DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells/FOIA	8-19-10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000079	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Stensland, Singleton Cleared 9/1/10, letter attached.	[ ] Prepare reply for appropriate signature DATE DUE _____ [X] FOIA DATE DUE 9-2-10 [ ] 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.			

From: Brandy Putnam
To: Brenda James; Elizabeth Hutto
Date: 8/19/2010 8:07 AM
Subject: Fwd: Re: FOIA Requests

Please log FOIA Request. Thanks!

Brandy Putnam
Department of Health and Human Services
Phone Number (803)-898-1016
Fax Number (803)-255-8228

>>> <pardoll@carolina.rr.com> 8/18/2010 5:52 PM >>>
Thanks, would like to request a copy of the most recent Medicaid cost report on file for the following nursing home"

Brookview House
510 Thompson Street
Gaffney, SC 29340

--
Mike Pardoll
Senior Vice President/Investments
Marcus & Millichap
Senior Housing Division
405 Eagle Bend Drive
Waxhaw, NC 28173
704-443-0600
704-443-0601 (fax)
704-609-5663 (cell)

---- Brandy Putnam <PUTNAM@scdhhs.gov> wrote:
> Mike,
>
> You can forward any FOIA Requests for Nursing Home information to me
> thru e-mail and I will get them to the necessary person for the
> information to be sent to you. Thanks!
>
>
>
>
> Brandy Putnam
> Department of Health and Human Services
> Phone Number (803)-898-1016
> Fax Number (803)-255-8228
>
>
> Confidentiality Note
> This message is intended for the use of the person or entity to which it
> is addressed and may contain information, including health information,
> that is privileged, confidential, and the disclosure of which is
> governed by applicable law. If the reader of this message is not the
> intended recipient, or the employee or agent responsible to deliver it
> to the intended recipient, you are hereby notified that any
> dissemination, distribution or copying of this information is STRICTLY
> PROHIBITED.
>
> If you have received this in error, please notify us immediately and
> destroy the related message.
>
>

Log 079

South Carolina Department of
Health & Human Services

Emma Forkner • Director
Mark Sanford • Governor

September 1, 2010

Mr. Mike Pardoll, Senior Vice President/Investments
Marcus & Millichap
Senior Housing Division
405 Eagle Bend Drive
Waxhaw, NC 28173

Dear Mr. Pardoll:

Enclosed you will find the information and the billing for processing your recent Freedom of Information Act request from our office.

I hope this information is helpful to you. If you should have any questions, please contact Brandy Putnam at (803) 898-1040.

Sincerely,

William L. Wells

William L. Wells, CPA
Deputy Director

WLW/bp

Enclosures

P. O. Box 8297 Columbia South Carolina 29202-8297
(803) 898-2503 Fax (803) 255-8235

South Carolina Department of
Health & Human Services

Emma Forkner • Director
Mark Sanford• Governor

September 1, 2010

TO: Mr. Mike Pardoll
Senior Vice President/Investments
Marcus & Millichap

FROM: William L. Wells, CPA
Deputy Director

SUBJECT: Cost of Processing FOIA Request # 079

The South Carolina Department of Health and Human Services has received and processed your FOIA request. The cost for processing this information is as follows:

Staff processing time at $10.00 per hour	1	Hours	$10.00
Pages copied at $.10 per page	46	Pages	$ 4.60
Pages faxed at $.20 per page		Pages	$
Shipping and Handling Costs			$
Other costs associated with the FOIA request:			$ 2.75
Total Amount Due SCDHHS:			**$17.35**

Please remit the above amount to the following address:

Bureau of Fiscal Affairs
South Carolina Department of Health and Human Services
Post Office Box 8297
Columbia, South Carolina 29202-8297

Please contact Brandy Putnam at (803) 898-1040 should you have any questions.

