DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

* Relogged to Rios per Susan, 10/13/06 lm

TO	DATE
Rios	10-12-06

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000302	[X] Prepare reply for the Director's signature DATE DUE 10-19-06
2. DATE SIGNED BY DIRECTOR Cleared 11/6/06, letter attached ✓	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] 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.			

STATE OF SOUTH CAROLINA
THE SENATE

ROBERT W. HAYES, JR.
SENATOR YORK COUNTY
SENATORIAL DISTRICT NO. 15

COMMITTEES:
ETHICS, CHAIRMAN
BANKING AND INSURANCE
CORRECTIONS AND PENOLOGY
EDUCATION
FINANCE
MEDICAL AFFAIRS

SENATE ADDRESS:
SUITE 205
GRESSETTE SENATE OFFICE BLDG.
P.O. BOX 142
COLUMBIA, SC 29202
TEL.: (803) 212-6410
FAX: (803) 212-6499
EMAIL: SET@SCSENATE.ORG

HOME ADDRESS:
P.O. BOX 904
ROCK HILL, SC 29731
803-324-2400

October 23, 2006

Log Bowling
"Robby's Sign."

Mr. Robert M. Kerr
Office of Executive Director
Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206

Dear ~~Mr. Kerr~~ Robby:

Please find enclosed correspondence I received from Ms. Lisa Joy Martin. She is a Canadian citizen, but has "Permanent Residence Status" to live in the United States, and is a resident of Rock Hill. She states in the past she has been a recepient of Medicaid. Recently, she had surgery with the approval for payment from her Medicaid staff person, but after the surgery was performed, this decision was reversed leaving her with the responsibility for medical bills that she has no financial capacity to pay.

Would you please have someone from your staff review Ms. Martin's situation and let me know if there is anything we can do to help? It is appears she was of the understanding that Medicaid would pay. This matter, following the dramatic death of her child at birth, has caused her much grief and stress.

Thank you for your help in this matter.

With warm regards, I am

Sincerely,

Robert W. Hayes, Jr.

RWHJr./jpl

Enclosure

cc: Ms. Lisa Joy Martin

Lisa J. Martin
632 Taylor St
Rock Hill, SC 29730
704-644-7040

October 4, 2006

Dear Senator Hayes,

I, Lisa Joy Martin have been instructed by Mr. Phillip Land to inform you of my complications with health insurance through State of South Carolina Medicaid. To begin, I was admitted into Spartanburg Regional Hospital 08/10/05 with emergency complications regarding my pregnancy. My baby was delivered and died due to his umbilical cord being wrapped around him. This event left me devastated and I am not sure to this day if that service was covered. This whole situation had left me so depressed I stopped calling and concerning myself with anything around me. Eventually I bounced back and started prioritizing my life goals. By advice from a Spartanburg Doctor I had a tubal ligation performed on me at Surgery Center of Pelham in Greenville,SC in December, 2005 which I was also told this service would be covered and payments were reversed. Initially I was approved for a Family Planning Service Partners for Health card with privileges covering me from 09/01/05 - 09/30/06 being that I was 5-6 months pregnant and would have qualified for emergency services (Permanent resident US - green card) as stated in the enclosed letter(copy). Approximately January 2006 I had started receiving collection letters from all of the hospitals and physicians' offices that the payments from Medicaid insurance for the bills had been reversed. A total of approx. $10,000 or better which has left me in a bind being that I am a single divorced mother. I even contacted a few of the bill collectors and made over $1,000 worth of payments to keep my credit afloat until this situation was cleared up which never did get reconciled. My correspondence through this whole matter has been with my former social worker Betsy Carroll (Spartanburg office) and her supervisor (Tammy Douglas). Tammy Douglas, informed me in our last conversation in January was to write a letter to the Columbia office and reiterate my situation to a higher being (no said name) at the Dept. of Health and Human Services, may this would help resolved matters. That idea was not successful, I was only shuffled around from person to person without any solution. Right now to this very day of I have personally paid back over $2,500 in payments for these bills and still trying, even though I feel this responsibility is not mine. I am aware of situations where illegal immigrants' health issues have been taken care of better than my personal situation and I am here as a legal permanent resident for almost seven years, and soon to become a U.S. citizen. I have lots of paperwork proving my situation and willing to forward all of it if necessary to resolve this matter and hopefully reimburse me for the monies I have borrowed and spent to keep my credit worthy of being totally destroyed. I am not even close to being a lazy person and always willing to work or lend a helping hand to anyone and I pray now that someone can bless me with this same helpful hand. It would be most appreciated and praised if this can be resolved. Thank you so very much. Looking forward to your response.

Sincerely,

Lisa Joy Martin

P.S. Here are numbers for above mentioned people.
Myself (Lisa Joy Martin) 704-644-7040 313-279-1329 S.S#368-25-0542 D.O.B 06/18/68
Social Worker (Betsy Carroll) 803-898-3010
Supervisor (Tamara Douglas) 803-898-3006
Eligibility Worker (Romie Bostick) 1-888-549-0820 ext. 83016

State of South Carolina

Department of Health and Human Services

Mark Sanford
Governor

September 16, 2005

Robert M. Kerr
Director

Lisa J Martin
Apt G-201
201 Powell Mill Rd
Spartanburg, SC 29301
Budget Group Number: 28958914

Dear Ms. Martin,

Your application for the Family Planning Waiver has been approved. Your coverage will begin 09/01/2005 and end 09/30/2006. You can use your card for family planning services only. Family planning services include prescriptions, office visits, birth control methods, lab work, examination and counseling related to family planning. Your coverage does not include treatment for routine side effects or complications associated with family planning methods.

You will receive a Partners For Health Medicaid card. Keep this card in a safe place. You will not receive a new card each month. Please show this card to the doctor, clinic or pharmacy each time you go for family planning services. If you have an old yellow Family Planning card in your possession, please destroy it.

The Medicaid Program wants you to receive primary care medical services from providers that you know and trust. Community health care centers can offer you primary medical care services if you do not already have a doctor. You will need to contact the nearest community health care center in your area to get an appointment and discuss ways to pay for the primary care medical services. Medicaid will continue to pay for Family Planning services only. For a listing of the centers nearest you, please contact your local health department.

If you have a permanent sterilization procedure, you are not eligible for Family Planning Services. Please contact your case worker at the number listed below.

Please call 1-888-549-0820 if you have questions, a change of address, your card is lost or stolen or you need a list of the community health centers.

Sincerely,

Romie Bostick
Eligibility Worker
Ext. 83016

OCWI ALERT NOTICE

FROM:

STATE OFFICE COUNTY DHHS
P. O. Box 100101
Columbia SC 29202-0000

TO:

LISA J MARTIN
201 POWELL MILL RD
APT G-201
SPARTANBURG SC 29301

DATE PRINTED:	01/17/2006
BUDGET GROUP #:	09087814
HH #:	101064729
MEDICAID #:	9780275057
WORKER #:	TDOUG
	47 TDOUG

CLIENT NAME: LISA J MARTIN

DEAR LISA J MARTIN

PLEASE DETACH AT PERF AND RETURN TOP PORTION WITH YOUR PAYMENT **STATEMENT**

PATIENT NAME: MARTIN ,LISA SERVICE DATE: 08/03/05 PAGE NO. 1

DATE	DESCRIPTION	AMOUNT
08/03/05	EMERGENCY ROOM	551.00
08/03/05	RADIOLOGY	177.00

faxing code to Betsy Carroll 11/3/5

to: Pat
313-792-7162

ACCOUNT BALANCE	ESTIMATED INSURANCE DUE	ACCOUNT NUMBER
728.00	0.00	304410459

MESSAGES:
PLEASE INCLUDE ACCOUNT NUMBER(S) ON YOUR CHECK OR MONEY ORDER.
THERE WILL BE A $25 FEE FOR RETURNED CHECKS.

PROMPT PAYMENT ON THIS ACCOUNT WILL PRESERVE
YOUR GOOD CREDIT RATING PLEASE SEND PAYMENT TODAY.

PATIENT BALANCE DUE
►►►► **$728.00**

PAYMENT DUE BY:
►►►► **10/28/05**

BILL DATE: 10/10/05

FOR BILLING INQUIRIES, CALL: 800-858-9503 OFFICE HOURS 8:00am - 4:30pm, MON - FRI

9261-7614*1MV0FF37J000015

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

P.O. Box 1051
Spartanburg, SC 29304
Address Service Requested

April 5, 2006

C.B.A., INC.

A collection agency

126 Knollwood Drive
P.O. Box 1051
Spartanburg, South Carolina 29304-1051
Telephone (864) 574-1160
(800) 874-2615
FAX (864) 587-4790

Martin,Lisa 1355038
125 Foster St
Chesnee, SC 29323-9144

ACCOUNT IDENTIFICATION

Re: Regional Maternal-Fetal Med

Acct# 5207604

Acct. No. : 1355038
Client Acct. No. : 5207604
Client No. : 13631
Balance Due : $297.00

The above past due bill has been referred to this office for collection.

Unless you notify this office within 30 days after receiving this notice that you dispute the validity of this debt or any portion thereof, this office will assume this debt is valid. If you notify this office in writing within 30 days from receiving this notice, this office will: Obtain verification of the debt or obtain a copy of a judgment and mail you a copy of such judgment or verification. If you request this office in writing within 30 days after receiving this notice, this office will provide you with the name and address of the original creditor, if different from the current creditor.

This is an attempt to collect a debt and any information obtained will be used for that purpose.

Detach and Return with Payment

Enter the requested information in the spaces provided below.

From: Lisa Martin

Address: _____

City, State, Zip: _____

Telephone - Home: _____ Work: _____

To pay by credit card, please complete the following:
Check one: ☐ Visa ☐ MasterCard
Card Number: _____
*Control #: _____ Expiration Date: __/__/__
Payment Amount: $_____
Signature: _____

*The control number is usually found on the back of your card in the signature space and is the three digits following the last four numbers of your card.

Account Number : 1355038
Client Acct. No : 5207604
Client No. : 13631
Balance Due : $297.00 Date: April 5, 2006
Amount Enclosed : $_____

C.B.A., INC.
P.O. BOX 1051
SPARTANBURG, SC 29304

Enclosing this notice with your payment will expedite credit to your account.

N1 000376P 1 365 000339 95 064589 S-CRE

Patient Name
LISA J MARTIN

Spartanburg Pathology Associates, PA

Your Pathology Service Provider

Account #	Statement Date
GWD- 8006137-4	12/20/05

Please contact our billing agent, PSA, to submit payment, update information, or speak with a billing representative.

Due Date	Amount Due
01/09/06	110.00

IMPORTANT MESSAGE

SECOND NOTICE, PLEASE REMIT PROMPTLY.

YOUR PROMPT ATTENTION IS NEEDED. SEND BALANCE SHOWN BY DUE DATE. THANK YOU.

www.pathologybilling.com

Servicio en espanol, por favor llame.

TOLL FREE: 1-877-835-0598
TOLL FREE FAX: 1-877-268-1254

Office hours:
Mon-Thur 8am-10pm EST
Fri 8am-8pm, Sat 10am-4pm

Our records indicate the following insurance:
Primary Ins: MEDICAID OF SC

Referring Physician:
MARY HADDAD MD

1

DATE	PROC. CODE	DESCRIPTION	Number of Specimens	AMOUNT
08/09/05	8834226	IMMUNOCYTOCHEMISTRY	1	110.00
10/26/05		MEDICAID ADJUSTMENTS		.00
		NOT ENROLLED OR ELIGIBLE		

Medicaid
97802750S7

Confirm # 503524
Bon Secours
(313) 343-1000
Grosse Pointe

Oakwood Annapolis Hospital
Wayne (734) 467-4062

Called Oakwood - 1/27/06 JM

These charges are not included in any other hospital or physician statement. For more information or to update insurance information, see the back of this statement or visit www.pathologybilling.com.

BILLING OFFICE ADDRESS:

804 1

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

STATEMENT DATE	DUE DATE	ACCOUNT #
12/20/05	01/09/06	GWD- 8006137-4

AMOUNT DUE
$ 110.00

Check # _____
(please do not staple)

AMOUNT ENCLOSED $

Patient Name: LISA J MARTIN

☐ Please check box if address or insurance information is incorrect and indicate change(s) on reverse side.

Do Not Mail Credit Card Information.
To pay by Credit Card, visit us at: www.pathologybilling.com
or call: 1-877-835-0598

ADDRESSEE:

LISA J MARTIN

201 POWELL MILL RD APT G201
SPARTANBURG SC 29301-1567

O2

MAKE CHECKS PAYABLE TO & REMIT TO:

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

(803) 898-3006
Supervisor Tammy Douglas

PATIENT STATEMENT OF ACCOUNT

PATIENT ACCOUNTS
804 Scott Nixon Memorial Drive
Augusta, GA 30907

Address Service Requested

ACCOUNT NO.	CODE	STATEMENT DATE
0522101371	FP363	12/15/05

** CREDIT CARD PAYMENTS PROCESSED BY ANESTHESIOLOGY SERVICES AUGUSTA, GA **

CHECK CARD USING FOR PAYMENT

MASTERCARD ☐ VISA ☐ DISCOVER ☐ AM. EX. ☐

CARD NUMBER | 4 DIG CID | EXP. DATE

SIGNATURE (REQUIRED)

PRINT NAME ON CARD | PAY THIS AMOUNT $1,800.00

SHOW AMOUNT PAID HERE $

ADDRESSEE

LISA MARTIN
G201
201 POWELL MILL RD
SPARTANBURG SC 29301-1526

MAKE CHECK PAYABLE TO

Foothills Anesthesia Consultan
PO BOX 4391
SPARTANBURG SC 29305-4391

☐ CHECK HERE FOR ADDRESS CHANGE. PLEASE MAKE CHANGES ON BACK
www.kam2000.com/pa

DETACH AND RETURN TOP PORTION WITH PAYMENT

STATEMENT OF SERVICES RENDERED

SERVICE DATE	CASE NUMBER	CPT CODE	DESCRIPTION OF PROCEDURE OR SERVICE	CHARGES / PAYMENT & ADJ. PATIENT	CHARGES / PAYMENT & ADJ. INSURANCE
8 10 05	3310308	01967	Anesthesiology Services by Dr. D. SHANTHA for Dr. M.Haddad		
			Billed To Insurance		$1,800.00
			Patient Responsible		($1,800.00
			Billed To Patient	$1,800.00	

called them 1/27/06 pv

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	NEW BALANCE	PATIENT	INSURANCE
$1,800.00	$0.00	$0.00	$0.00	$0.00		$1,800.00	$0.00

ACCOUNT NO.	STATEMENT DATE	
0522101371	12/15/05	PATIENT IS RESPONSIBLE FOR "PATIENT NEW BALANCE" PAYMENT IS DUE WITHIN 15 DAYS OF RECEIPT OF STATEMENT.

OFFICE HOURS: 8:00AM-4:15PM EST PHONE NO: 1 888 850 6304

THIS IS A BILL FOR SERVICES NOT INCLUDED ON YOUR HOSPITAL BILL.
PLEASE CALL OUR OFFICE WITH QUESTIONS CONCERNING YOUR BILL.
IF PAYMENT HAS BEEN MADE PLEASE DISREGARD THIS BILL. THANK YOU.

** CREDIT CARD PAYMENTS PROCESSED BY ANESTHESIOLOGY SERVICES AUGUSTA, GA **

SPARTANBURG OB/GYN, P.A.

SPECIALIZING IN OBSTETRICS, URINARY INCONTINENCE,
AND THE UPSTATE'S LEADER IN MINIMALLY INVASIVE SURGERY

NGUYEN N. GIEP, M.D.
ANN J. KELLY, M.D.
BANG N. GIEP, M.D.
PETER A. SEREQUE, M.D.
NANCY W. HENDRIX, M.D.
HOANG N. GIEP, M.D.
N. DAWN BINGHAM, M.D.

