROM:

D. Moore, Constituent Services

DATE:

8/15/06

TOTAL NUMBER OF PAGES CONTAINED IN THIS TRANSMISSION 14
(including this cover sheet)

If you have any problems receiving this document, please contact Leslie Sims at
(803) 734-0347.

Wade Hampton Building
Columbia, South Carolina 29201
(803) 734-0347

08/15/2006 03:09PM

Mail Log

612582

SX

INQUIRY

LAST NAME
FIRST NAME
TITLE
AGENCY
ADDRESS

Pinckney

Cheryl

Ms.

PO Box 49171

CITY

Greenwood

CO

STATE

SC

ZIP 29649

Area Code
PHONE#

864

992-5537

FAX#

E-MAIL

DATE RECVD

8/9/2006

Status

follow-up

+/-

COMMENT

SH
DIV

DIV/LTR

Constituent

Moore

CC:

Pending

RESPONDENT

Moore

Agency Date

Final Date

Letter

Resp

Mail Date

NRN Date

OR

Phone

8/11/2006

Resp

TimeToResp

2

TimeToMail

TotalTime

2

Notes

Open 8/11/2006

Beckman Mental Health Ctr (when CP took her daughter for an assessment, she didn't need it--6/19, but one week later beckman called back to say they'd changed their mind) documents show that her 15-yr-old daughter Lori Clark (SS#:435-81-7711) has been court ordered to get counseling (why? got in 3 fights in 8th grade) Cornerstone (told her she didn't need their assistance) treats people on drugs/alc. Union Eval Ctr--LC went there for 45 days during 9th grade; she thought she was all right but Union was saying she needed more counseling

Letter to D. Moore and Governor Sanford. Concerns re: she has exhausted all of her Medicaid doctor visits and she is suffering from cancer. Also, concerns re: *Back*

Date

Event

Place

PROLEGIS

GEN 1

CON LEGIS

GEN 2

Time

1:30 PM

HEALTH Ctr.

RECEIVED

610582

AUG 09-2006

Referred to AS
Answered mae

Cheryl Pinkney

P.O. Box 49171

Greenswood, S.C.

296149

Phone: 864-492-5537

OR 864 942-7237

Enclosed are copies from Beckman. These are not what I ask for. They refused to give me the paper work. And I signed stating she needed no counseling.

As you see Cornerstone was very polite. And mailed a letter of her not

needing counseling.

Counselor at Beckman was Tracey, unknown last name. But she is a supervisor and never gave us what I asked for. This is not designed to hurt or to get anyone in trouble. It's for me and my child to be dealt with fairly. And without abusing Medicaid in the process.

God will handle all things anyway. 😊

Dear Dorothy, And Grae Sanford,
I will try and make this as simple as
I can. I have Cerebral Tunnell Syndrome
and cancer in my neck so bare with
the writing, (Thank you)

First I'd like to say that I read
the Article in Monday 8-8-06, about Medicaid.
There are problems everywhere with Medicaid.
So I hate to think of it being knowingly
misused.

I had a Pancreatic-Splenectomy,
and Cancer of the ovaries in March 2006
I had a 4 wk stay in hospitals
Charleston & Greenwood. Plus home health.
This was much needed, A matter of life and
death.

I exhausted all my Dr. visits. So I
to Emergency Room, I found out I have
more Medical Problems And I have more
Cancer.

So the point I'm trying to make is
I have serious Medical Problems that I
had to wait to get taken care of.

2

The Second thing I'm touching on, is now I think, not sure yet, But something doesn't feel right about Beckman Mental Health Center, here in Greenwood.

My daughter and I was at the Pro. Off. today. Pro. Off. told me to get a copy of the Paper from Beckman stating they did not see a need for my daughter to have counseling.

I got the Run-a-Round when I got to Beckman. I waited Patiently an hour for Lacey to give me the Paper. I call Gov. Sanford Office, as I waited and talk to Dorothy. Beckman act as though they could not give me the Paper. I signed along with counselors and my daughter, the Paper that stated (Lori) my daughter did not need the counseling. Then after I stated I still do not have the Paper.