William L Wells
Signature

Sept 1, 2010
Date

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	8-19-10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 101080	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Cleared 8/24/10, letter attached. ✓	[X] Prepare reply for appropriate signature DATE DUE 8-30-10 [ ] 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.			

House of Representatives
State of South Carolina

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

Committees:
Ethics, Chairman
Ways and Means
Ways and Means Budget and Finance
Ways and Means Property Tax
Ways and Means Public Education and
Special Schools Subcommittee, Chairman
School Bus Specification Committee

519-B Blatt Building
Columbia, SC 29211

Tel. (803) 734-3114

August 18, 2010

Emma Forkner, Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

RE: Cherry C. Bentley; SSN 247-41-7443

Dear Ms. Forkner:

I am writing this letter on behalf of Ms. Cherry Bentley. The enclosed information was presented to me as an emergency. It is my understanding that Ms. Bentley is in need of a mammogram and can not afford to pay for one.

I am asking that you please review the enclosed information and give Ms. Bentley's application some priority.

Thank you for your assistance in this matter.

Respectfully,

J. Roland Smith

J. Roland Smith
House District 84

Enclosures

cc: Cherry C. Bentley, 109 Hill Top Court, Beech Island, SC 29842

Date Application Received by DHHS: _____

South Carolina Department of Health and Human Services
Application for South Carolina Healthy Connections
Coverage for Children, Pregnant Women, and Families

Note: You only need to tell us the Social Security Number and answer the question about being a US citizen for the people for whom you are applying. However, if you give us your Social Security Number, even if you are not applying for benefits, it may help us process your application faster. We only use Social Security Numbers to help us verify income.

- *Original documents to prove US citizenship and identity must be provided for all persons applying for coverage.*
- *If applying for someone who is not a citizen, United States Citizenship and Immigration Services (USCIS) documents, such as an I-551 (Green Card) or I-94, must be provided to support his/her legal entry in the US.*
- *If applying for Emergency Services Only for someone who is not a citizen, the applicant is not required to provide USCIS documentation or a Social Security Number.*

1. Tell us about yourself (Primary Individual)

Name (First, Middle Initial, Last): Cherry C Bentley
Social Security Number: (not required for emergency services) 247-41-7443
Date of Birth: 10-18-62

Address where you get mail (include apartment number) 109 Hill top Ct
City Beech Island **State** SC **Zip Code** 29842
County: Aiken

Home Address (if not the same as your mailing address)
City **State** **Zip Code**
Telephone Number: ( )

US Citizen? ☑ Yes ☐ No
Are you applying for yourself? ☑ Yes ☐ No
Need retroactive coverage for the past three months? ☐ Yes ☒ No
Which Months: _____

Your Full Name at Birth: This helps us verify citizenship: Cherry Carlinda Bentley
County/State where you were born: Sumter SC
Your Mother's Full Name at her Birth: Nancy Jean Risher

Sex: ☑ Female ☐ Male
Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Separated ☑ Divorced
Are you Disabled? ☐ Yes ☒ No
Are you Pregnant? ☐ Yes ☒ No
If Pregnant, Due Date: _____
Are you currently attending school? ☐ Yes What grade? _____ ☒ No

Do you have Health Insurance now? ☐ Yes ☒ No If yes, Company Name _____ Policy ID# _____

Are you the parent, stepparent, or guardian of any of the children listed on the application? ☐ Yes ☐ No

What language do you use most?
☑ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Sign Language ☐ Vietnamese ☐ Other:

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

2. Tell us about your spouse or other adult in the home who may be the parent or guardian of the children

Name (First, Middle Initial, Last):
Social Security Number: (not required for emergency services)
Date of Birth:

US Citizen? ☐ Yes ☐ No
Applying for Coverage? ☐ Yes ☐ No
Need retroactive coverage for the past three months? ☐ Yes ☐ No
Months Requested: _____

Full Name at Birth: This helps us verify citizenship
County/State where born:
Mother's Full Name at her Birth:

Sex: ☐ Female ☐ Male
Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Separated ☐ Divorced
Are you Disabled? ☐ Yes ☐ No
Are you Pregnant? ☐ Yes ☐ No
If Pregnant, Due Date: _____
Currently attending school? ☐ Yes What grade? _____ ☐ No

Does this person currently have Health Insurance? ☐ Yes ☐ No If yes, Company Name _____ Policy ID# _____

Is this person the parent, stepparent, or guardian of any of the children listed on the application? ☐ Yes ☐ No

Relationship to You?
☐ Spouse ☐ Boyfriend/Girlfriend ☐ Other:

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

3. Tell us about the children who live with you. A Social Security Number is not required if applying for Emergency Services Only

	Child 1	Child 2	Child 3
Full Name (First, Middle, Last)	Taylor Elizabeth Spires	Brandon Chanee Dorsey	Bentley Blaze Mintz
US Citizen	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No
Social Security Number	247-91-8273	658-03-6660	656-34-8977
Medicare or Social Security Claim Number			
Date of Birth of the Child			
City, County and State where the Child was born			
Sex	☑ Female ☐ Male	☐ Female ☑ Male	☐ Female ☑ Male
Applying for Coverage	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mother's Full Name at her Birth	Cherry Carlinda Bentley	Cherry Carlinda Bentley	Taylor Elizabeth Spires
Put a check for all that applies	☐ Disabled ☐ Pregnant Due Date:	☐ Disabled ☐ Pregnant Due Date:	☐ Disabled ☐ Pregnant Due Date:
Race	☑ White ☐ African American ☐ Native American/American Indian ☐ Hispanic ☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ Asian American ☐ Refugee Entrant ☐ Other	☑ White ☐ African American ☐ Native American/American Indian ☐ Hispanic ☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ Asian American ☐ Refugee Entrant ☐ Other	☑ White ☐ African American ☐ Native American/American Indian ☐ Hispanic ☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ Asian American ☐ Refugee Entrant ☐ Other
Is the Child now attending school	☐ Yes School Name and grade ☑ No	☑ Yes School Name and grade 6th ☐ No	☐ Yes School Name and grade ☑ No 0
Relationship of the Child to the Primary Individual	☑ Child ☐ Step-child ☐ Grandchild ☐ Other	☑ Child ☐ Step-child ☐ Grandchild ☐ Other	☐ Child ☐ Step-child ☑ Grandchild ☐ Other
Relationship of the Child to the Spouse/Other Adult in the Home	☐ Child ☐ Step-child ☐ Grandchild ☐ Other	☐ Child ☐ Step-child ☐ Grandchild ☐ Other	☐ Child ☐ Step-child ☐ Grandchild ☐ Other
Does the Child get Child Support payments?	☐ Yes ☑ No Amount: Paid by: Court Ordered? ☐ Yes ☐ No	☑ Yes ☐ No Amount: 25.00 weekly Paid by: Tommy Dorsey Court Ordered? ☐ Yes ☑ No	☐ Yes ☐ No Amount: Paid by: Court Ordered? ☐ Yes ☐ No
Do you pay someone for childcare for this Child while you work or attend school?	Name of Provider or Daycare Center no Phone Number: Amount you pay: How often: ABC Voucher? ☐ Yes ☐ No	Name of Provider or Daycare Center no Phone Number: Amount you pay: How often: ABC Voucher? ☐ Yes ☐ No	Name of Provider or Daycare Center no Phone Number: Amount you pay: How often: ABC Voucher? ☐ Yes ☐ No
Need retroactive coverage for the past three months?	☐ Yes ☑ No Which Months:	☐ Yes ☑ No Which Months:	☐ Yes ☑ No Which Months:
Does the Child have Health Insurance now?	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	If yes, please give us a copy of the front and back of all health insurance cards.		
If the Child does not have health insurance now, did the Child have Health Insurance in the past six (6) months? *(Not including Medicaid)*	☑ Yes ☐ No If **Yes**, please answer the following: Type of Policy medicade Company Name Policy ID# Date Policy Ended: Reason Insurance ended:	☑ Yes ☐ No If **Yes**, please answer the following: Type of Policy medicade Company Name Policy ID# Date Policy Ended: Reason Insurance ended:	☑ Yes ☐ No If **Yes**, please answer the following: Type of Policy medicade Company Name Policy ID# Date Policy Ended: Reason Insurance ended:

	Child 4	Child 5	Child 6
Full Name (First, Middle, Last)			
US Citizen	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Social Security Number			
Medicare or Social Security Claim Number			
Date of Birth of the Child			
City, County and State where the Child was born			
Sex	☐ Female ☐ Male	☐ Female ☐ Male	☐ Female ☐ Male
Applying for Coverage	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mother's Full Name at her Birth			
Put a check for all that applies for the Child	☐ Disabled ☐ Pregnant Due Date: ________	☐ Disabled ☐ Pregnant Due Date: ________	☐ Disabled ☐ Pregnant Due Date: ________
Race	☐White ☐African American ☐Native American/American Indian ☐Hispanic ☐Cuban ☐Mexican ☐Puerto Rican ☐Asian American ☐Refugee Entrant ☐Other ________	☐White ☐African American ☐Native American/American Indian ☐Hispanic ☐Cuban ☐Mexican ☐Puerto Rican ☐Asian American ☐Refugee Entrant ☐Other ________	☐White ☐African American ☐Native American/American Indian ☐Hispanic ☐Cuban ☐Mexican ☐Puerto Rican ☐Asian American ☐Refugee Entrant ☐Other ________
Is the Child now attending school	☐ Yes School Name and grade ☐ No ________	☐ Yes School Name and grade ☐ No ________	☐ Yes School Name and grade ☐ No ________
Relationship of the Child to the Primary Individual	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ________	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ________	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ________
Relationship of the Child to the Spouse/Other Adult in the Home	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ________	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ________	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ________
Does the Child get Child Support payments?	☐ Yes ☐ No Amount: ________ Paid by: ________ Court Ordered? ☐ Yes ☐ No	☐ Yes ☐ No Amount: ________ Paid by: ________ Court Ordered? ☐ Yes ☐ No	☐ Yes ☐ No Amount: ________ Paid by: ________ Court Ordered? ☐ Yes ☐ No
Do you pay someone for childcare for this Child while you work or attend school?	Name of Provider or Daycare Center ________ ________ Phone Number: ________ Amount you pay: ________ How often: ________ ABC Voucher? ☐ Yes ☐ No	Name of Provider or Daycare Center ________ ________ Phone Number: ________ Amount you pay: ________ How often: ________ ABC Voucher? ☐ Yes ☐ No	Name of Provider or Daycare Center ________ ________ Phone Number: ________ Amount you pay: ________ How often: ________ ABC Voucher? ☐ Yes ☐ No
Need retroactive coverage for the past three months?	☐ Yes ☐ No Which Months: ________	☐ Yes ☐ No Which Months: ________	☐ Yes ☐ No Which Months: ________
Does the Child have Health Insurance now?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	If yes, please give us a copy of the front and back of all health insurance cards.		
If the Child does not have health insurance now, did the Child have Health Insurance in the past six (6) months? *(Not including Medicaid)*	☐ Yes ☐ No If **Yes**, please answer the following: Type of Policy ________ Company Name ________ Policy ID# ________ Date Policy Ended: ________ Reason Insurance ended: ________ ________ ________	☐ Yes ☐ No If **Yes**, please answer the following: Type of Policy ________ Company Name ________ Policy ID# ________ Date Policy Ended: ________ Reason Insurance ended: ________ ________ ________	☐ Yes ☐ No If **Yes**, please answer the following: Type of Policy ________ Company Name ________ Policy ID# ________ Date Policy Ended: ________ Reason Insurance ended: ________ ________ ________