MAIN OFFICE
853 N. CHURCH ST. • SUITE 700
SPARTANBURG, SC 29303
PHONE: 864.560.7002
FAX: 864.560.6009
TAMMY LEWIS
OFFICE MANAGER

January 4, 2006

Lisa Martin
201 Powell Mill Rd G 201
Spartanburg, SC 29301

Dear Mrs. Martin,

As a courtesy we filed your South Carolina Medicaid for your visit to us on 12/02/2005, however, Medicaid is showing that you were not eligible for the month of December. Please contact your case worker to get this resolved.

If we do not hear from you within 30 days of the date of this letter we will have no choice but to look to you for payment of these charges.

If you have any questions please don't hesitate to contact us at 560-7002 ext 145.

Sincerely,

Kim Thomas
Accounts Receivable

SATELLITE OFFICES

141 9 N. LIMESTONE
GAFFNEY, SC 29340

2755 S. HWY 14
GREER, SC 29650

1330 BOILING SPRINGS ROAD
SPARTANBURG, SC 29303

133 N. HOWARD AVENUE
LANDRUM, SC 29356

Patient Name
LISA J MARTIN

Spartanburg Pathology Associates, PA

Your Pathology Service Provider

Account #	Statement Date
GWD- 8010671-4	12/27/05

Please contact our billing agent, PSA, to submit payment, update information, or speak with a billing representative.

Due Date	Amount Due
01/16/06	345.00

IMPORTANT MESSAGE

SECOND NOTICE, PLEASE REMIT PROMPTLY.
YOUR PROMPT ATTENTION IS NEEDED. SEND BALANCE SHOWN BY DUE DATE. THANK YOU.

www.pathologybilling.com

Servicio en espanol, por favor llame.

TOLL FREE: 1-877-835-0598
TOLL FREE FAX: 1-877-268-1254

Office hours:
Mon-Thur 8am-10pm EST
Fri 8am-8pm, Sat 10am-4pm

Our records indicate the following insurance:
Primary Ins: MEDICAID OF SC

Referring Physician:
MICHAEL R WATKINS MD

1

DATE	PROC. CODE	DESCRIPTION	Number of Specimens	AMOUNT
08/10/05	8830926	MICROSCOPIC ANALYSIS, VI	1	345.00
10/26/05		MEDICAID ADJUSTMENTS		.00
		NOT ENROLLED OR ELIGIBLE		
		FAMILY PLANNING COVERAGE ONLY		

called 11/27/06 fm

These charges are not included in any other hospital or physician statement. For more information or to update insurance information, see the back of this statement or visit www.pathologybilling.com.

BILLING OFFICE ADDRESS:

1101 1

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

STATEMENT DATE	DUE DATE	ACCOUNT #
12/27/05	01/16/06	GWD- 8010671-4

AMOUNT DUE
$ 345.00

Check # _____
(please do not staple)

AMOUNT ENCLOSED $

Patient Name: LISA J MARTIN

☐ Please check box if address or insurance information is incorrect and indicate change(s) on reverse side.

Do Not Mail Credit Card Information.
To pay by Credit Card, visit us at: www.pathologybilling.com
or call: 1-877-835-0598

ADDRESSEE:

LISA J MARTIN

201 POWELL MILL RD APT G201
SPARTANBURG SC 29301-1567

MAKE CHECKS PAYABLE TO & REMIT TO:

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

Financing app Bon Secours 757-889-5810

NOTICE OF AMOUNT DUE

PELLETTIERI & ASSOCIATES, LTD

RE: BON SECOURS HOSPITAL

$50 payment 2/22/06 & asof 1/27/0

STATEMENT DATE: January 31, 2006

ACCOUNT NUMBER: 3679669

AMOUNT DUE: $1062.80 662.80

REFERENCE#: 3090015 612.80 asof 2/22/

ADDRESSEE:

Lisa J Martin
201 Powell Mill Rd
Apt G201
Spartanburg SC 29301-1567

MAKE CHECKS PAYABLE TO:

Bon Secours Cottage Hospi
PO Box 77000
Department 771144
Detroit MI 48277-1144

****** PLEASE CALL ******
Phone: (630) 424-4000 Ext: 3081 • Fax: (630) 424-4002
Outside Illinois: (800) 837-2458 Ext: 3081
Pay Online at www.pnapayment.com

Please be advised that this firm represents the above named creditor. Your account has been referred to this office for collection of the Amount Due shown above.

Demand is hereby made upon you for payment of the Amount Due. If you cannot make remittance of the total amount due, but wish to make partial payment and discuss payment terms, call this office with your proposal. **You are hereby advised that this is an attempt to collect a debt, and that this firm is acting pursuant to the Fair Debt Collection Practice Act, 15 U.S.C.A., Sec. 1692 et seq.; and information obtained will be used for this purpose.**

If you do not dispute the validity of this debt, or any portion thereof, within 30 days of receipt of this letter, we will assume it is valid. If you do dispute the validity of this debt, or any portion thereof, please notify us in writing within 30 days of receipt of this letter and we will mail verification of the debt, or copy of the judgment, if applicable, to you. We will also provide you with the name and address of the original creditor, if different from the current creditor, if you request the same from us in writing, within 30 days of receipt of this letter.

We will accept checks or credit cards over the phone at the above phone numbers or you can pay online at www.pnapayment.com

Thank you,

Pellettieri & Associates, LTD

PLEASE INCLUDE YOUR REFERENCE# ON PAYMENT.
PLEASE SEE REVERSE SIDE FOR IMPORTANT INFORMATION

Retain Top Portion For Your Records
***** Please Return Bottom Portion With Payment *****

001890PAPCLD1FTY34B6AE48

Pellettieri & Associates, LTD
991 Oak Creek Dr.
Lombard, IL 60148-6408
RETURN SERVICE REQUESTED

Letter Date : 01/31/06
Reference# : 3090015
Account# : 3679669
Creditor: BON SECOURS HOSPITAL
Amount Due : $1062.80
Date of Service: 08-01-2005
Patient : LISA J MARTIN

MAKE CHECKS PAYABLE TO:

3090015 - PLD1F - 001890
Lisa J Martin
201 Powell Mill Rd
Apt G201
Spartanburg SC 29301-1567

Bon Secours Cottage Hospi
PO Box 77000
Department 771144
Detroit MI 48277-1144

GBA

GEORGE BROWN ASSOCIATES, INC.

2200 Crown Point Executive Drive • Charlotte, NC 28227 • (704) 844-8777

Member: American Collectors Association

1946771-4
LISA MARTIN
125 FOSTER ST
CHESNEE SC 29323

JUL 19 2006

CREDITOR SURGERY CENTER AT PELHAM
ACCOUNT NUMBER 4201
ACCOUNT BALANCE 2921.00

PLEASE REVIEW THE ABOVE DOLLAR AMOUNT THAT IS BEING REPORTED AGAINST YOU. IF YOU HAVE PAID ALL OR A PORTION OF THIS AMOUNT TO OUR CLIENT LISTED ABOVE, OR PAYMENTS SENT HERE AND POSSIBLY MISSAPPLIED, PLEASE LET US KNOW IMMEDIATELY.

YOUR CREDIT RECORD IS VERY IMPORTANT TO YOU. WE WANT TO BE SURE IT IS ACCURATE.

CALL OUR OFFICE AT 1-800-432-8338 MONDAY THROUGH FRIDAY. OUR OFFICE HOURS OR 8AM TO 5PM.

```
1EDHMS54 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 10/12/06
 MEDSPROD                      RECIPIENT INFORMATION                ACTION:
                    MEMBER PERIOD START: 01/23/06  END:             PAGE: 0001
 NAME: MARTIN LISA J                                  HH NAME: MARTIN LISA J
 RCP NUMBER: 9780275057      HH NUMBER: 101064729     ACTION TYPE: MAINTENANCE
 SSN: 368-25-0542  VC: V     APL STATUS:              ACTION DATE: 01/24/06
 PRIMARY INDIVIDUAL:         APL CO: 42    WORKER ID: BARTH    LOCATION: 055
 201 POWELL MILL RD                        SSCN: 368250542A    RRN:
 APT G-201                                 RACE: 02   SEX: F   MARITAL STATUS: S
                                           TPL INSURANCE: N    RELATION: SELF
 SPARTANBURG                 SC 29301-     DOB: 06/18/1968     DOD:
 CORRECT RCP NUMBER: _________             LIV ARRANGEMENT: HOME INCOME TRUST:
                                           PROVIDER:

     BG       BEG         END                  BENEFITS QMB RETRO  % OF POV   CHIP
S  NUMBER     ELIG        ELIG      PCAT QCAT  TYPE     IND  IND    LEVEL     NUMBER
_ 09087814 08/01/2005 09/01/2005 87   30    EMERGENCY N    N        .00
_ 89035830 09/01/1981 09/01/1981 87   30              N    Y        .00
_ 28958914 08/01/1981 08/01/1981 55   30    LIMITED   N    Y        .00


 UPDATED: USER ID: BARTH     DATE: 11/28/05  SYSTEM ID: TTR1004  DATE: 11/12/05
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
```

File w/→302

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

November 6, 2006

Ms. Lisa J. Martin
632 Taylor Street
Rock Hill, South Carolina 29730

Dear Ms. Martin:

Senator Robert Hayes asked our agency to assist with your questions about Medicaid eligibility and your outstanding medical bills. We hope to be of some assistance.

After reviewing your situation, we have determined you are eligible for Medicaid's Family Planning Waiver services from September 1, 2005 through January 1, 2006. This coverage pays for services related to family planning only. We apologize for any inconvenience this problem may have caused you. We contacted the medical providers regarding the bills that you submitted with your letter and informed them of your retroactive Medicaid coverage. Please refer to the enclosed chart regarding our contact with your medical providers. According to our records, you were determined eligible for Emergency Services only for the month of August 2005. This coverage pays for any emergency service, which includes any service related to your pregnancy during the month of August 2005.

If you continue to receive bills from these providers you will need to submit copies of the enclosed "Verification of Retroactive Medicaid" form along with your past bills to your medical providers. If your providers accept South Carolina Medicaid and are willing to bill the program for these past services, they should submit their claims to our agency as soon as possible. If you obtained services from medical providers that will not bill Medicaid, then you are responsible for paying those bills.

If your medical providers have billing questions or concerns, they can contact one of the following Medicaid representatives:

Margaret Riley at (803) 898-2674 *(Hospitals)*
Chris Lykes at (803) 898-2547 *(Physician Offices)*

I am returning your bills to you. If you have any questions about your retroactive Medicaid coverage please contact Ms. Jennifer Dabbs at (803) 898-3965.

Again, please accept our apology for any inconvenience this problem may have caused you. We hope this retroactive Medicaid coverage will assist with your outstanding medical bills.

Sincerely,

Gary Ries
Deputy Director

GR/jod
Enclosures

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

Brought spoke w/Judy in Sen Hayes office 11/7/06 9:25am

#302

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

November 6, 2006

Ms. Lisa J. Martin
632 Taylor Street
Rock Hill, South Carolina 29730

Dear Ms. Martin:

Senator Robert Hayes asked our agency to assist with your questions about Medicaid eligibility and your outstanding medical bills. We hope to be of some assistance.

After reviewing your situation, we have determined you are eligible for Medicaid's Family Planning Waiver services from September 1, 2005 through January 1, 2006. This coverage pays for services related to family planning only. We apologize for any inconvenience this problem may have caused you. We contacted the medical providers regarding the bills that you submitted with your letter and informed them of your retroactive Medicaid coverage. Please refer to the enclosed chart regarding our contact with your medical providers. According to our records, you were determined eligible for Emergency Services only for the month of August 2005. This coverage pays for any emergency service, which includes any service related to your pregnancy during the month of August 2005.

If you continue to receive bills from these providers you will need to submit copies of the enclosed "Verification of Retroactive Medicaid" form along with your past bills to your medical providers. If your providers accept South Carolina Medicaid and are willing to bill the program for these past services, they should submit their claims to our agency as soon as possible. If you obtained services from medical providers that will not bill Medicaid, then you are responsible for paying those bills.

If your medical providers have billing questions or concerns, they can contact one of the following Medicaid representatives:

Margaret Riley at (803) 898-2674 *(Hospitals)*
Chris Lykes at (803) 898-2547 *(Physician Offices)*

I am returning your bills to you. If you have any questions about your retroactive Medicaid coverage please contact Ms. Jennifer Dabbs at (803) 898-3965.

Again, please accept our apology for any inconvenience this problem may have caused you. We hope this retroactive Medicaid coverage will assist with your outstanding medical bills.

Sincerely,

Gary Ries
Deputy Director

GR/jod
Enclosures

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

Please refer to the chart below regarding our contact with your medical providers.

Annapolis Oakwood Hospital	We contacted Patient Accounts at 800-858-9503 and were told that Medicaid paid the account in full on 3/29/06.
Spartanburg Regional Medical Center	Medicaid paid on 9/29/06. No remaining balance.
C.B.A., Inc. regarding Regional Maternal-Fetal Medical	Spoke with a billing representative at Regional Maternal Fetal Medical and they said they tried to bill back in 8/05 and there were problems with the claim going through. They said they tried to contact you by phone and letter, but never got a response. Now they are not willing to bill Medicaid because it was over a year ago. You will remain responsible for this bill.
Spartanburg Pathology Associates, PA	Medicaid paid for date of service 8/9/05 on 2/10/06. Medicaid paid for date of service 8/10/05 on 2/10/06.
Foothills Anesthesia Consultants	Medicaid paid this bill on 6/2/06.
Spartanburg OB/GYN, P.A.	Medicaid paid this bill.
Pellettieri & Associates, LTD regarding Bon Secours Cottage Hospital	This hospital does not accept SC Medicaid; therefore you will be responsible for this bill. We contacted them on 10/24/06 and they are not willing to enroll in SC Medicaid, but they do offer financing options. For more information on available financing call 313-343-1000.
George Brown Associates, Inc. regarding Surgery Center At Pelham	"Verification of Retroactive Medicaid" form was faxed to Robert Brown on 10/24/06. You may want to follow up with him regarding this bill. He can be reached at 800-432-8338.

Mark Sanford
Governor

Robert M. Kerr
Director

Susan

Check letter. Also chart - can't we get someone at BCBSSC to review the previously submitted CBA claim & see if they can pay it?

Gary

Susan/BZ's chg made 11/12

Ms. Lisa J. Martin
632 Taylor Street
Rock Hill, South Carolina 29730

Dear Ms. Martin:

Senator Robert Hayes asked our agency to assist with your questions about Medicaid eligibility and your outstanding medical bills. We hope to be of some assistance.

After reviewing your situation, we have determined you are eligible for Medicaid's Family Planning [Waiver] services from September 1, 2005 through January 1, 2006. This coverage pays for services related to family planning only. We apologize for any inconvenience this problem may have caused you. We contacted the medical providers regarding the bills that you submitted with your letter and informed them of your retroactive Medicaid coverage. Please refer to the enclosed chart regarding our contact with your medical providers. According to our records, you were determined eligible for Emergency Services only for the month of August 2005. This coverage pays for any emergency service, which includes any service related to your pregnancy during the month of August 2005.

If you continue to receive bills from these providers you will need to submit copies of the enclosed "Verification of Retroactive Medicaid" form along with your past bills to your medical providers. If your providers accept South Carolina Medicaid and are willing to bill the program for these past services, they should submit their claims to our agency as soon as possible. If you obtained services from medical providers that will not bill Medicaid, then you are responsible for paying those bills.

If your medical providers have billing questions or concerns, they can contact one of the following Medicaid representatives:

Margaret Riley at (803) 898-2674 *(Hospitals)*
Chris Lykes at (803) 898-2547 *(Physician Offices)*

I am returning your bills to you. If you have any questions about your retroactive Medicaid coverage please contact Ms. Jennifer Dabbs at (803) 898-3965.