I ask for Lacey came out personally arguing with me.

Lacey (counselor) stated to me, the Probation officer told her (Lacey) that we needed counseling because Judge ordered it.

B 3

But the Probation Officer had just told me earlier that day, Brekman decided heri needed counseling. So I didn't know who or what to believe by then.

And No One ever show me paper work from Union or even lobby they derive at heri needed counseling in the first place.

And to top that off they were gonna misuse Medicaid to send her to Cornerstone also. I couldn't understand that either knowing my daughter do not smoke or drink.

Cornerstone had me and my daughter sign a bunch of papers, on the first initial visit and told me to bring her Medicaid Card on next visit. But I had started making a fuss on that too, about abusing Medicaid! (better enclosed.) From Cornerstone closing case.

5 4

So basically I feel the misuse of Medicaid, because I have asked Probation officers for the paperwork from Union, about (Lori) She told me she didn't have it, and ask the attorney, he say he didn't have a copy either. So how am I supposed to know Why they are even suggesting Lori to receive Counseling, if I can't Read Any paperwork. As if it is a secret.

And My main point is I feel Medicaid could be better used for the sick and Needy, and not the Greedy. Beckman told my daughter and myself they did not see where Lori Needed Counseling, then they Refused to give me the paperwork. We both signed stating Lori did Not Need Beckman

I feel all seems shady to me. Also Lori had the trouble she had in the 8th Grade (8th) She has long grown out of fighting. But I want lie, I have Medical Issues of my own, Ceter, Surgeries, I would hate to see Medicaid misused, or abused.

Even Beckman, (at first) didn't see the usage or benefit of counseling. Now ~~Q~~ I feel that they just realized they lost money more so

than anything. And a lot of question in my mind is the way the situation was handled from beginning. Because when I asked for the paperwork from Union, no one seem to want to give it to me. And I also know they violated the FOIA Act. Freedom of Information Act.

What I want out of this, I want all the paperwork from when Mori went to the Evaluation Center in Union. Why are they keeping it secret. And I want to know why some kids that have done far worse things, parents who have money pay and get them off, and poor kids they take Medicaid and use it to their (staff) advantage. And not the child.

If she had it (Lori) changed since the 8th grade it would be the first to say so. But when one person say she need help, then one says she doesn't

I feel something, somewhere isn't too correct.

The main thing I want is Fairness. I could tell something was not right when they were setting her up for Cornerstone 'I use her Medicaid Card, But I started questioning that too.

If you ask me I feel everything should be investigated.

I talk with Ms. Shepard (Social Worker) at Evaluation (center in Union. if was liery sick, a week before Surgery. I was on lots of meds not really together, and she had the Rudest, And Nastiest attitude I ever heard. It was as if (Kori) had committed murder, or worse.

Then DJS and Solicitor knew when Kori Returned home I had Just had the Major Surgery, - But no one told the Judge at the time. So how was I supposed to get to Cornerstone - Beckman comm. Service right at that moment.

I Praise God I am still here.

And I just ask them to give me time to heal, And they kept pressuring me

7

Even though I told them my Dr. had me on strict bed rest, And I had home health care.

I'm not asking for sympathy or hard not pay for her faults. But I do want Fairness - And No lies. And I hope Medicaid is not unfairly being used on healthy people such as (Lori) Because I know besides myself there are really really sick people who need Medicaid badly And some who are very poor And sick and can't get Medicaid.

If there are any questions Please feel free to call me at 844-992-5537 Plus they are supposed to be sending someone to my home every week for 8 weeks. I guess the state will cover that too. I have no idea why cause I've seen no paperwork, or Luns told why. Please Check out what goes on and why

Thank you
Cheryl ~~Stacy~~

AUG. 15. 2006 3:04PM
 THE BECKMAN CENTER FOR MENTAL HEALTH SERVICES SCREENING NO. 541NW P. 11/14
 Office: Greenwood Date: 6/19/06

Office: ST. LOUIS

Date: 6/2/00

SCREENING

☐ EMERGENCY EVALUATION

☐ On behalf of ☒ With the following:

Length of Contact _____ H/S, _____

Type of Contact: ☐ Phone / Electronic ☒ AM ☐ PM
Time of Contact: 1:30
☐ Other (specify) _____

Afterhours ☐ Yes ☒ No ☐ Home or other ☐ MHC ☐ Hospital ☐ Jail ☐ School

☐ Law Enforcement ☒ Court ☐ Other

Location of Face-to-Face ☒ MHC ☐ Physician ☐ School ☐ Family ☐ Law Enforcement

Currently under Detention Order ☐ yes ☐ no

Referred to MH by ☐ Self ☐ Physician ☐ Other

1

☐ Other, _____ must be ordered

Reason for Referral _____

IDENTIFYING INFORMATION _____

Name (Last) Clark (First) Lois
☐ Male ☒ Female Phone (442-7237) (Home) () ()
 Employed ☐ Yes ☒ No (Work) _____

Name (last) CLARK Phone (942-1221)
☐ Male ☒ Female
 Employed ☐ Yes ☒ No

Age 15 Sex ☐ Male ☒ Female SS# 435-21-771 ☐ Alien ☐ Other _____

DOB 2-15-91
☒ Black
☐ Hispanic
☐ Amer. Indian
☐ Asian
☐ Married
☐ Widowed
☐ Unknown

Race ☐ White ☒ Black ☐ Divorced ☐ Separated ☐ Married

County of Residence

Marital Status ☒ Never married ☐ Married ☐ Divorced ☐ Widowed

Address ☐ Home ☐ School ☐ Work ☐ Other

City Greenswood (City) (State) MS (Zip) 38901

County of Residence ☐ RCF ☐ Jail

Address 614 Jacob
(Street) (PO Box)
w/Children ☐ w/Siblings ☒ w/Parents ☐

Living Situation ☐ Alone ☐ w/ Spouse ☐ Shelter ☐ Foster Home ☐ Other _____
(if applicable)

☐ Group Home
 ☐ Institution
 ☐ Shelter
 ☐ Farm

CID # _____

☐ Group 1
☐ None
☐ Current
☒ Former

CURRENT HISTORY: (check ALL that apply)

☐ BCNHS status

☒ PSYCHIATRIC / A&D TREATMENT HISTORY:

☐ Other

☐ W/SHPI ☐ MV ☐ Bryan ☐ Harris ☐ Other

Inpatient ☒ None ☐ SCSH ☐ WSHFI ☐ other SCMHHC ☐ other

Outpatient/Other ☐ None ☒ BCMHS ☐ Other ☐

Date of last mental health service 4/1/11

PRELIMINARY ASSESSMENT

PRELIMINARY ASSESSMENT

Self-Reported (S) Reported by Other (O) ☐ ☐

☐ S ☒ C Mood Disturbance

<input type="checkbox"/> S	<input type="checkbox"/> Delusions	<input type="checkbox"/>	<input type="checkbox"/> Disorganized Thoughts / Behaviors
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None	1	2	3	4	5	6	7	8	9	10
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Suicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Gesture/Attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Committed Ideation					
Homicidal Gesture/Attempt					
Tearfulness					
Low Energy / Fatigue					
Drug Use					
Alcohol / Drug Screen Results					

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Homicidal Gestures or Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Destructive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Effort, Giving Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/>	Criminal Threats or Behavior	<input type="checkbox"/>	Other _____
<input checked="" type="checkbox"/>	Violent / Akahesha	<input type="checkbox"/>	
<input type="checkbox"/>	Attention Seeking Behavior	<input type="checkbox"/>	
<input type="checkbox"/>	Affective Disturbance	<input type="checkbox"/>	

	Agitation / Agitated	Change in Sleep Patterns	Affective Disturbance	Dissociative Reaction	Clinician Observed (C)	by Other (O)
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Change in appetite Patterns	Self-Reported (S)	Reported by Other (O)
Change in appetite (that apply)		

☐ Allergies

☐ Any other immune disorder

S O C	<input type="checkbox"/>	Epilepsy (seizures)	<input type="checkbox"/>
	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>
	<input type="checkbox"/>	HIV / Other infections	<input type="checkbox"/>
	<input type="checkbox"/>	Serious Head or Body Injury	<input type="checkbox"/>