4. **Tell us about the income of each family member in the home.**
Enter GROSS pay before taxes and deductions, not take home pay. Enter zero ("0") if you are not working. **You must send us proof of income for the past 4 weeks.**

Your Income from Employment	Spouse/Other Adult's Income from Employment (if living in the home)
Name of person working Cherry C Beuttler	Name of person working _____
Employer's Name Hallman Motors	Employer's Name _____
Employer's Address 103 Oneal Dr pine log Rd, Warrenville SC.	Employer's Address _____
Does this person work for the Government of the State of South Carolina? ☐ Yes ☒ No	Does this person work for the Government of the State of South Carolina? ☐ Yes ☐ No
Employer's Phone Number (including area code) 803-645-1200	Employer's Phone Number (including area code) _____
Gross amount earned per pay period before taxes? $ 50.00	Gross amount earned per pay period before taxes? $ _____
How often paid? ☒ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly	How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly

Is anyone self-employed? ☐ **Yes** ☒ **No** **If yes, you must send copies of all the most recently filed Personal and Business Federal income tax forms including all forms and schedules.**
Please name Self-Employment Business and/or Partnership: _____

Does anyone in your home receive, or have applied for, any other income? ☐ Yes ☐ No
If Yes, check all boxes that apply and complete the table below

☐ Social Security benefits (RSDI) ☐ Supplemental Security Income (SSI) ☐ Disability benefits
☐ Pension/retirement benefits ☐ Workers' compensation ☐ Unemployment benefits
☐ Veterans benefits ☐ Money from friends or relatives ☐ Rental Income
☐ Military allotments ☐ Room and/or board income ☐ Interest/dividend income
☐ Land contract, mortgage or other notes payable to a household member (Please provide a copy of the contract, mortgage, note or other agreement)
☐ Other: _____

Person receiving/expecting money	Income source/type	How often received	Amount received	Expected to continue?	Date expecting, if not yet started
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

5. **Are there any adults in the home who are not currently working?** ☐ Yes ☒ No
If Yes, tell us who and when they last worked: _____

6. **If your family does not have any income, explain how you pay your bills.** _____

7. **Does the equity value of all your assets add up to more than $30,000? Do not count the value of the home you live in or up to $20,000 of equity value per vehicle for each licensed driver.**

☐ **Yes, my assets are over $30,000** ☒ **No, my assets are less than $30,000**

Assets are things that you own, such as cars, boats, trailers, non-homestead property, checking and savings accounts, cash, and CDs. Equity value is how much something is worth minus any money owed on it. (For example, a vehicle that is valued at $5000, and $2000 is still owed on it, has an equity value of $3000.)

8. **Do you pay court ordered child support for a child outside your home?** *(If yes, please provide proof)* ☐ Yes ☐ No

Name of Child	How much do you pay?	How often do you pay this amount?

9. **Do you pay someone to take care of a dependent adult while you work or attend school?** ☐ Yes ☐ No

Name of Adult	Who do you pay?	How much do you pay?	How often do you pay?

IMPORTANT

Check below to tell us what you attached.

- **Sending this information in with the application will help us to process your application faster.**
- **You must read and sign this form on the last page to complete your application.**

☐ Proof of Income
- ☐ Copies of pay stubs for the **last 4 weeks for any adult person listed**; *or* a letter from employer that shows last 4 weeks of GROSS pay.
- ☐ A copy of the letter telling the gross amount of any benefits received (Social Security, Unemployment, VA, Workers' Compensation, etc.)
- ☐ Proof of all other income for the last 4 weeks, including child support.
  NOTE: You may be required to apply for additional potential benefits, such as unemployment or Social Security Benefits.