Again, please accept our apology for any inconvenience this problem may have caused you. We hope this retroactive Medicaid coverage will assist with your outstanding medical bills.

Sincerely,

Gary Ries
Deputy Director

GR/jod
Enclosures

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

Please refer to the chart below regarding our contact with your medical providers.

Annapolis Oakwood Hospital	We contacted Patient Accounts at 800-858-9503 and were told that Medicaid paid the account in full on 3/29/06.
Spartanburg Regional Medical Center	Medicaid paid on 9/29/06. No remaining balance.
C.B.A., Inc. regarding Regional Maternal-Fetal Medical	Spoke with a billing representative at Regional Maternal Fetal Medical and they said they tried to bill back in 8/05 and there were problems with the claim going through. They said they tried to contact you by phone and letter, but never got a response. Now they are not willing to bill Medicaid because it was over a year ago. You will remain responsible for this bill.
Spartanburg Pathology Associates, PA	Medicaid paid for date of service 8/9/05 on 2/3/06. Medicaid paid for date of service 8/10/05 on 2/10/06.
Foothills Anesthesia Consultants	Medicaid paid this bill on 6/2/06.
Spartanburg OB/GYN, P.A.	Medicaid paid this bill.
Pellettieri & Associates, LTD regarding Bon Secours Cottage Hospital	This hospital does not accept SC Medicaid; therefore you will be responsible for this bill. We contacted them on 10/24/06 and they are not willing to enroll in SC Medicaid, but they do offer financing options. For more information on available financing call 313-343-1000.
George Brown Associates, Inc. regarding Surgery Center At Pelham	"Verification of Retroactive Medicaid" form was faxed to Robert Brown on 10/24/06. You may want to follow up with him regarding this bill. He can be reached at 800-432-8338.

paid date pulled from MMIS is also 2/10/06

PATIENT NAME: MARTIN ,LISA SERVICE DATE: 08/03/05 PAGE NO. 1

DATE	DESCRIPTION	AMOUNT
08/03/05	EMERGENCY ROOM	551.00
08/03/05	RADIOLOGY	177.00

faxing code to Betsy Carroll 11/3/5

to: Pat
313-792-7162

ACCOUNT BALANCE	ESTIMATED INSURANCE DUE	ACCOUNT NUMBER
728.00	0.00	304410459

MESSAGES:
PLEASE INCLUDE ACCOUNT NUMBER(S) ON YOUR CHECK OR MONEY ORDER.
THERE WILL BE A $25 FEE FOR RETURNED CHECKS.

PROMPT PAYMENT ON THIS ACCOUNT WILL PRESERVE
YOUR GOOD CREDIT RATING PLEASE SEND PAYMENT TODAY.

PATIENT BALANCE DUE
▸▸▸▸ **$728.00**

PAYMENT DUE BY:
▸▸▸▸ **10/28/05**

BILL DATE: 10/10/05

FOR BILLING INQUIRIES, CALL: 800-858-9503 OFFICE HOURS 8:00am - 4:30pm, MON - FRI

9261-7614*1MV0FF37J000015

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

SPARTANBURG REGIONAL MEDICAL CENTER
1001 NORTH PINE STREET
SPARTANBURG, SC 29303

F/C:PS P/T:IP

MARTIN,LISA J 0522101371 08/09/05 08/10/05 1

MARY HADDAD

LISA JOY MARTIN
201 POWELL MILL RD
G201
SPARTANBURG SC 29301

502002 PENDING SPONSOR INPAT

999 368250542 08/19/05

CODE	DESCRIPTION	QTY
110	ROOM-BOARD/PVT	650.00
250	PHARMACY	682.58
258	IV SOLUTIONS	713.06
259	DRGS/OTHER	106.16
300	LABORATORY	1,294.00
636	DRUGS/DETAIL CODE	1,292.57
964	PRO FEE/ANES CRNA	588.00
	TOTAL CHARGES	5,326.37
	TOTAL PAYMENTS/ADJUSTMENTS	0.00

569-6068
Rob 11C

BENEFITS ASSIGNED

5,326.37

5,326.37

5,326.37

P.O. Box 1051
Spartanburg, SC 29304
Address Service Requested

April 5, 2006

C.B.A., INC.

A collection agency

126 Knollwood Drive
P.O. Box 1051
Spartanburg, South Carolina 29304-1051
Telephone (864) 574-1160
(800) 874-2615
FAX (864) 587-4790

Martin,Lisa 1355038
125 Foster St
Chesnee, SC 29323-9144

ACCOUNT IDENTIFICATION

Re: Regional Maternal-Fetal Med Acct# 5207604

Acct. No.	: 1355038
Client Acct. No.	: 5207604
Client No.	: 13631
Balance Due	**: $297.00**

The above past due bill has been referred to this office for collection.

Unless you notify this office within 30 days after receiving this notice that you dispute the validity of this debt or any portion thereof, this office will assume this debt is valid. If you notify this office in writing within 30 days from receiving this notice, this office will: Obtain verification of the debt or obtain a copy of a judgment and mail you a copy of such judgment or verification. If you request this office in writing within 30 days after receiving this notice, this office will provide you with the name and address of the original creditor, if different from the current creditor.

This is an attempt to collect a debt and any information obtained will be used for that purpose.

---------- Detach and Return with Payment ----------

Enter the requested information in the spaces provided below:

From: Lisa Martin

Address: _____

City, State, Zip: _____

Telephone - Home: _____ Work: _____

To pay by credit card, please complete the following:
Check one: ☐ Visa ☐ MasterCard
Card Number: _____
*Control #: _____ Expiration Date: __/__/__
Payment Amount: $_____
Signature: _____

*The control number is usually found on the back of your card in the signature space and is the three digits following the last four numbers of your card.

Account Number	: 1355038
Client Acct. No	: 5207604
Client No.	: 13631
Balance Due	: $297.00 Date: April 5, 2006
Amount Enclosed	: $_____

C.B.A., INC.
P.O. BOX 1051
SPARTANBURG, SC 29304

Enclosing this notice with your payment will expedite credit to your account.

N1 000376P 1 365 O00339 95 064589 S-CRE

LISA J MARTIN

Spartanburg Pathology Associates, PA

Your Pathology Service Provider

Account #	Statement Date
GWD- 8006137-4	12/20/05

Due Date	Amount Due
01/09/06	110.00

Please contact our billing agent, PSA, to submit payment, update information, or speak with a billing representative.

IMPORTANT MESSAGE

SECOND NOTICE, PLEASE REMIT PROMPTLY.

YOUR PROMPT ATTENTION IS NEEDED. SEND BALANCE SHOWN BY DUE DATE. THANK YOU.

www.pathologybilling.com

Servicio en espanol, por favor llame

TOLL FREE: 1-877-835-0598
TOLL FREE FAX: 1-877-268-1254

Office hours:
Mon-Thur 8am-10pm EST
Fri 8am-8pm, Sat 10am-4pm

Our records indicate the following insurance:
Primary Ins: MEDICAID OF SC

Referring Physician:
MARY HADDAD MD

1

DATE	PROC. CODE	DESCRIPTION	Number of Specimens	AMOUNT
08/09/05	8834226	IMMUNOCYTOCHEMISTRY	1	110.00
10/26/05		MEDICAID ADJUSTMENTS		.00
		NOT ENROLLED OR ELIGIBLE		

Medicaid
97802D057

Confirm # 503524
Bon Secours
(313) 343-1000
Grosse Pointe

Oakwood Annapolis Hospital
Wayne (734) 467-4062

Called Oakwood 1/27/06 fm

These charges are not included in any other hospital or physician statement. For more information or to update insurance information, see the back of this statement or visit www.pathologybilling.com.

BILLING OFFICE ADDRESS:

804 1

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

STATEMENT DATE	DUE DATE	ACCOUNT #
12/20/05	01/09/06	GWD- 8006137-4

AMOUNT DUE
$ 110.00

Check # _____
(please do not staple)

AMOUNT ENCLOSED $

VISA MasterCard DISCOVER

Patient Name: LISA J MARTIN

☐ Please check box if address or insurance information is incorrect and indicate change(s) on reverse side.

Do Not Mail Credit Card Information.
To pay by Credit Card, visit us at: www.pathologybilling.com
or call: 1-877-835-0598

ADDRESSEE:

LISA J MARTIN

201 POWELL MILL RD APT G201
SPARTANBURG SC 29301-1567

Dr

MAKE CHECKS PAYABLE TO & REMIT TO:

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

(803) 898-3006

Douglas

PATIENT STATEMENT OF ACCOUNT

PATIENT ACCOUNTS
804 Scott Nixon Memorial Drive
Augusta, GA 30907

Address Service Requested

CHECK CARD USING FOR PAYMENT

MASTERCARD ☐ VISA ☐ DISCOVER ☐ AM. EX.

CARD NUMBER | 4 DIG CID | EXP. DATE

SIGNATURE (REQUIRED)

PRINT NAME ON CARD

PAY THIS AMOUNT $1,800.00

SHOW AMOUNT PAID HERE $

ACCOUNT NO.	CODE	STATEMENT DATE
0522101371	FP363	12/15/05

** CREDIT CARD PAYMENTS PROCESSED BY ANESTHESIOLOGY SERVICES AUGUSTA, GA **

ADDRESSEE

LISA MARTIN
G201
201 POWELL MILL RD
SPARTANBURG SC 29301-1526

MAKE CHECK PAYABLE TO

Foothills Anesthesia Consultan
PO BOX 4391
SPARTANBURG SC 29305-4391

☐ CHECK HERE FOR ADDRESS CHANGE. PLEASE MAKE CHANGES ON BACK
www.kam2000.com/pa

DETACH AND RETURN TOP PORTION WITH PAYMENT

STATEMENT OF SERVICES RENDERED

SERVICE DATE	CASE NUMBER	CPT CODE	DESCRIPTION OF PROCEDURE OR SERVICE	CHARGES / PAYMENT & ADJ. PATIENT	INSURANCE
8 10 05	3310308	01967	Anesthesiology Services by Dr. D. SHANTHA for Dr. M.Haddad Billed To Insurance Patient Responsible Billed To Patient	$1,800.00	$1,800.0 ($1,800.0

called them 1/27/06 SV

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	NEW BALANCE	PATIENT	INSURANCE
$1,800.00	$0.00	$0.00	$0.00	$0.00		$1,800.00	$0.0

ACCOUNT NO.	STATEMENT DATE	
0522101371	12/15/05	PATIENT IS RESPONSIBLE FOR "PATIENT NEW BALANCE" PAYMENT IS DUE WITHIN 15 DAYS OF RECEIPT OF STATEMENT.

OFFICE HOURS: 8:00AM-4:15PM EST PHONE NO: 1 888 850 6304

THIS IS A BILL FOR SERVICES NOT INCLUDED ON YOUR HOSPITAL BILL.
PLEASE CALL OUR OFFICE WITH QUESTIONS CONCERNING YOUR BILL.
IF PAYMENT HAS BEEN MADE PLEASE DISREGARD THIS BILL. THANK YOU.

** CREDIT CARD PAYMENTS PROCESSED BY ANESTHESIOLOGY SERVICES AUGUSTA, GA **

SPARTANBURG OB/GYN, P.A.

SPECIALIZING IN OBSTETRICS, URINARY INCONTINENCE,
AND THE UPSTATE'S LEADER IN MINIMALLY INVASIVE SURGERY

NGUYEN N. GIEP, M.D.
ANN J. KELLY, M.D.
BANG N. GIEP, M.D.
PETER A. SEREQUE, M.D.
NANCY W. HENDRIX, M.D.
HOANG N. GIEP, M.D.
N. DAWN BINGHAM, M.D.

MAIN OFFICE
853 N. CHURCH ST. • SUITE 700
SPARTANBURG, SC 29303
PHONE: 864.560.7002
FAX: 864.560.6009
TAMMY LEWIS
OFFICE MANAGER

January 4, 2006

Lisa Martin
201 Powell Mill Rd G 201
Spartanburg, SC 29301

Dear Mrs. Martin,

As a courtesy we filed your South Carolina Medicaid for your visit to us on 12/02/2005, however, Medicaid is showing that you were not eligible for the month of December. Please contact your case worker to get this resolved.

If we do not hear from you within 30 days of the date of this letter we will have no choice but to look to you for payment of these charges.

If you have any questions please don't hesitate to contact us at 560-7002 ext 145.

Sincerely,

Kim Thomas
Accounts Receivable

SATELLITE OFFICES

141 9 N. LIMESTONE
GAFFNEY, SC 29340

2755 S. HWY 14
GREER, SC 29650

1330 BOILING SPRINGS ROAD
SPARTANBURG, SC 29303

133 N. HOWARD AVENUE
LANDRUM, SC 29356

LISA J MARTIN

Spartanburg Pathology Associates, PA

Your Pathology Service Provider

Account #	Statement Date
GWD- 8010671-4	12/27/05

Please contact our billing agent, PSA, to submit payment, update information, or speak with a billing representative.

Due Date	Amount Due
01/16/06	345.00

IMPORTANT MESSAGE

SECOND NOTICE, PLEASE REMIT PROMPTLY.

YOUR PROMPT ATTENTION IS NEEDED. SEND BALANCE SHOWN BY DUE DATE. THANK YOU.

www.pathologybilling.com

Servicio en espanol, por favor llame

TOLL FREE: 1-877-835-0598
TOLL FREE FAX: 1-877-268-1254

Office hours:

Mon-Thur 8am-10pm EST
Fri 8am-8pm, Sat 10am-4pm

Our records indicate the following insurance:
Primary Ins: MEDICAID OF SC

Referring Physician:
MICHAEL R WATKINS MD

1

DATE	PROC. CODE	DESCRIPTION	Number of Specimens	AMOUNT
08/10/05 10/26/05	8830926	MICROSCOPIC ANALYSIS, VI MEDICAID ADJUSTMENTS NOT ENROLLED OR ELIGIBLE FAMILY PLANNING COVERAGE ONLY	1	345.00 .00

called 1/27/06 fm

These charges are not included in any other hospital or physician statement. For more information or to update insurance information, see the back of this statement or visit www.pathologybilling.com.

BILLING OFFICE ADDRESS:

1101 1

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

STATEMENT DATE	DUE DATE	ACCOUNT #
12/27/05	01/16/06	GWD- 8010671-4

AMOUNT DUE
$ 345.00

Check # _____
(please do not staple)

AMOUNT ENCLOSED $

Patient Name: LISA J MARTIN

☐ Please check box if address or insurance information is incorrect and indicate change(s) on reverse side.

Do Not Mail Credit Card Information.
To pay by Credit Card , visit us at: www.pathologybilling.com
or call: 1-877-835-0598

ADDRESSEE:

LISA J MARTIN

201 POWELL MILL RD APT G201
SPARTANBURG SC 29301-1567

MAKE CHECKS PAYABLE TO & REMIT TO:

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

financing app Bon Secours 757-889-581

NOTICE OF AMOUNT DUE

PELLETTIERI & ASSOCIATES, LTD

RE: BON SECOURS HOSPITAL

$50 payment 2/22/06 & as of 1/27

STATEMENT DATE: January 31, 2006

ACCOUNT NUMBER: 3679669

AMOUNT DUE: $1062.80 662.80 as of

REFERENCE#: 3090015 612.80 2/2

ADDRESSEE:

Lisa J Martin
201 Powell Mill Rd
Apt G201
Spartanburg SC 29301-1567

MAKE CHECKS PAYABLE TO:

Bon Secours Cottage Hospi
PO Box 77000
Department 771144
Detroit MI 48277-1144

****** PLEASE CALL ******
Phone: (630) 424-4000 Ext: 3081 • Fax: (630) 424-4002
Outside Illinois: (800) 837-2458 Ext: 3081
Pay Online at www.pnapayment.com

Please be advised that this firm represents the above named creditor. Your account has been referred to this office for collection of the Amount Due shown above.