[illegible][illegible]

☐ Hypertension
☐ Thyroid Problems

Don Clark address 214 South St. Shrewsbury
date of birth 2-15-91 SS# 433-81-1711 medical record # authorize the release of my
SCDMH health information, as specified below to My Child Shrewsbury DSO or her
husband

for the following purpose: to develop treatment plan for the continued care for the above named client

I authorize the release of the following information for the time period from 6-19-06 to 6-19-07

☒ Information from all SCDMH inpatient and outpatient facilities, centers, clinics, programs and offices

OR

☐ Information only from _____

AND The information authorized to be released includes:

- | | |
|--|---|
| <input type="checkbox"/> All information from above | <input type="checkbox"/> Diagnoses |
| <input type="checkbox"/> Clinical History & Evaluation | <input type="checkbox"/> Admission and Discharge Dates |
| <input type="checkbox"/> Individualized Treatment Plan Progress Summaries | <input type="checkbox"/> Discharge Summary (Summary of Treatment) |
| <input type="checkbox"/> Physician's Medication Orders | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Psychiatric History and Mental Status Examination | <input type="checkbox"/> Consultant Notes |
| <input type="checkbox"/> Billing and Payment Information | <input type="checkbox"/> Written summary (copy attached) |

Other _____

I understand that the above information is protected by applicable law and if this form is not complete, SCDMH may not be able to release the information. I understand that the information may include alcohol/drug abuse and/or HIV/AIDS/ARC and other infectious disease information about me. I do not want the following information disclosed:

This Authorization is valid for one year from my signing unless an earlier date, condition or event is specified here:

I understand that information disclosed may be subject to re-disclosure by the entity named above. I may cancel this authorization by writing the local Privacy Officer where I received or am receiving treatment. I understand that if I cancel this Authorization, SCDMH cannot take back any use or release made with my Authorization, and SCDMH must keep records of my treatment. I understand that I may refuse to sign this Authorization and my refusal will not limit my access to SCDMH treatment or other services. I also understand that applicable law may permit or require the use, disclosure or re-disclosure of information about me without my Authorization. I have been given a copy of this Authorization.

Child Signature of Individual/Personal Representative Printed Name _____ Date _____

Authority if signed by Personal Representative

Michael W. W. Signature of DMH Staff releasing information Printed Name _____ Date Released 08/15/2006

CORNERSTONE

Laying the foundation for healthier lifestyles with individuals, families and communities

July 12, 2006

Cheryl Clark
214 Jacob
Greenwood, SC 29649

RE: Lori Clark
YASO060383

Dear Cheryl:

As we discussed on June 29, I staffed your case and the recommendation that was given was to not admit Lori to substance use counseling at this time. Should problems occur at a later time in regard to substance, suspected use or suspicion of such issues, please feel free to contact us again. I would like to wish you good luck as you continue to raise this young lady. A copy of this letter has been forwarded to her probation officer to substantiate her compliance with the referral.

Sincerely,


Nelson Jones IV, NCAC I
Clinical Counselor

NJIV:hs

CC: Gaye Childs

CONFIDENTIAL

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

1420 Spring Street
Greenwood, SC 29646
Phone 864-227-1001
Fax 864-227-3619

400 Church Street
Edgefield, SC 29824
Phone 803-637-4050
Fax 803-637-4047

504 N. Mine Street
McCormick, SC 29835
Phone 864-852-3306
Fax 864-852-3148

P.O. Box 921
Abbeville, SC 29620
Phone 864-366-9661
Fax 864-366-5314

Greenwood-Edgefield-McCormick-Abbeville Commission On Alcohol and Drug Abuse

AUG. 15, 2006 3:05PM

PROTECTED HEALTH INFORMATION NO. 541 P. 14/14

AUTHORIZATION TO DISCLOSE/OBTAIN

Debi Clark

address

214 Pearl St. Shrewsbury

date of birth

8-15-91

SS#

435-81-1711

medical record #

Shrewsbury DSO

authorize the release of my

SCDMH health information, as specified below to

My Child Shrewsbury DSO

12 year

for the following purpose: to develop treatment plan for the continued care for the above named client