☐ Proof of income for the past 3 months if you have received medical services.
☐ If you are self employed, the most recent income tax forms including all schedules.
☐ Verification of the childcare/dependent adult expenses (statement from daycare, receipt, etc.)
☐ United States Citizenship and Immigration Services (USCIS) documents, such as an I-551 (Green Card) or I-94, for each non-citizen applying for full Healthy Connections. Does not apply to Emergency Services Only.
☐ Original Documents of citizenship and identity for each US citizen applying for coverage. (If you have provided this information since July 1, 2006, you do not have to provide it again.)

Other documents can be used to provide proof. If you are not sure what to send, call our toll-free line at 1-888-549-0820 for help.

The South Carolina Department of Social Services' Child Support Enforcement Division (CSED) provides services to establish paternity and child support, modify child support orders, and enforce support orders. Services are available to Healthy Connections beneficiaries without charge. I understand that if I check "no" and ask for child support services later, I will have to pay a $25 fee. I want to voluntarily apply for these services:
☐ Yes ☐ No

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 Healthy Connections 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 Healthy Connections Card(s).

   a. I know that, in accordance with the federal rules governing the Healthy Connections 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 Healthy Connections 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' Medical Assistance programs, and the TANF and Food Stamp agency (Department

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 Healthy Connections 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 Healthy Connections 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 Healthy Connections coverage.

7. 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.

   If eligibility is for my child(ren) only, I am not required to report any changes in my situation, except for change of address. If I report any other changes in my situation, it will not affect their eligibility for benefits until the next scheduled review.

8. I know that I may request a hearing if I believe an error has been made in processing my application.

9. I have read the Rights and Responsibilities, or they have been read to me.

10. By signing this application, I certify that the information I have provided to DHHS is true and accurate to the best of my knowledge.

11. I authorize the release of any information necessary to establish my family's eligibility. I authorize the copying of this signature page to be used as a release form to verify information. It shall remain valid and in force until:
    - Revoked by me in writing;
    - My application has been denied; or
    - My case has been closed.

(If possible, both the Applicant and Authorized Representative should sign.)

Applicant's Signature: _____ Date: Aug-12-2010

If an Authorized Representative is completing this application, please complete the following:

Name: _____ Phone Number: _____

Address: _____ Relationship: _____

_____

Signature of Authorized Representative: _____ Date: _____

Log 0080

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

August 24, 2010

The Honorable J. Roland Smith
South Carolina House of Representatives
P.O. Box 11867
519-B Blatt Building
Columbia, South Carolina 29211

Dear Representative Smith:

Thank you for contacting our agency on behalf of Ms. Cherry Bentley regarding her Medicaid eligibility and healthcare needs.

A member of our staff has been in direct contact with Ms. Bentley to address her questions and concerns regarding Medicaid eligibility and the rules and regulations governing the program. She was also provided with contact information for a Constituent Services staff member should she need assistance in the future.

Thank you for 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/jjgl

South Carolina Department of
Health & Human Services

Emma Forkner • Director
Mark Sanford • Governor

August 24, 2010

Ms. Cherry Bentley
109 Hill Top Court
Beech Island, South Carolina 29842

Dear Ms. Bentley:

Representative Roland Smith contacted this agency on your behalf regarding Medicaid eligibility and your healthcare needs.

Your application for Medicaid's Low Income Families program was received in our Aiken county office on August 20, 2010. Your eligibility worker, Angela Reames, needs additional information from you before a decision can be made. Ms. Reames mailed you a letter on August 20, 2010 requesting this information be returned by September 10, 2010. It is important you return this information as quickly as possible. Please contact Ms. Reames at (803) 642-3691 if you have questions about the requested documentation.

Enclosed is information on other programs and organizations that assist residents in South Carolina with their healthcare services, prescriptions, inpatient hospitalization and daily living needs.

If you have questions about the Medicaid program, please contact Jenny Lynch in Constituent Services at (803) 898-3965. We hope this information is helpful.

Sincerely,

Alicia Jacobs
Deputy Director

AJ/jgl
Enclosures

Medicaid Eligibility and Beneficiary Services
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2502 • Fax (803) 255-8235