Demand is hereby made upon you for payment of the Amount Due. If you cannot make remittance of the total amount due, but wish to make partial payment and discuss payment terms, call this office with your proposal. **You are hereby advised that this is an attempt to collect a debt, and that this firm is acting pursuant to the Fair Debt Collection Practice Act, 15 U.S.C.A., Sec. 1692 et seq.; and information obtained will be used for this purpose.**

If you do not dispute the validity of this debt, or any portion thereof, within 30 days of receipt of this letter, we will assume it is valid. If you do dispute the validity of this debt, or any portion thereof, please notify us in writing within 30 days of receipt of this letter and we will mail verification of the debt, or copy of the judgment, if applicable, to you. We will also provide you with the name and address of the original creditor, if different from the current creditor, if you request the same from us in writing, within 30 days of receipt of this letter.

We will accept checks or credit cards over the phone at the above phone numbers or you can pay online at www.pnapayment.com

Thank you,

Pellettieri & Associates, LTD

PLEASE INCLUDE YOUR REFERENCE# ON PAYMENT.
PLEASE SEE REVERSE SIDE FOR IMPORTANT INFORMATION

Retain Top Portion For Your Records
***** Please Return Bottom Portion With Payment *****

001890PAPCLD1FTY34B6AE48

Pellettieri & Associates, LTD
991 Oak Creek Dr.
Lombard, IL 60148-6408
RETURN SERVICE REQUESTED

Letter Date : 01/31/06
Reference# : 3090015
Account# : 3679669
Creditor: BON SECOURS HOSPITAL
Amount Due : $1062.80
Date of Service: 08-01-2005
Patient : LISA J MARTIN

MAKE CHECKS PAYABLE TO:

3090015 - PLD1F - 001890
Lisa J Martin
201 Powell Mill Rd
Apt G201
Spartanburg SC 29301-1567

Bon Secours Cottage Hospi
PO Box 77000
Department 771144
Detroit MI 48277-1144

GBA

GEORGE BROWN ASSOCIATES, INC.

2200 Crown Point Executive Drive • Charlotte, NC 28227 • (704) 844-8777

Member: American Collectors Association

1946771-4
LISA MARTIN
125 FOSTER ST
CHESNEE SC 29323

JUL 19 2006

CREDITOR SURGERY CENTER AT PELHAM
ACCOUNT NUMBER 4201
ACCOUNT BALANCE 2921.00

PLEASE REVIEW THE ABOVE DOLLAR AMOUNT THAT IS BEING REPORTED AGAINST YOU. IF YOU HAVE PAID ALL OR A PORTION OF THIS AMOUNT TO OUR CLIENT LISTED ABOVE, OR PAYMENTS SENT HERE AND POSSIBLY MISSAPPLIED, PLEASE LET US KNOW IMMEDIATELY.

YOUR CREDIT RECORD IS VERY IMPORTANT TO YOU. WE WANT TO BE SURE IT IS ACCURATE.

CALL OUR OFFICE AT 1-800-432-8338 MONDAY THROUGH FRIDAY. OUR OFFICE HOURS OR 8AM TO 5PM.

South Carolina Department of Health and Human Services

Verification of Retroactive Medicaid

Date: 10/18/06

To: Lisa J. Martin
632 Taylor Street
Rock Hill, SC 29730

Re: Lisa J. Martin

Medicaid Number: 9780275057

Retroactive Medicaid coverage was entered into the Department of Health and Human Services computer system for the above-named individual on the following date:

10/18/06.

* The retroactive period began on the following date: September 1, 2005.

* The retroactive period ended on the following date: January 1, 2006.

Please be reminded that all bills must be submitted within six (6) months of the individual's eligibility determination or one (1) year from the date of service delivery, whichever is later.

Jamie C. Bostick
Medicaid Eligibility Worker

803-898-3016
Telephone Number

* This coverage is under the Family Planning Program and pays for services related to F.P. only.

DHHS Form 945 (May 2004)

Susan/Bz'c
chg
made
11/2

Susan
Check letter. Also
chart - can we get
someone at BCBSSC
to review the previously
submitted CBA claim
that they can pay
it?
Thx
Gary

Mark Sanford
Governor

Robert M. Kerr
Director

Ms. Lisa J. Martin
632 Taylor Street
Rock Hill, South Carolina 29730

Dear Ms. Martin:

Senator Robert Hayes asked our agency to assist with your questions about Medicaid eligibility and your outstanding medical bills. We hope to be of some assistance.

After reviewing your situation, we have determined you are eligible for Medicaid's Family Planning Waiver services from September 1, 2005 through January 1, 2006. This coverage pays for services related to family planning only. We apologize for any inconvenience this problem may have caused you. We contacted the medical providers regarding the bills that you submitted with your letter and informed them of your retroactive Medicaid coverage. Please refer to the enclosed chart regarding our contact with your medical providers. According to our records, you were determined eligible for Emergency Services only for the month of August 2005. This coverage pays for any emergency service, which includes any service related to your pregnancy during the month of August 2005.

If you continue to receive bills from these providers you will need to submit copies of the enclosed "Verification of Retroactive Medicaid" form along with your past bills to your medical providers. If your providers accept South Carolina Medicaid and are willing to bill the program for these past services, they should submit their claims to our agency as soon as possible. If you obtained services from medical providers ou are responsible for paying those bills.

10/30

illing questions or concerns, they can contact one of the following Medicaid

Margaret Riley at (803) 898-2674 *(Hospitals)*
Chris Lykes at (803) 898-2547 *(Physician Offices)*

If you have any questions about your retroactive Medicaid coverage please
303) 898-3965.

11/16
Bz - See Red x2 + support doc - Please review, Sign off/Comment, and return - Thanks.
Susan

enience this problem m
ur outstanding medical

Sincerely,

Gary Ries
Deputy Direct

ty and Beneficiary Servic
nbia, South Carolina 292
02 • Fax (803) 255-8235

GARY CONTACTED US TO CONTACT ALL THE PROVIDERS. WE ALSO MODIFIED LETTER TO TAKE OUT APOLOGY FOR "ERROR". 10/26/06
JM/AMC.

Please refer to the chart below regarding our contact with your medical providers.

Annapolis Oakwood Hospital	We contacted Patient Accounts at 800-858-9503 and were told that Medicaid paid the account in full on 3/29/06.
Spartanburg Regional Medical Center	Medicaid paid on 9/29/06. No remaining balance.
C.B.A., Inc. regarding Regional Maternal-Fetal Medical	Spoke with a billing representative at Regional Maternal Fetal Medical and they said they tried to bill back in 8/05 and there were problems with the claim going through. They said they tried to contact you by phone and letter, but never got a response. Now they are not willing to bill Medicaid because it was over a year ago. You will remain responsible for this bill.
Spartanburg Pathology Associates, PA	Medicaid paid for date of service 8/9/05 on 2/3/06. Medicaid paid for date of service 8/10/05 on 2/10/06.
Foothills Anesthesia Consultants	Medicaid paid this bill on 6/2/06.
Spartanburg OB/GYN, P.A.	Medicaid paid this bill.
Pellettieri & Associates, LTD regarding Bon Secours Cottage Hospital	This hospital does not accept SC Medicaid; therefore you will be responsible for this bill. We contacted them on 10/24/06 and they are not willing to enroll in SC Medicaid, but they do offer financing options. For more information on available financing call 313-343-1000.
George Brown Associates, Inc. regarding Surgery Center At Pelham	"Verification of Retroactive Medicaid" form was faxed to Robert Brown on 10/24/06. You may want to follow up with him regarding this bill. He can be reached at 800-432-8338.

paid date posted from MMIS is also 2/10/06

MMDCLM86 S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES 11/01/06
SKELETAL UB92 CLAIM 3 OF 6

CLAIM CTL NO 06060120310238002 RECIPIENT NO 9780275057
NAME LISA J MARTIN TPL IND N RSP IND
PROV NAME OAKWOOD HOSPITAL & MED CTR PROV NO 11218B
ADDRESS 18101 OAKWOOD BLVD PROV TYPE 02
DEARBORN MI
ZIP CODE 48123-2500 TELEPHONE 313-791-4739
CHECK DATE 03/24/06 AMOUNT PAID $115.00
PRIM DIAG 632. PRIOR AUTH
REFERENCE NO A304410459 THIRD PARTY AMT $0.00
CANCEL CCN FUND CODES DJ
FIRST DATE SERV 08/03/05 ADMIT DATE 08/03/05 HHS DAYS/VISITS PAID
LAST DATE SERV 08/03/05 DISCHARGE DATE 03/08/06 BILLING CODE
OP DATA 1-3 PATIENT STATUS 01 CARRIER 1: CARRIER 2:

	PRIN SURG	OTH SURG1	OTH SURG2	OTH SURG3	OTH SURG4	OTH S
CODE						
DATE	00/00/00	00/00/00	00/00/00	00/00/00	00/00/00	00/0

OTHER DIAG 785.2

TOT CLM CHRGS: $728.00 REIMBURSE TYP: 5 TOT ALLOWED AMT: $0

PF3->DRG PF5->INTRNL CLM PF6->RETURN PF7->PREV CLM PF8->NEXT CLM
PF10->PREV MENU PF11->DIAG INFO PF12->SURG CODE PF13->BASIC CLM

Medicaid Family Planning Waiver Service

Paid under Emergency Services

MMDCLM05 SC DHHS - SKELETAL HIC CLAIM 11/01/06

CLAIM CTL NO 0614900408810100A RECIPIENT NO 9780275057 4 OF 6

NAME LISA J MARTIN TPL INDICATOR N

PROV NAME FOOTHILLS ANESTHESIA CONS PROV NO GP0770 THIRD PARTY

ADDRESS 101 E WOOD ST PROV TYPE 21

SPARTANBURG SC

ZIP CODE 29303- TELEPHONE 864-560-6455

CK DATE 06/02/06 AMT PD $254.00 PRIM DIAG 632. SEC DIAG

SUBFILES *L PRIOR AUTH THIRD PARTY AMT $.00

SEL	LINE NO	DATE OF SERVICE	PLACE SER	PROC CODE	PROC MOD	INDIV PROV	PRAC SP	UNITS	VIS REMB	FUND CODE	AMOUNT PAID
_	01	08/11/05	21 (1)	01967	0QK	191321	03	001		B4	$254.00

TOTAL CLAIM CHARGE: $1,800.00 CARRIER 1: CARRIER 2:

*** MARK SELECTION(S) AND PRESS APPROPRIATE PFKEY FOR DETAIL ***

ENTER->PROC INFO PF5->INTRNL CLM PF6->RET PF7->PRV SKL CLM PF8->NXT SKL CLM

PF10->PREV MENU PF11->DIAG INFO PF12->IND PROV INFO PF13->BASIC CLM

MDCLM05 SC DHHS - SKELETAL HIC CLAIM 11/01/06

CLAIM CTL NO 06152004008118OOA RECIPIENT NO 9780275057 5 OF 6

NAME LISA J MARTIN TPL INDICATOR N

PROV NAME SPARTANBURG REG MED CENTER PROV NO 400079 THIRD PARTY

ADDRESS 101 EAST WOOD STREET PROV TYPE 21

SPARTANBURG SC

ZIP CODE 29303-3040 TELEPHONE 864-560-6000

CK DATE 06/09/06 AMT PD $254.00 PRIM DIAG 650. SEC DIAG

SUBFILES *L PRIOR AUTH THIRD PARTY AMT $.00

SEL	LINE NO	DATE OF SERVICE	PLACE SER	PROC CODE	PROC MOD	INDIV PROV	PRAC SP	UNITS	VIS REMB	FUND CODE	AMOUNT PAID
_	01	08/10/05	21 (1)	01967	0QX	AN1022	25	001		Y3	$254.00

TOTAL CLAIM CHARGE: $588.00 CARRIER 1: CARRIER 2:

*** MARK SELECTION(S) AND PRESS APPROPRIATE PFKEY FOR DETAIL ***

ENTER->PROC INFO PF5->INTRNL CLM PF6->RET PF7->PRV SKL CLM PF8->NXT SKL CLM

PF10->PREV MENU PF11->DIAG INFO PF12->IND PROV INFO PF13->BASIC CLM

MDCLM86 S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES 11/01/06
SKELETAL UB92 CLAIM 6 OF 6

CLAIM CTL NO 06151004124409002 RECIPIENT NO 9780275057
NAME LISA J MARTIN TPL IND N RSP IND
PROV NAME SPARTANBURG REG MED CENTER PROV NO 369963
ADDRESS 101 EAST WOOD STREET PROV TYPE 01
SPARTANBURG SC
ZIP CODE 29303-3040 TELEPHONE 864-560-6000
CHECK DATE 09/29/06 AMOUNT PAID $706.47
PRIM DIAG 632. PRIOR AUTH
REFERENCE NO 522101371 THIRD PARTY AMT $0.00
CANCEL CCN FUND CODES C9
FIRST DATE SERV 08/09/05 ADMIT DATE 08/09/05 HHS DAYS/VISITS PAID 001
LAST DATE SERV 08/10/05 DISCHARGE DATE 08/10/05 BILLING CODE 1
DRG VALUE 380 PATIENT STATUS 01 CARRIER 1: CARRIER 2:

	PRIN SURG	OTH SURG1	OTH SURG2	OTH SURG3	OTH SURG4	OTH SURG5
CODE	96.49					
DATE	08/10/05	00/00/00	00/00/00	00/00/00	00/00/00	00/00/00

OTHER DIAG 305.1

TOT CLM CHRGS: $6,688.37 REIMBURSE TYP: U TOT ALLOWED AMT: $6,688.37

PF3->DRG PF5->INTRNL CLM PF6->RETURN PF7->PREV CLM PF8->NEXT CLM
PF10->PREV MENU PF11->DIAG INFO PF12->SURG CODE PF13->BASIC CLM

MDCLM05 SC DHHS - SKELETAL HIC CLAIM 11/01/06

CLAIM CTL NO 0603200767814900A RECIPIENT NO 9780275057 1 OF 6

NAME LISA J MARTIN TPL INDICATOR N

PROV NAME SPARTANBURG PATHOLOGY ASSO PROV NO PA4799 THIRD PARTY

ADDRESS PO BOX 52990 PROV TYPE 21

GREENWOOD SC

ZIP CODE 29648- TELEPHONE 864-583-8089

CK DATE 02/10/06 AMT PD $35.93 PRIM DIAG 634.90 SEC DIAG

SUBFILES *P PRIOR AUTH THIRD PARTY AMT $.00

SEL	LINE NO	DATE OF SERVICE	PLACE SER	PROC CODE	PROC MOD	INDIV PROV	PRAC SP	UNITS	VIS REMB	FUND CODE	AMOUNT PAID
_	01	08/09/05	21 (1)	88342	026	P10037	38	001		B4	$35.93

TOTAL CLAIM CHARGE: $110.00 CARRIER 1: CARRIER 2:

*** MARK SELECTION(S) AND PRESS APPROPRIATE PFKEY FOR DETAIL ***

ENTER->PROC INFO PF5->INTRNL CLM PF6->RET PF7->PRV SKL CLM PF8->NXT SKL CLM

PF10->PREV MENU PF11->DIAG INFO PF12->IND PROV INFO PF13->BASIC CLM

MMDCLM05 SC DHHS - SKELETAL HIC CLAIM 11/01/06

CLAIM CTL NO 0603200769814900A RECIPIENT NO 9780275057 2 OF 6

NAME LISA J MARTIN TPL INDICATOR N

PROV NAME SPARTANBURG PATHOLOGY ASSO PROV NO PA4799 THIRD PARTY

ADDRESS PO BOX 52990 PROV TYPE 21

GREENWOOD SC

ZIP CODE 29648- TELEPHONE 864-583-8089

CK DATE 02/10/06 AMT PD $96.49 PRIM DIAG 656.40 SEC DIAG

SUBFILES *P PRIOR AUTH THIRD PARTY AMT $.00

SEL	LINE NO	DATE OF SERVICE	PLACE SER	PROC CODE	PROC MOD	INDIV PROV	PRAC SP	UNITS	VIS REMB	FUND CODE	AMOUNT PAID
_	01	08/10/05	21 (1)	88309	026	275838	38	001		B4	$96.49