I authorize the release of the following information for the time period from 6-19-04 to 6-19-07

☒ Information from all SCDMH inpatient and outpatient facilities, centers, clinics, programs and offices

OR

☐ Information only from

AND The information authorized to be released includes:

- | | |
|--|---|
| <input type="checkbox"/> All information from above | <input type="checkbox"/> Diagnoses |
| <input type="checkbox"/> Clinical History & Evaluation | <input type="checkbox"/> Admission and Discharge Dates |
| <input type="checkbox"/> Individualized Treatment Plan Progress Summaries | <input type="checkbox"/> Discharge Summary (Summary of Treatment) |
| <input type="checkbox"/> Physician's Medication Orders | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Psychiatric History and Mental Status Examination | <input type="checkbox"/> Consultant Notes |
| <input type="checkbox"/> Billing and Payment Information | <input type="checkbox"/> Written summary (copy attached) |

Other

I understand that the above information is protected by applicable law and if this form is not complete, SCDMH may not be able to release the information. I understand that the information may include alcohol/drug abuse and/or HIV/AIDS/ARC and other infectious disease information about me. I do not want the following information disclosed:

This Authorization is valid for one year from my signing unless an earlier date, condition or event is specified here:

I understand that information disclosed may be subject to re-disclosure by the entity named above. I may cancel this authorization by writing the local Privacy Officer where I received or am receiving treatment. I understand that if I cancel this Authorization, SCDMH cannot take back any use or release made with my Authorization, and SCDMH must keep records of my treatment. I understand that I may refuse to sign this Authorization and my refusal will not limit my access to SCDMH treatment or other services. I also understand that applicable law may permit or require the use, disclosure or re-disclosure of information about me without my Authorization. I have been given a copy of this Authorization.

Debi Clark

Signature of Individual/Personal Representative

Printed Name

Date

Authority if signed by Personal Representative

Debi Clark

Signature of DMH Staff releasing information

Printed Name

Method of Release

Date Released

oral in writing

10/28/04

Debi Clark

08/15/2006 03:09PM



State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

August 25, 2006

Ms. Cheryl Pinckney
Post Office Box 49171
Greenwood, South Carolina 29649

Dear Ms. Pinckney:

We received a copy of your letter expressing concern in relation to the appropriate use of Medicaid and services received at Beckman Mental Health Center. We commend your efforts to ensure that your daughter receives appropriate care. DHHS policies encourage client/family involvement throughout the treatment process.

In order to receive Medicaid reimbursement, providers must adhere to strict medical necessity criteria for provision of services. Once services are determined to be medically necessary, Medicaid beneficiaries have freedom of choice of which Medicaid provider from which they receive services. Medicaid policy allows for providers to refer clients to other service providers to determine if other treatment options will better meet their needs.

We intend to share your concerns with the State Departments of Mental Health (DMH) and Juvenile Justice, to make them aware of this matter and to ensure that Medicaid services to your daughter were delivered in accordance with applicable Medicaid policies and procedures. It may be necessary for you to contact the court system to obtain a copy of any legal documents that may mandate your daughter receiving mental health counseling services. This information should assist you in determining the most appropriate Medicaid provider to render these services.

In regards to South Carolina Medicaid's policy for the 12 office visit limit, additional visits may be approved by DHHS' Medical Director, when the attending physician submits a written request indicating the medical necessity of the additional visits. Please have your doctor's office contact their Medicaid Physician Services Program Manager at (803) 898-2660 for additional information and instructions.

Log #151

Ms. Cheryl Pinckney

August 25, 2006

page 2

You may contact Mr. Geoff Mason, SCDMH at (803) 898-8348 for additional assistance regarding the treatment options and release of any documents from the community mental health center. If you have any additional questions or concerns about behavioral health services covered by Medicaid, you may contact Ms. Pheobia Cooper at (803) 898-2565 for additional assistance.

Sincerely,

Sheila F. Mills

Sheila Mills, MPH
Bureau Chief

SLM/mac