TOTAL CLAIM CHARGE: $345.00 CARRIER 1: CARRIER 2:

*** MARK SELECTION(S) AND PRESS APPROPRIATE PFKEY FOR DETAIL ***

ENTER->PROC INFO PF5->INTRNL CLM PF6->RET PF7->PRV SKL CLM PF8->NXT SKL CLM

PF10->PREV MENU PF11->DIAG INFO PF12->IND PROV INFO PF13->BASIC CLM

MMDCLM05 SC DHHS - SKELETAL HIC CLAIM 11/01/06

CLAIM CTL NO 0528300171810700A RECIPIENT NO 9780275057 1 OF 1

NAME LISA J MARTIN TPL INDICATOR N

PROV NAME SPARTANBURG CO HLTH DEPT PROV NO DHEC42 THIRD PARTY

ADDRESS PO BOX 4217 PROV TYPE 22

SPARTANBURG SC

ZIP CODE 29305-4217 TELEPHONE 864-596-3337

CK DATE 10/14/05 AMT PD $95.63 PRIM DIAG V25.09 SEC DIAG V25.41

SUBFILES *RRRR PRIOR AUTH THIRD PARTY AMT $.00

SEL	LINE NO	DATE OF SERVICE	PLACE SER	PROC CODE	PROC MOD	INDIV PROV	PRAC SP	UNITS	VIS REMB	FUND CODE	AMOUNT PAID
_	01	09/08/05	71 (D)	99204	0FP	DHEC42	51	001		AO	$79.65
_	02	09/08/05	71 (D)	A4267	0FP	DHEC42	51	002		AO	$1.48
_	03	09/08/05	71 (D)	S4993	0FP	DHEC42	51	003		AO	$11.85
_	04	09/08/05	71 (D)	85018	0FP	DHEC42	51	001		AO	$2.65

TOTAL CLAIM CHARGE: $95.98 CARRIER 1: CARRIER 2:

*** MARK SELECTION(S) AND PRESS APPROPRIATE PFKEY FOR DETAIL ***

ENTER->PROC INFO PF5->INTRNL CLM PF6->RET PF7->PRV SKL CLM PF8->NXT SK

PF10->PREV MENU PF11->DIAG INFO PF12->IND PROV INFO PF13->BASIC CLM

Billed under Family Planning Waiver Services

MMDCLM05 SC DHHS - SKELETAL HIC CLAIM 11/01/06

CLAIM CTL NO 0528300172810700A RECIPIENT NO 9780275057 1 OF 1

NAME LISA J MARTIN TPL INDICATOR N

PROV NAME DEPT OF HEALTH AND ENVIRON PROV NO 428015 THIRD PARTY

ADDRESS 8231 PARKLAND ROAD PROV TYPE 80

COLUMBIA SC

ZIP CODE 29223-4903 TELEPHONE 803-758-7960

CK DATE 10/14/05 AMT PD $11.95 PRIM DIAG V25.09 SEC DIAG V25.41

SUBFILES *YY PRIOR AUTH THIRD PARTY AMT $.00

SEL	LINE NO	DATE OF SERVICE	PLACE SER	PROC CODE	PROC MOD	INDIV PROV	PRAC SP	UNITS	VIS REMB	FUND CODE	AMOUNT PAID
_	01	09/08/05	81 (A)	80061	0FP	428015		001		MH	$10.95
_	02	09/08/05	81 (A)	82947	0FP	428015		001		MH	$1.00

TOTAL CLAIM CHARGE: $14.00 CARRIER 1: CARRIER 2:

*** MARK SELECTION(S) AND PRESS APPROPRIATE PFKEY FOR DETAIL ***

ENTER->PROC INFO PF5->INTRNL CLM PF6->RET PF7->PRV SKL CLM PF8->NXT SKL CLM

PF10->PREV MENU PF11->DIAG INFO PF12->IND PROV INFO PF13->BASIC CLM

MMDCLM05 SC DHHS - SKELETAL HIC CLAIM 11/01/06

CLAIM CTL NO 0528300173810700A RECIPIENT NO 9780275057 1 OF 3

NAME LISA J MARTIN TPL INDICATOR N

PROV NAME DEPT OF HEALTH AND ENVIRON PROV NO 428015 THIRD PARTY

ADDRESS 8231 PARKLAND ROAD PROV TYPE 80

COLUMBIA SC

ZIP CODE 29223-4903 TELEPHONE 803-758-7960

CK DATE 10/14/05 AMT PD $11.81 PRIM DIAG V25.09 SEC DIAG V25.41

SUBFILES *Y PRIOR AUTH THIRD PARTY AMT $.00

SEL	LINE NO	DATE OF SERVICE	PLACE SER	PROC CODE	PROC MOD	INDIV PROV	PRAC SP	UNITS	VIS REMB	FUND CODE	AMOUNT PAID
_	01	09/08/05	81 (A)	88164	0FP	428015		001		MH	$11.81

TOTAL CLAIM CHARGE: $14.73 CARRIER 1: CARRIER 2:

*** MARK SELECTION(S) AND PRESS APPROPRIATE PFKEY FOR DETAIL ***

ENTER->PROC INFO PF5->INTRNL CLM PF6->RET PF7->PRV SKL CLM PF8->NXT SKL CLM

PF10->PREV MENU PF11->DIAG INFO PF12->IND PROV INFO PF13->BASIC CLM

MDCLM05 SC DHHS - SKELETAL HIC CLAIM 11/01/06

CLAIM CTL NO 0527800328814600A RECIPIENT NO 9780275057 1 OF 1

NAME LISA J MARTIN TPL INDICATOR N

PROV NAME SPARTANBURG OB-GYN PA PROV NO PA1854 THIRD PARTY

ADDRESS 853 N CHURCH ST STE 700 PROV TYPE 21

SPARTANBURG SC

ZIP CODE 29303-3098 TELEPHONE 864-560-7006

CK DATE 10/14/05 AMT PD $102.90 PRIM DIAG V25.49 SEC DIAG

SUBFILES *P PRIOR AUTH THIRD PARTY AMT $.00

SEL	LINE NO	DATE OF SERVICE	PLACE SER	PROC CODE	PROC MOD	INDIV PROV	PRAC SP	UNITS	VIS REMB	FUND CODE	AMOUNT PAID
_	01	10/04/05	11 (3)	99204	000	199706	27	001	AMB	BS	$102.90

TOTAL CLAIM CHARGE: $170.00 CARRIER 1: CARRIER 2:

*** MARK SELECTION(S) AND PRESS APPROPRIATE PFKEY FOR DETAIL ***

ENTER->PROC INFO PF5->INTRNL CLM PF6->RET PF7->PRV SKL CLM PF8->NXT SKL CLM

PF10->PREV MENU PF11->DIAG INFO PF12->IND PROV INFO PF13->BASIC CLM

```
MDCLM05              SC DHHS - SKELETAL HIC CLAIM                    11/01/06
 CLAIM CTL NO  0533400747812000A  RECIPIENT NO  9780275057          2 OF     3
 NAME  LISA            J  MARTIN                                TPL INDICATOR  N
 PROV NAME  SPARTANBURG OB-GYN PA       PROV NO  PA1854        THIRD PARTY
 ADDRESS    853 N CHURCH ST STE 700     PROV TYPE  21
            SPARTANBURG             SC
 ZIP CODE   29303-3098                  TELEPHONE 864-560-7006
 CK DATE  05/12/06  AMT PD         $28.70  PRIM DIAG   V25.49  SEC DIAG
    SUBFILES  *P           PRIOR AUTH               THIRD PARTY AMT        $.00

 SEL   LINE  DATE OF  PLACE   PROC   PROC INDIV  PRAC UNITS VIS FUND    AMOUNT
        NO   SERVICE   SER    CODE   MOD  PROV    SP       REMB CODE     PAID
  _     01  11/28/05  11 (3)  99212  000  199706  27   001 AMB   BC       $28.70

 TOTAL CLAIM CHARGE:     $58.00                  CARRIER 1:      CARRIER 2:
*** MARK SELECTION(S) AND PRESS APPROPRIATE PFKEY FOR DETAIL ***
 ENTER->PROC INFO  PF5->INTRNL CLM  PF6->RET  PF7->PRV SKL CLM  PF8->NXT SKL CLM
 PF10->PREV MENU   PF11->DIAG INFO   PF12->IND PROV INFO   PF13->BASIC CLM
```

```
MDCLM05              SC DHHS - SKELETAL HIC CLAIM                    11/01/06
 CLAIM CTL NO  0534608307013300A  RECIPIENT NO  9780275057          3 OF     3
 NAME  LISA           J  MARTIN                              TPL INDICATOR  N
 PROV NAME  SPARTANBURG OB-GYN PA       PROV NO  PA1854       THIRD PARTY
 ADDRESS    853 N CHURCH ST STE 700     PROV TYPE  21
            SPARTANBURG             SC
 ZIP CODE   29303-3098                  TELEPHONE 864-560-7006
 CK DATE  05/26/06  AMT PD        $266.51  PRIM DIAG   V25.2   SEC DIAG
     SUBFILES  *P           PRIOR AUTH              THIRD PARTY AMT        $.00

 SEL   LINE  DATE OF  PLACE   PROC   PROC INDIV  PRAC UNITS VIS FUND    AMOUNT
        NO   SERVICE   SER    CODE   MOD  PROV    SP       REMB CODE     PAID
  _     01  12/02/05  22 (2)  58670  000  199706  27   001 100%  BD      $266.51




 TOTAL CLAIM CHARGE:  $1,500.00                  CARRIER 1:      CARRIER 2:
*** MARK SELECTION(S) AND PRESS APPROPRIATE PFKEY FOR DETAIL ***
 ENTER->PROC INFO  PF5->INTRNL CLM  PF6->RET  PF7->PRV SKL CLM  PF8->NXT SKL CLM
 PF10->PREV MENU   PF11->DIAG INFO   PF12->IND PROV INFO   PF13->BASIC CLM
```

LEGISLATIVE LOG #	0302		
LEGISLATOR/INQUIRER	Senator Robert W. Hayes, Jr.		
CONSTITUENT	Lisa Joy Martin		
SSN	368-25-0542		
BC ASSIGNED LOG	Jacobs		
DATE REC'D BY AGENCY	10/12/2006	***LOG LETTER DUE DATE***	10/19/2006
DATE DRAFT DUE GR	10/18/2006	***DATE REFERRED TO BC***	10/13/2006

Brief Description of Issue/Problem	Date	Staff Person	Phone #	Action Taken
The case was approvecd in error. The client did not meet the 5 yr/ 40 quarter criteria. When the worker found the error, they reversed the eligibility instead of giving a 10 day notice , since the error was our fault.	10/13/2006	Jan	8-2502	Jacobs box.
	10/13/2006	Jill	8-3936	Gave to mark to distribute (1:20pm)
	10/13/2006	Jenny	8-3965	Printed MEDS sheets, portal notice
	10/16/2006	Jenny	8-3965	Supervisor, Tammy Douglas out all week. Spoke with Jean Richardson and Rosetta Evans. Case closed out due to not meeting the 5yr/40 quarter criteria. If 10 day notice was done it would have ended on 1/1/06. MEDS is not showing any eligibility for this BG . Per Avis Newton in MEDS User Services, request was sent to them on 11/29/05 requesting that the eligibility be taken out of the system
	10/16/2006	Jenny	8-3965	Spoke with Betty Moses. She said we need to go back and give them coverage for 9/1/05-1/1/06 since the mistake was clearly our fault.
	10/16/2006	Jenny	8-3965	Requested worker, Romie Bostick to complete a MEDS correction sheet and notify me once it was faxed. She said she would send first thing in the morning.
	10/16/2006	Jenny	8-3965	Spoke with Margaret Riley (hospital services) and Chris Lykes (physician services). Most of the bills in question have already been paid by Medicaid. They said the doctors/hospitals would have to contact them directly if there are other bills that have not been paid. Left a message for Ms. Martin.
	10/17/2006	Jenny	8-3965	Bryan will contact Sen. Hayes office. No letter will go out to them. Left another message for Ms. Martin.
	10/18/2006	Jenny	8-3965	Had eligibility worker, Romie Bostick complete the form for retroactive coverage to send with letter for billing purposes.
	10/18/2006	Jenny	8-3965	To Alicia
	10/19/2006	Jill	8-3936	To 14th Floor (11:45am)
	10/19/2006	Jan	8-2502	Reviewed and to Gary
	10/20/2006	Jan	8-2502	Returned to Alicia. Gary wants to discuss.

"CONFIDENTIAL INFORMATION ENCLOSED"

Faxed form 945
George Brown Associates
Surgery Center at Pelham

DATE: 10/24/06

TO: Robert Brown
Telephone #:
Fax #: 704-844-8779

FROM: Jenny Dabbs

Total Number of Pages Transmitted: 2 (Including Cover Sheet)

COMMENTS: (Lisa Martin)
Regarding account # 1940771-4. Date of service was 12/12/05. Please resubmit the claim. Client has retro coverage.

Bureau Name
P. O. Box 8206 Columbia South Carolina 29202-8206
Enter Telephone Number Fax Enter Fax Number

Rev: 4/03

TRANSACTION REPORT

Transmission
Transaction(s) completed

NO.	TX DATE/TIME	DESTINATION	DURATION	PGS.	RESULT	MODE
91	OCT. 24 14:01	9170484487796	0° 00' 31"	002	OK	N ECM

OCT-24-06 (TUE) 14:02 CLTC SUMTER TEL:803 905 1987 P. 001

South Carolina Department of Health and Human Services

Verification of Retroactive Medicaid

Date: 10/18/06

To: Lisa J. Martin
632 Taylor Street
Rock Hill, SC 29730

Re: Lisa J. Martin

Medicaid Number: 9780275057

Retroactive Medicaid coverage was entered into the Department of Health and Human Services computer system for the above-named individual on the following date: 10/18/06.

\# The retroactive period began on the following date: September 1, 2005.

* The retroactive period ended on the following date: January 1, 2006.

Please be reminded that all bills must be submitted within six (6) months of the individual's eligibility determination or one (1) year from the date of service delivery, whichever is later.

Jamie C. Bostick
Medicaid Eligibility Worker

803-898-3016
Telephone Number

* This coverage is under the Family Planning Program and pays for services related to F.P. only.

DHHS Form 945 (May 2004)

WEB-1 Case Details

Case Administration
Initial Verification
Additional Verification
View Cases
User Administration
Change Password
Change Profile
Reports
View Reports

Initial Verification

Alien Number: 078470240 **Benefits:** Medicaid

Initiated By: FHAR1332 **Initiated On:** 08/18/2005

Initial Verification Results

Last Name:	MARTIN	**First Name**	
Middle Initial:	J	**COA:**	
Country:	CANAD - CANADA	**Date of Bir**	
Date of Entry:	01/30/2001	**EAD Expir Date:**	
System Response:	LAWFUL PERMANENT RESIDENT-EMPLOYMENT A		

Print Case Details | Request Additional Verification

* = required entry

5yrs/40 quarters was not met.

should get coverage through 1/1/06 for 10 day notice.
Error was our fault.

South Carolina Medicaid Program
Notice that Medicaid Coverage Will End

STATE OFFICE COUNTY DHHS
P. O. Box 100101
Columbia SC 29202-0000

Date: **11/30/2005**
Worker Name:
ROMIE BOSTICK
Telephone: **803 898-3016**
BG #: **28958914**
HH #: **101076312**
47 RBOST

LISA J MARTIN
201 POWELL MILL RD
APT G201
SPARTANBURG SC 29301

Medicaid coverage for the people listed below will end on: **09/01/2005**

Beneficiary name:
LISA J. MARTIN

Beneficiary Medicaid ID#:
9780275057

Reasons: Medicaid coverage will end because:
You have not met eligibility rules.

You may get a copy of the manual or policy information that requires your case to be closed from your worker. Manual/policy reference supporting this action:
101.09.04

You may qualify for Medicaid under other programs if there have been changes in your family, health or income since your last application or review. If there have been changes that we do not know about, you should re-apply.

To re-apply you can do one of the following:

- Contact a Medicaid eligibility worker in the county where you live.
- Call 1-888-549-0820 and ask that a Medicaid application be mailed to you. This is a free call.
- Use the computer to get an application from our website at www.dhhs.state.sc.us.

If the reason shown above states that your Medicaid coverage will stop because of "Failure to Return Review Form" AND you have not received a review form or have already returned your review form, please contact your worker right away.

Fair Hearing

If you feel your case has been closed in error, you may ask for a fair hearing before the South Carolina Department of Health and Human Services.

- To ask for a fair hearing, send a request in writing, along with a copy of this letter, within 30 days to your worker.
- You can hire an attorney to help you or you can have someone come to the hearing and speak for you.
- If you request a hearing within 10 days of the date on this letter, you can ask in your request that your Medicaid coverage continue until a final decision is made by the hearing officer. However, if the hearing officer rules that the decision to close your case was correct, you will be required to pay back any Medicaid benefits you received while your case was being reviewed.

From: Jan Polatty
To: Bryan Kost; Jennifer Dabbs
Date: 10/17/2006 4:09 PM
Subject: Re: Log # 0302

CC: Denise Epps

I agree.....

Bryan, How about if I copy you on the constituent letter for you to use in your contact. Thanks, Jan

>>> Jennifer Dabbs 10/17/06 2:47 PM >>>
I have prepared a written response for Ms. Martin. (Will send to Alicia tomorrow) Senator Hayes office does not request that we notify them in writing. Since we are trying to get away from legislative letters when we don't have the HIPAA form completed, I thought you might want to contact his office and let them know we are assisting Ms. Martin rather than doing a letter. Since I don't have the HIPAA form, I really wouldn't be able to say anything other than the fact that we are addressing her concerns. How do you want to handle this? Thanks!

Jennifer Dabbs
Supervisor, Division of Constituent Services
Bureau of Eligibility Policy & Oversight
(803) 898-3965
(803) 255-8350 FAX
lynchjen@scdhhs.gov

From: Bryan Kost
To: Jennifer Dabbs
Date: 10/17/2006 3:07 PM
Subject: Re: Log # 0302- Sen. Hayes

Hi:
I'd be happy to call his admin. lady and let her know. I'll await the final letter, though, just so I have a sense of what I'm talking about. Thanks!

Bryan Kost
DHHS Public Information
803.898.2865
cell- 429.3201
kostbr@scdhhs.gov

>>> Jennifer Dabbs 10/17/2006 2:47 PM >>>
I have prepared a written response for Ms. Martin. (Will send to Alicia tomorrow) Senator Hayes office does not request that we notify them in writing. Since we are trying to get away from legislative letters when we don't have the HIPAA form completed, I thought you might want to contact his office and let them know we are assisting Ms. Martin rather than doing a letter. Since I don't have the HIPAA form, I really wouldn't be able to say anything other than the fact that we are addressing her concerns. How do you want to handle this? Thanks!

Jennifer Dabbs
Supervisor, Division of Constituent Services
Bureau of Eligibility Policy & Oversight
(803) 898-3965
(803) 255-8350 FAX
lynchjen@scdhhs.gov

555-0089719
MARTIN, LISA J
06/18/1968

✓ initially received 9/13/2005

- DHHS USE ONLY -
FAMILY SIZE
INCOME
DATE RECEIVED

Brian Carroll

1. Your Name 998027505 7 natalig (First / Middle / Last) Telephone: 864 574 1311 (Area Code)

Home Address 201 Powell Mill Rd Apt G201 (Street) Spartanburg (City) SC (State) 29301 (Zip Code) County: 42

2. Tell us information about yourself first and then about the family members who live with you:
(You only need to provide Social Security Number or citizenship information for yourself. If you are not a U.S. Citizen, please provide a copy of your Immigration and Naturalization Service (INS) documents.)

1. Lisa Martin	(APPLICANT)	6/18/68	F	B	Yes	yes	D	367250542
2. Kiara Taylor	Daughter	4/10/93	F	B		yes	S	
3.								
4.								
5.								

3. Do you or anyone in your family have income from work or any other source? [✓] YES [ ] NO If yes, complete the following:

1. Lisa Martin	Job	1396
2.		

4. Do you or your parents pay for child care? [ ] YES [✓] NO If yes, complete the following:

1.	2.	3.

5. Do you have health insurance that pays for Family Planning? [ ] YES [✓] NO If yes, give:
Name of Company _____, Policy Number _____ and Insured's Name _____

6. Have you received Family Planning services during the last three months? [✓] YES [ ] NO If yes, which months Retro 07/25/05
If yes, was your income the same those months as it is now? [✓] YES [ ] NO If no, what was it? _____

7. Do you have a *Partners for Health* Medicaid card in your possession? [ ] YES [✓] NO

8. Have you had a permanent sterilization procedure? [ ] YES [✓] NO
If you have had a permanent sterilization procedure, you are not eligible for Family Planning S...

JAN 23 PM 4:11 DHHS 10 28

9. What is your primary language? [✓] ENGLISH [ ] SPANISH [ ] KOREAN [ ] OTHER _____

~~THE FOLLOWING STATEMENTS EXPLAIN YOUR RIGHTS AND RESPONSIBILITIES. IF YOU DO NOT UNDERSTAND SOME OF THE STATEMENTS, YOU SHOULD DISCUSS THE STATEMENT(S) WITH THE WORKER DURING THE INTERVIEW. YOU ARE RESPONSIBLE FOR GIVING COMPLETE AND ACCURATE INFORMATION.~~

- I UNDERSTAND THAT I MUST REPORT ANY AND ALL CHANGES IN MY INCOME, LIVING ARRANGEMENTS OR OTHER INFORMATION WHICH WILL AFFECT MY FAMILY PLANNING SERVICES WITHIN TEN (10) DAYS OF THE DATE OF THE CHANGE(S). I UNDERSTAND THAT FAILURE TO REPORT PROMPTLY IS A CRIME UNDER STATE LAW FOR WHICH I CAN BE TAKEN TO COURT.
- I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION ON ME TO DHHS. A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
- I UNDERSTAND THAT I SHALL FURNISH MY SOCIAL SECURITY NUMBER TO THE DHHS OR APPLY FOR A SOCIAL SECURITY NUMBER IF I DO NOT HAVE ONE.
- I UNDERSTAND THAT MY CASE RECORD IS CONFIDENTIAL AND NO INFORMATION WILL BE RELEASED FROM IT UNLESS PROPERLY AUTHORIZED BY ME OR AS PROVIDED FOR UNDER STATE/FEDERAL LAWS. HOWEVER, INFORMATION ABOUT MY ELIGIBILITY MAY BE SHARED TO HELP ME GET OTHER BENEFITS.
- I UNDERSTAND THAT ANY INFORMATION I HAVE GIVEN IS SUBJECT TO BEING REVIEWED AND VERIFIED BY DHHS AND DHEC. ALSO, I UNDERSTAND THAT I MUST COOPERATE FULLY WITH STATE AND FEDERAL WORKERS IF MY CASE IS SELECTED FOR A COMPLETE REVIEW.
- I UNDERSTAND THAT THIS APPLICATION WILL BE CONSIDERED WITHOUT REGARD TO RACE, COLOR, SEX, AGE, HANDICAP, RELIGION, NATIONAL ORIGIN OR POLITICAL BELIEF.
- TO FILE A COMPLAINT OF DISCRIMINATION, CONTACT USDA OR HHS. WRITE USDA, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 326-W, WHITTEN BUILDING, 1400 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20250-9410 OR CALL (202) 720-5964 (VOICE AND TDD). WRITE HHS, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 506-F, 200 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20201 OR CALL (202) 619-0403 (VOICE) OR (202) 619-3257 (TDD). USDA AND HSS ARE EQUAL OPPORTUNITY PROVIDERS AND EMPLOYERS.
- I UNDERSTAND THAT I MAY REQUEST A HEARING IF I AM NOT SATISFIED WITH THE ACTION TAKEN ON MY CASE OR IF I FEEL THAT I HAVE BEEN DISCRIMINATED AGAINST.
- I UNDERSTAND THAT BY APPLYING FOR FAMILY PLANNING I AM ASSIGNING MY RIGHTS TO ANY PAYMENTS FOR FAMILY PLANNING SERVICES TO THE STATE.

I CERTIFY THAT I HAVE READ OR HAD READ TO ME ALL THE STATEMENTS ON THIS FORM AND THAT THE INFORMATION GIVEN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF I HAVE DELIBERATELY GIVEN ANY FALSE INFORMATION OR HAVE WITHHELD ANY INFORMATION REGARDING MY SITUATION, I AM LIABLE FOR PROSECUTION FOR FRAUD AND/OR PERJURY.

[redacted]

APPLICANT'S SIGNATURE [signature] Date 7/25/05

PARENT'S (OR GUARDIAN) SIGNATURE (required if applicant is under 16) _____ Date _____

I have reviewed the statements on this form, a listing of community health centers, and discussed the importance of getting primary care services with the applicant/recipient.

Worker's signature Patricia A. Mullis Location 4201 Telephone 864-596-2227 Date 7/25/05

MAIL APPLICATIONS TO: DHHS Division of Central Eligibility Processing
P.O. Box 100101 Columbia, South Carolina 29202-3101
Questions: 1-888-549-0820

555-0089719
Family Plan MARTIN, LISA J
6/18/1968

- DHHS USE ONLY -

FAMILY SIZE
INCOME LIMIT
FAMILY INCOME
DATE RECEIVED
EFFECTIVE DATE
APPROVAL/DENIAL DATE

1. Tell us who you are and where you live:

Your Name ___ LISA J MARTIN

Home Address _ 201 POWELL MILL RD APTG201
SPARTANBURG, SC 29301-

First Middle Last

Telephone: 468 574-8577
Area Code

State Zip Code

County: 42

2. Tell us information about yourself first and then about the family members who live with you:
(You only need to provide Social Security Number or citizenship information for yourself. If you are not a U.S. Citizen, please provide a copy of your Immigration and Naturalization Service (INS) documents.)

NAME	RELATIONSHIP	BIRTHDATE	SEX	RACE	US CITIZEN?	SC RESIDENT?	MARITAL STATUS	SOCIAL SECURITY NUMBER
LISA J MARTIN	(APPLICANT)	6/18/68	F	B	YES	YES	S	368235242
2.								
3.								
4.								
5.								

3. Do you or anyone in your family have income from work or any other source? [ ] YES [X] NO If yes, complete the following:

NAME OF PERSON WHO GETS THE INCOME	SOURCE OF INCOME	GROSS MONTHLY INCOME
1.		
2.		

3A - DHHS/DHEC USE ONLY
Gross Earned Income
Standard Deduction
Child Care Deduction
Net Earned Income
30% Unearned Income
Family Income

4. Do you or your parents pay for child care? [ ] YES [X] NO If yes, complete the following:

NAME OF CHILD(REN) RECEIVING CARE		
1.	2.	3.

5. Do you have health insurance that pays for Family Planning? [ ] YES [X] NO If yes, give:
Name of Company _____, Policy Number _____ and Insured's Name _____

6. Have you received Family Planning services during the last three months? [X] YES [ ] NO If yes, which months 9/8/05
If yes, was your income the same those months as it is now? [X] YES [ ] NO If no, what was it? _____

7. Do you have a *Partners for Health* Medicaid card in your possession? [ ] YES [X] NO

8. Have you had a permanent sterilization procedure? [ ] YES [X] NO
If you have had a permanent sterilization procedure, you are not eligible for Family Planning Services.

SEP 1 2005
DHEC 0920 4 3 25

9. What is your primary language? [X] ENGLISH [ ] SPANISH [ ] KOREAN [ ] OTHER _____

THE FOLLOWING STATEMENTS EXPLAIN YOUR RIGHTS AND RESPONSIBILITIES. IF YOU DO NOT UNDERSTAND SOME OF THE STATEMENTS, YOU SHOULD DISCUSS THE STATEMENT(S) WITH THE WORKER DURING THE INTERVIEW. YOU ARE RESPONSIBLE FOR GIVING COMPLETE AND ACCURATE INFORMATION.

- **I UNDERSTAND THAT I MUST REPORT ANY AND ALL CHANGES IN MY INCOME, LIVING ARRANGEMENTS OR OTHER INFORMATION WHICH WILL AFFECT MY FAMILY PLANNING SERVICES WITHIN TEN (10) DAYS OF THE DATE OF THE CHANGE(S). I UNDERSTAND THAT FAILURE TO REPORT PROMPTLY IS A CRIME UNDER STATE LAW FOR WHICH I CAN BE TAKEN TO COURT.**
- **I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION ON ME TO DHHS. A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.**
- **I UNDERSTAND THAT I SHALL FURNISH MY SOCIAL SECURITY NUMBER TO THE DHHS OR APPLY FOR A SOCIAL SECURITY NUMBER IF I DO NOT HAVE ONE.**
- **I UNDERSTAND THAT MY CASE RECORD IS CONFIDENTIAL AND NO INFORMATION WILL BE RELEASED FROM IT UNLESS PROPERLY AUTHORIZED BY ME OR AS PROVIDED FOR UNDER STATE/FEDERAL LAWS. HOWEVER, INFORMATION ABOUT MY ELIGIBILITY MAY BE SHARED TO HELP ME GET OTHER BENEFITS.**
- **I UNDERSTAND THAT ANY INFORMATION I HAVE GIVEN IS SUBJECT TO BEING REVIEWED AND VERIFIED BY DHHS AND DHEC. ALSO, I UNDERSTAND THAT I MUST COOPERATE FULLY WITH STATE AND FEDERAL WORKERS IF MY CASE IS SELECTED FOR A COMPLETE REVIEW.**
- **I UNDERSTAND THAT THIS APPLICATION WILL BE CONSIDERED WITHOUT REGARD TO RACE, COLOR, SEX, AGE, HANDICAP, RELIGION, NATIONAL ORIGIN OR POLITICAL BELIEF.**
- **TO FILE A COMPLAINT OF DISCRIMINATION, CONTACT USDA OR HHS. WRITE USDA, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 326-W, WHITTEN BUILDING, 1400 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20250-9410 OR CALL (202) 720-5964 (VOICE AND TDD). WRITE HHS, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 506-F, 200 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20201 OR CALL (202) 619-0403 (VOICE) OR (202) 619-3257 (TDD). USDA AND HSS ARE EQUAL OPPORTUNITY PROVIDERS AND EMPLOYERS.**
- **I UNDERSTAND THAT I MAY REQUEST A HEARING IF I AM NOT SATISFIED WITH THE ACTION TAKEN ON MY CASE OR IF I FEEL THAT I HAVE BEEN DISCRIMINATED AGAINST.**
- **I UNDERSTAND THAT BY APPLYING FOR FAMILY PLANNING I AM ASSIGNING MY RIGHTS TO ANY PAYMENTS FOR FAMILY PLANNING SERVICES TO THE STATE.**

I CERTIFY THAT I HAVE READ OR HAD READ TO ME ALL THE STATEMENTS ON THIS FORM AND THAT THE INFORMATION GIVEN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF I HAVE DELIBERATELY GIVEN ANY FALSE INFORMATION OR HAVE WITHHELD ANY INFORMATION REGARDING MY SITUATION, I AM LIABLE FOR PROSECUTION FOR FRAUD AND/OR PERJURY.

DHEC USE ONLY - CERTIFICATION

I request that payment of Medicare/Medicaid or other Third Party Insurance benefits be made on behalf of the South Carolina Department of Health and Environmental Control for services provided me. DHEC may exchange medical or other confidential information necessary for the Center for Medicare and Medicaid Services or its agents to process claims for these benefits for related services. I also agree to participate in treatment plans, assignment of insurance, Medicaid or Medicaid HMO to DHEC for services provided. I understand that my participation in payment for services is determined by specific program guidelines.

APPLICANT'S SIGNATURE [signature] Date 9/8/05

PARENT'S (OR GUARDIAN) SIGNATURE (required if applicant is under 16) _____ Date _____

I have reviewed the statements on this form, a listing of community health centers, and discussed the importance of getting primary care services with the applicant/recipient.

Worker's signature [signature] Location 401 Telephone (864) 596-2727 Date 9/8/05

MAIL APPLICATIONS TO: DHHS Division of Central Eligibility Processing
P.O. Box 100101 Columbia, South Carolina 29202-3101
Questions: 1-888-549-0820

DHHS FORM 400 (012/04)

Family Planning Application

555-0089719
MARTIN, LISA J
06/18/1968

- DHHS USE ONLY -

FAMILY SIZE	DATE RECEIVED
INCOME LIMIT	EFFECTIVE DATE
FAMILY INCOME	APPROVAL/DENIAL DATE

1. Your Name _____ (First / Middle / Last) Telephone: 864 504 1311 (Area Code)

Home Address 201 Powell Mill Rd Apt G201 (Street) Spartanburg (City) SC (State) 29301 (Zip Code) County: 42

2. Tell us information about yourself first and then about the family members who live with you:
(You only need to provide Social Security Number or citizenship information for yourself. If you are not a U.S. Citizen, please provide a copy of your Immigration and Naturalization Service (INS) documents.)

NAME	RELATIONSHIP	BIRTHDATE	SEX	RACE	US CITIZEN?	SC RESIDENT?	MARITAL STATUS	SOCIAL SECURITY NUMBER
1. Lisa Martin	(APPLICANT)	6/18/68	F	B	yes	yes	D	362250542
2. Kiara Taylor	Daughter	4/10/93	F	B	yes	yes	S	574-19-5992
3.								
4.								
5.								

3. Do you or anyone in your family have income from work or any other source? [✓] YES [ ] NO If yes, complete the following:

NAME OF PERSON WHO GETS THE INCOME	SOURCE OF INCOME	GROSS MONTHLY INCOME
1. Lisa Martin	Job	1396
2.		

3A - DHHS/DHEC USE ONLY

Gross Earned Income	= 1396
Standard Deduction	- 100
Child Care Deduction	- 290
Net Earned Income	= 1006
Gross Unearned Income	+ 0
Family Income	= 1296

4. Do you or your parents pay for child care? [ ] YES [✓] NO If yes, complete the following:

NAME OF CHILD(REN) RECEIVING CARE		
1.	2.	3.

5. Do you have health insurance that pays for Family Planning? [ ] YES [✓] NO If yes, give:
Name of Company _____, Policy Number _____ and Insured's Name _____

6. Have you received Family Planning services during the last three months? [✓] YES [ ] NO If yes, which months Petro 07/25/05
If yes, was your income the same those months as it is now? [✓] YES [ ] NO If no, what was it? _____

7. Do you have a *Partners for Health* Medicaid card in your possession? [ ] YES [✓] NO

8. Have you had a permanent sterilization procedure? [ ] YES [✓] NO
If you have had a permanent sterilization procedure, you are not eligible for Family Planning Services.

JUL 27 2005 DHHS 08 22 18

9. What is your primary language? [✓] ENGLISH [ ] SPANISH [ ] KOREAN [ ] OTHER _____

THE FOLLOWING STATEMENTS EXPLAIN YOUR RIGHTS AND RESPONSIBILITIES. IF YOU DO NOT UNDERSTAND SOME OF THE STATEMENTS, YOU SHOULD DISCUSS THE STATEMENT(S) WITH THE WORKER DURING THE INTERVIEW. YOU ARE RESPONSIBLE FOR GIVING COMPLETE AND ACCURATE INFORMATION.

- **I UNDERSTAND THAT I MUST REPORT ANY AND ALL CHANGES IN MY INCOME, LIVING ARRANGEMENTS OR OTHER INFORMATION WHICH WILL AFFECT MY FAMILY PLANNING SERVICES WITHIN TEN (10) DAYS OF THE DATE OF THE CHANGE(S). I UNDERSTAND THAT FAILURE TO REPORT PROMPTLY IS A CRIME UNDER STATE LAW FOR WHICH I CAN BE TAKEN TO COURT.**
- **I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION ON ME TO DHHS. A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.**
- **I UNDERSTAND THAT I SHALL FURNISH MY SOCIAL SECURITY NUMBER TO THE DHHS OR APPLY FOR A SOCIAL SECURITY NUMBER IF I DO NOT HAVE ONE.**
- **I UNDERSTAND THAT MY CASE RECORD IS CONFIDENTIAL AND NO INFORMATION WILL BE RELEASED FROM IT UNLESS PROPERLY AUTHORIZED BY ME OR AS PROVIDED FOR UNDER STATE/FEDERAL LAWS. HOWEVER, INFORMATION ABOUT MY ELIGIBILITY MAY BE SHARED TO HELP ME GET OTHER BENEFITS.**
- **I UNDERSTAND THAT ANY INFORMATION I HAVE GIVEN IS SUBJECT TO BEING REVIEWED AND VERIFIED BY DHHS AND DHEC. ALSO, I UNDERSTAND THAT I MUST COOPERATE FULLY WITH STATE AND FEDERAL WORKERS IF MY CASE IS SELECTED FOR A COMPLETE REVIEW.**
- **I UNDERSTAND THAT THIS APPLICATION WILL BE CONSIDERED WITHOUT REGARD TO RACE, COLOR, SEX, AGE, HANDICAP, RELIGION, NATIONAL ORIGIN OR POLITICAL BELIEF.**
- **TO FILE A COMPLAINT OF DISCRIMINATION, CONTACT USDA OR HHS. WRITE USDA, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 326-W, WHITTEN BUILDING, 1400 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20250-9410 OR CALL (202) 720-5964 (VOICE AND TDD). WRITE HHS, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 506-F, 200 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20201 OR CALL (202) 619-0403 (VOICE) OR (202) 619-3257 (TDD). USDA AND HSS ARE EQUAL OPPORTUNITY PROVIDERS AND EMPLOYERS.**
- **I UNDERSTAND THAT I MAY REQUEST A HEARING IF I AM NOT SATISFIED WITH THE ACTION TAKEN ON MY CASE OR IF I FEEL THAT I HAVE BEEN DISCRIMINATED AGAINST.**
- **I UNDERSTAND THAT BY APPLYING FOR FAMILY PLANNING I AM ASSIGNING MY RIGHTS TO ANY PAYMENTS FOR FAMILY PLANNING SERVICES TO THE STATE.**

I CERTIFY THAT I HAVE READ OR HAD READ TO ME ALL THE STATEMENTS ON THIS FORM AND THAT THE INFORMATION GIVEN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF I HAVE DELIBERATELY GIVEN ANY FALSE INFORMATION OR HAVE WITHHELD ANY INFORMATION REGARDING MY SITUATION, I AM LIABLE FOR PROSECUTION FOR FRAUD AND/OR PERJURY.

DHEC USE ONLY - CERTIFICATION

I request that payment of Medicare/Medicaid or other Third Party Insurance benefits be made on behalf of the South Carolina Department of Health and Environmental Control for any services provided me. DHEC may exchange medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services or its agents for the purpose of determining these benefits for related services. I also agree to participate in treatment plans, assignment of insurance, Medicaid or Medicare benefits to DHEC for services rendered, and co-payments in payment for services as determined by specific program guidelines.

APPLICANT'S SIGNATURE [signature] Date 7/25/05

PARENT'S (OR GUARDIAN) SIGNATURE (required if applicant is under 16) _____ Date _____

I have reviewed the statements on this form, a listing of community health centers, and discussed the importance of getting primary care services with the applicant/recipient.

Worker's signature Patricia A Mullis Location 4201 Telephone 864-596-2222 Date 7/25/05

MAIL APPLICATIONS TO: DHHS Division of Central Eligibility Processing
P.O. Box 100101 Columbia, South Carolina 29202-3101
Questions: 1-888-549-0820

DHHS FORM 400 (012/04)

Family Planning Application

555-0089719
MARTIN, LISA J
06/18/1968

- DHHS USE ONLY -

FAMILY SIZE	DATE RECEIVED
INCOME LIMIT	EFFECTIVE DATE
FAMILY INCOME	APPROVAL/DENIAL DATE

1.

Your Name _____ Telephone: 864 5041311
First Middle Last Area Code

Home Address 201 Powell Mill Rd Apt G201 County: 42
Street City State Zip Code
Spartanburg SC 29301

2. Tell us information about yourself first and then about the family members who live with you:
(You only need to provide Social Security Number or citizenship information for yourself. If you are not a U.S. Citizen, please provide a copy of your Immigration and Naturalization Service (INS) documents.)

NAME	RELATIONSHIP	BIRTHDATE	SEX	RACE	US CITIZEN	SC RESIDENT	MARITAL STATUS	SOCIAL SECURITY NUMBER
1. Lisa Martin	(APPLICANT)	6/18/68	F	B	Yes	yes	D	368250542
2. Ciara Taylor	Daughter	4/10/93	F	B	Yes	yes	S	378-12-5998
3.								
4.								
5.								

3. Do you or anyone in your family have income from work or any other source? [✓] YES [ ] NO If yes, complete the following:

NAME OF PERSON WHO GETS THE INCOME	SOURCE OF INCOME	GROSS MONTHLY INCOME
1. Lisa Martin	Job	1396
2.		

DHHS/DHEC USE ONLY	
Gross Earned Income	1396
Standard Deduction	75
Child Care Deduction	
Net Earned Income	1321
Gross Unearned Income	
Family Income	1296

4. Do you or your parents pay for child care? [ ] YES [✓] NO If yes, complete the following:

NAME OF CHILD(REN) RECEIVING CARE		
1.	2.	3.

5. Do you have health insurance that pays for Family Planning? [ ] YES [✓] NO If yes, give:
Name of Company _____, Policy Number _____ and Insured's Name _____

6. Have you received Family Planning services during the last three months? [✓] YES [ ] NO If yes, which months Retro 07/25/05
If yes, was your income the same those months as it is now? [✓] YES [ ] NO If no, what was it? _____

7. Do you have a *Partners for Health* Medicaid card in your possession? [ ] YES [✓] NO

8. Have you had a permanent sterilization procedure? [ ] YES [✓] NO
If you have had a permanent sterilization procedure, you are not eligible for Family Planning Services.

2005 AUG 15 PM 5 03 DHEC-PSI 0068

9. What is your primary language? [✓] ENGLISH [ ] SPANISH [ ] KOREAN [ ] OTHER _____

THE FOLLOWING STATEMENTS EXPLAIN YOUR RIGHTS AND RESPONSIBILITIES. IF YOU DO NOT UNDERSTAND SOME OF THE STATEMENTS, YOU SHOULD DISCUSS THE STATEMENT(S) WITH THE WORKER DURING THE INTERVIEW. YOU ARE RESPONSIBLE FOR GIVING COMPLETE AND ACCURATE INFORMATION.

- **I UNDERSTAND THAT I MUST REPORT ANY AND ALL CHANGES IN MY INCOME, LIVING ARRANGEMENTS OR OTHER INFORMATION WHICH WILL AFFECT MY FAMILY PLANNING SERVICES WITHIN TEN (10) DAYS OF THE DATE OF THE CHANGE(S). I UNDERSTAND THAT FAILURE TO REPORT PROMPTLY IS A CRIME UNDER STATE LAW FOR WHICH I CAN BE TAKEN TO COURT.**
- **I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION ON ME TO DHHS. A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.**
- **I UNDERSTAND THAT I SHALL FURNISH MY SOCIAL SECURITY NUMBER TO THE DHHS OR APPLY FOR A SOCIAL SECURITY NUMBER IF I DO NOT HAVE ONE.**
- **I UNDERSTAND THAT MY CASE RECORD IS CONFIDENTIAL AND NO INFORMATION WILL BE RELEASED FROM IT UNLESS PROPERLY AUTHORIZED BY ME OR AS PROVIDED FOR UNDER STATE/FEDERAL LAWS. HOWEVER, INFORMATION ABOUT MY ELIGIBILITY MAY BE SHARED TO HELP ME GET OTHER BENEFITS.**
- **I UNDERSTAND THAT ANY INFORMATION I HAVE GIVEN IS SUBJECT TO BEING REVIEWED AND VERIFIED BY DHHS AND DHEC. ALSO, I UNDERSTAND THAT I MUST COOPERATE FULLY WITH STATE AND FEDERAL WORKERS IF MY CASE IS SELECTED FOR A COMPLETE REVIEW.**
- **I UNDERSTAND THAT THIS APPLICATION WILL BE CONSIDERED WITHOUT REGARD TO RACE, COLOR, SEX, AGE, HANDICAP, RELIGION, NATIONAL ORIGIN OR POLITICAL BELIEF.**
- **TO FILE A COMPLAINT OF DISCRIMINATION, CONTACT USDA OR HHS. WRITE USDA, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 326-W, WHITTEN BUILDING, 1400 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20250-9410 OR CALL (202) 720-5964 (VOICE AND TDD). WRITE HHS, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 506-F, 200 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20201 OR CALL (202) 619-0403 (VOICE) OR (202) 619-3257 (TDD). USDA AND HSS ARE EQUAL OPPORTUNITY PROVIDERS AND EMPLOYERS.**
- **I UNDERSTAND THAT I MAY REQUEST A HEARING IF I AM NOT SATISFIED WITH THE ACTION TAKEN ON MY CASE OR IF I FEEL THAT I HAVE BEEN DISCRIMINATED AGAINST.**
- **I UNDERSTAND THAT BY APPLYING FOR FAMILY PLANNING I AM ASSIGNING MY RIGHTS TO ANY PAYMENTS FOR FAMILY PLANNING SERVICES TO THE STATE.**

I CERTIFY THAT I HAVE READ OR HAD READ TO ME ALL THE STATEMENTS ON THIS FORM AND THAT THE INFORMATION GIVEN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF I HAVE DELIBERATELY GIVEN ANY FALSE INFORMATION OR HAVE WITHHELD ANY INFORMATION REGARDING MY SITUATION, I AM LIABLE FOR PROSECUTION FOR FRAUD AND/OR PERJURY.

DHEC USE ONLY - CERTIFICATION

I request that payment of Medicare/Medicaid or other Third Party Insurance benefits be made on behalf of the South Carolina Department of Health and Environmental Control for any services provided me. DHEC may exchange medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services or its agents needed to determine these benefits for related services. I also agree to participate in treatment plans, assignment of insurance, Medicaid or Medicare benefits to DHEC for services rendered, prompt billing, and in payment for services as determined by specific program guidelines.

APPLICANT'S SIGNATURE L Martin Date 7/25/05

PARENT'S (OR GUARDIAN) SIGNATURE (required if applicant is under 16) _____ Date _____

I have reviewed the statements on this form, a listing of community health centers, and discussed the importance of getting primary care services with the applicant/recipient.

Worker's signature Patricia A Mullis Location 4/201 Telephone 864-596-2227 Date 7/25/05

MAIL APPLICATIONS TO: DHHS Division of Central Eligibility Processing
P.O. Box 100101 Columbia, South Carolina 29202-3101
Questions: 1-888-549-0820

DHHS FORM 400 (012/04)

```
MEDSVE04 P       S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES   DATE: 08/24/05
MEDSPROD                  SVES QC 40 INQUIRY INFORMATION

SSN: 368-25-0542 NAME: LISA J MARTIN                          RCP NUM: 9780275057
INPUT SSN: 368-25-0542  -----QC 40 INFORMATION---------------------------------
VERIFIED SSN: 368-25-0542   SSA NAME: LISA J MARTIN
STATE CODE: 042    STATE DATA:                                DOB: 06/18/1968
RAILROAD SERVICE:   0   CONDITION CODE:       MIN # QQ:  0   MAX # QQ:  0
--------------------------------COVERAGE PATTERN-------------------------------
1937-NNNN 1938-NNNN 1939-NNNN 1940-NNNN 1941-NNNN 1942-NNNN 1943-NNNN 1944-NNNN
1945-NNNN 1946-NNNN 1947-NNNN 1948-NNNN 1949-NNNN 1950-NNNN 1951-NNNN 1952-NNNN
1953-NNNN 1954-NNNN 1955-NNNN 1956-NNNN 1957-NNNN 1958-NNNN 1959-NNNN 1960-NNNN
1961-NNNN 1962-NNNN 1963-NNNN 1964-NNNN 1965-NNNN 1966-NNNN 1967-NNNN 1968-NNNN
1969-NNNN 1970-NNNN 1971-NNNN 1972-NNNN 1973-NNNN 1974-NNNN 1975-NNNN 1976-NNNN
1977-NNNN 1978-NNNN 1979-NNNN 1980-NNNN 1981-NNNN 1982-NNNN 1983-NNNN 1984-NNNN
1985-NNNN 1986-NNNN 1987-NNNN 1988-NNNN 1989-NNNN 1990-NNNN 1991-NNNN 1992-NNNN
1993-NNNN 1994-NNNN 1995-NNNN 1996-NNNN 1997-NNNN 1998-NNNN 1999-NNNN 2000-CCCC
2001-CCCC 2002-CCCC 2003-CCCN 2004-NNNN 2005-NNNN 2006-NNNN 2007-NNNN 2008-NNNN
2009-NNNN 2010-NNNN 2011-NNNN 2012-NNNN 2013-NNNN 2014-NNNN 2015-NNNN 2016-NNNN
2017-NNNN 2018-NNNN 2019-NNNN 2020-NNNN 2021-NNNN 2022-NNNN 2023-NNNN 2024-NNNN
UPDATED: SYSTEM ID: SVE3000   DATE: 08/20/05                  2025-NNNN
ME909513 SVE_QC40 DATA FOUND
 PF1->HELP  PF6->RETURN PF10->PREV MENU
```

9. What is your primary language? [✓] ENGLISH [ ] SPANISH [ ] KOREAN [ ] OTHER _____

THE FOLLOWING STATEMENTS EXPLAIN YOUR RIGHTS AND RESPONSIBILITIES. IF YOU DO NOT UNDERSTAND SOME OF THE STATEMENTS, YOU SHOULD DISCUSS THE STATEMENT(S) WITH THE WORKER DURING THE INTERVIEW. YOU ARE RESPONSIBLE FOR GIVING COMPLETE AND ACCURATE INFORMATION.

- **I UNDERSTAND THAT I MUST REPORT ANY AND ALL CHANGES IN MY INCOME, LIVING ARRANGEMENTS OR OTHER INFORMATION WHICH WILL AFFECT MY FAMILY PLANNING SERVICES WITHIN TEN (10) DAYS OF THE DATE OF THE CHANGE(S). I UNDERSTAND THAT FAILURE TO REPORT PROMPTLY IS A CRIME UNDER STATE LAW FOR WHICH I CAN BE TAKEN TO COURT.**
- **I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION ON ME TO DHHS. A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.**
- **I UNDERSTAND THAT I SHALL FURNISH MY SOCIAL SECURITY NUMBER TO THE DHHS OR APPLY FOR A SOCIAL SECURITY NUMBER IF I DO NOT HAVE ONE.**
- **I UNDERSTAND THAT MY CASE RECORD IS CONFIDENTIAL AND NO INFORMATION WILL BE RELEASED FROM IT UNLESS PROPERLY AUTHORIZED BY ME OR AS PROVIDED FOR UNDER STATE/FEDERAL LAWS. HOWEVER, INFORMATION ABOUT MY ELIGIBILITY MAY BE SHARED TO HELP ME GET OTHER BENEFITS.**
- **I UNDERSTAND THAT ANY INFORMATION I HAVE GIVEN IS SUBJECT TO BEING REVIEWED AND VERIFIED BY DHHS AND DHEC. ALSO, I UNDERSTAND THAT I MUST COOPERATE FULLY WITH STATE AND FEDERAL WORKERS IF MY CASE IS SELECTED FOR A COMPLETE REVIEW.**
- **I UNDERSTAND THAT THIS APPLICATION WILL BE CONSIDERED WITHOUT REGARD TO RACE, COLOR, SEX, AGE, HANDICAP, RELIGION, NATIONAL ORIGIN OR POLITICAL BELIEF.**
- **TO FILE A COMPLAINT OF DISCRIMINATION, CONTACT USDA OR HHS. WRITE USDA, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 326-W, WHITTEN BUILDING, 1400 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20250-9410 OR CALL (202) 720-5964 (VOICE AND TDD). WRITE HHS, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 506-F, 200 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20201 OR CALL (202) 619-0403 (VOICE) OR (202) 619-3257 (TDD). USDA AND HSS ARE EQUAL OPPORTUNITY PROVIDERS AND EMPLOYERS.**
- **I UNDERSTAND THAT I MAY REQUEST A HEARING IF I AM NOT SATISFIED WITH THE ACTION TAKEN ON MY CASE OR IF I FEEL THAT I HAVE BEEN DISCRIMINATED AGAINST.**
- **I UNDERSTAND THAT BY APPLYING FOR FAMILY PLANNING I AM ASSIGNING MY RIGHTS TO ANY PAYMENTS FOR FAMILY PLANNING SERVICES TO THE STATE.**

I CERTIFY THAT I HAVE READ OR HAD READ TO ME ALL THE STATEMENTS ON THIS FORM AND THAT THE INFORMATION GIVEN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF I HAVE DELIBERATELY GIVEN ANY FALSE INFORMATION OR HAVE WITHHELD ANY INFORMATION REGARDING MY SITUATION, I AM LIABLE FOR PROSECUTION FOR FRAUD AND/OR PERJURY.

DHEC USE ONLY - CERTIFICATION

[redacted] Third Party Insurance benefits be made on behalf of the South Carolina Department of Health and Environmental Control for any [redacted] medical or other confidential information as necessary to the Center for Medicare and Medicaid Services or its agents needed to determine [redacted] agree to participate in treatment plans, assignment of insurance, Medicaid or Medicare benefits to DHEC for services rendered and to participate [redacted] program guidelines.

APPLICANT'S SIGNATURE [signature] Date 7/25/05

PARENT'S (OR GUARDIAN) SIGNATURE (required if applicant is under 16) _____ Date _____

I have reviewed the statements on this form, a listing of community health centers, and discussed the importance of getting primary care services with the applicant/recipient.

Worker's signature Patricia A Mullis Location 4201 Telephone 864-596-2222 Date 7/25/05

MAIL APPLICATIONS TO: DHHS Division of Central Eligibility Processing
P.O. Box 100101 Columbia, South Carolina 29202-3101
Questions: 1-888-549-0820

DHHS FORM 400 (012/04)

Family Planning Application

555-0089719
MARTIN, LISA J
06/18/1968

- DHHS USE ONLY -

FAMILY SIZE	DATE RECEIVED
INCOME LIMIT	EFFECTIVE DATE
FAMILY INCOME	APPROVAL/DENIAL DATE

1. Your Name _____ (First / Middle / Last) Telephone: 864 504 1311 (Area Code)

Home Address 201 Powell Mill Rd Apt G201 (Street) County: 42
Spartanburg (City) SC (State) 29301 (Zip Code)

2. Tell us information about yourself first and then about the family members who live with you:
(You only need to provide Social Security Number or citizenship information for yourself. If you are not a U.S. Citizen, please provide a copy of your Immigration and Naturalization Service (INS) documents.)

	NAME	RELATIONSHIP TO 1ST	BIRTHDATE	SEX	RACE	US CITIZEN?	SC RESIDENT?	MARITAL STATUS	SOCIAL SECURITY NUMBER
1.	Lisa Martin	(APPLICANT)	6/18/68	F	B	Yes	yes	D	368250542
2.	Kiara Taylor	Daughter	4/10/93	F	B	Yes	yes	S	[illegible]
3.									
4.									
5.									

3. Do you or anyone in your family have income from work or any other source? [✓] YES [ ] NO If yes, complete the following:

	NAME OF PERSON WHO EARNED THE INCOME	SOURCE	GROSS MONTHLY INCOME
1.	Lisa Martin	Job	1396
2.			

OFFICE USE ONLY	
Gross Earned Income	1396
Standard Deduction	[illegible]
Child Care Deduction	[illegible]
Net Earned Income	[illegible]
Gross Unearned Income	[illegible]
Family Income	1296

4. Do you or your parents pay for child care? [ ] YES [✓] NO If yes, complete the following:

NAMES OF CHILDREN RECEIVING CARE		
1.	2.	3.

5. Do you have health insurance that pays for Family Planning? [ ] YES [✓] NO If yes, give:
Name of Company _____, Policy Number _____ and Insured's Name _____

6. Have you received Family Planning services during the last three months? [✓] YES [ ] NO If yes, which months retro 7/25/05
If yes, was your income the same those months as it is now? [✓] YES [ ] NO If no, what was it? _____

7. Do you have a *Partners for Health* Medicaid card in your possession? [ ] YES [✓] NO

8. Have you had a permanent sterilization procedure? [ ] YES [✓] NO
If you have had a permanent sterilization procedure, you are not eligible for Family Planning Services.

SEP 12 2005 DHHS 0 8 1 5 02 8 1 3

South Carolina Department of Health and Human Services
Welcomes your application for the
South Carolina Partners for Health Medicaid Program

SCANNED
OCT 12 2005

If you already have Medicaid, you do not need to fill out this form.

Please Print Clearly

1. Tell us who you are and where you live.

Last Name: Martin	First Name: Lisa	M.I.: J	Phone Where We Can Reach You: 864-574-[illegible]
Mailing Address (Include Apartment/Lot Number): 201 Powell Mill Rd. Apt G-201	City: Spartanburg	State: SC	Zip Code: 29301
Street Address, if different (Include Apartment/Lot Number)	City	State	Zip Code

County: Spartanburg

2. Tell us who in your family lives with you. List the person shown in item 1 on the first line below.

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 want Partners for Health Medicaid. However, if you give us your Social Security number, it may help us process your application faster. We only use Social Security numbers to help us verify your income.

Last Name (List spouse, parent(s), and children)	First Name (List spouse, parent(s), and children)	Middle Initial	Check (✓) if this person is applying for Medicaid	(See note above) Social Security Number	Marital Status	Date of Birth	Sex M	Sex F	Race	How is this person related to you?	Is this person pregnant? (See Note 1 below) Yes	Is this person pregnant? (See Note 1 below) No	Is this person disabled? Yes	Is this person disabled? No	Is this person a foster child? Yes	Is this person a foster child? No	Is this person a US Citizen? (See Note 2 below) Yes	Is this person a US Citizen? (See Note 2 below) No	Has this person received medical services in the past 3 months? Yes	Has this person received medical services in the past 3 months? No
Ciara Taylor	Ciara	J	✓	376-19-5992	S	4/10/93		✓	B	Son/daughter		✓		✓		✓		✓		✓
Martin	Lisa	J	✓	368-25-0542	S	6/18/68		✓	B	self	✓		✓			✓		✓		✓

Note 1: Date baby is due: Dec. 16/05 *Provide proof of due date from doctor, nurse, or Health Department for each pregnant woman.*
Note 2: Provide Bureau of Citizenship and Immigration Services (BCIS) documents for each non citizen requesting coverage.

3. Do you pay someone to take care of your child(ren) under 12 and/or of a dependent adult in your home while you work, or do you pay court ordered child support for a child outside your household?

☑ No ☐ Yes ___ *(number of children under age 12 and/or dependent adults for whom you pay for care)*

Name of child/dependent adult	Age	Do you participate in the ABC (childcare) Voucher program?	How much do you pay for this care?	How often do you pay this amount?	Who do you pay? Please give their name and telephone number.

4. Tell us about any health insurance covering anyone for whom you are applying, including Medicaid in another state.
Even if you already have health insurance, you and/or your children can still qualify for Partners for Health Medicaid.

Insurance Company or Employer	Policy Number	Policyholder's Name	Policyholder's SSN	Persons Covered	What type of coverage is this?	How much do you pay per month for this coverage?	Does your employer pay any of this cost?

5. Tell us what language you use most:
☑ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Sign Language ☐ Vietnamese ☐ Other _____

If you are applying for someone who is age 65 or older or disabled, answer #6. If not, you can skip to #7.

6. Tell us how much money your family has in cash or in bank accounts. $ 600.00 Name of bank: BB&T
$ _____ Name of bank: _____

Does anyone in your family own the following?

Asset	Yes?	No?	Who owns it?	Value	Asset	Yes?	No?	Who owns it?	Value
Land other than home				$	Boats/campers/etc.				$
Buildings other than home				$	Life Insurance				$
Cars/trucks	✓		Lisa Martin	$ 3000.00	Other (explain) *such as trusts, IRAs, CDs, lump sums, etc.*				
Stocks/Bonds				$					
Burial plots/funds				$					

7. Tell us how much income your family has. Enter GROSS pay, not take home pay. Enter zero ("0") if you are not working.

Your Income From Employment	Other Parent's Income From Employment *(if living in the home)*
Employer Name and Phone Number	Employer Name and Phone Number
Amount you earn each pay period before taxes: $ _____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Hours worked each pay period _____ Does this employer offer health insurance? ☐ Yes ☐ No How much would it cost you? _____	Amount other parent earns each pay period before taxes: $ _____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Hours worked each pay period _____ Does this employer offer health insurance? ☐ Yes ☐ No How much would it cost you? _____

Other Income	Amount	How often do you get this income?	Which family member gets this income?
Child Support	$		
Alimony	$		
Social Security Payment	$		
Unemployment Benefits	$		
Veterans Benefits	$		
Other (Please explain)	$		

8. ATTACH REQUIRED PROOF. **Check below to tell us what you attached. If you do not send this proof, processing your application may be delayed.**

- ☐ Copies of pay stubs for the last 4 weeks; *or* a letter from my employer that shows last 4 weeks of GROSS pay.
- ☐ A copy of the letter I received telling me 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.
- ☐ I am self-employed and I have attached a copy of my most recent federal income tax form including all schedules.
- ☑ My family has no income.

CHECK WHAT APPLIES BELOW AND ATTACH PROOF:

- ☐ I have attached verification of the childcare/dependent adult expenses (statement from daycare, receipt, etc.).
- ☐ I am applying for someone who is age 65 or older or disabled and have attached proof of resources, listed in #6 on page 2.
- ☑ I have attached BCIS documents for each non-citizen.

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.

9. Does anyone listed on this application already have a plastic SC Partners for Health Medicaid card? ☐ Yes ☑ No

If yes, list their name and Medicaid Health Insurance Number here: _____

10. Take this completed, signed form and required proof to a Medicaid eligibility worker or mail to:

South Carolina Partners for Health Medicaid
Division of Central Eligibility Processing
Post Office Box 100101
1801 Main Street
Columbia, South Carolina 29202-3101

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

Applicant or Authorized Representative must sign to indicate Rights and Responsibilities have been read. If possible, both Applicant and Authorized Representative should sign.

Applicant's Signature: [signature] Authorized Representative's Signature: _____ Date: 8/19/25

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 Medicaid 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 apply for these services now. ☐ Yes ☑ No

Rights and Responsibilities

1. I know that my children under age 19 who are eligible for Partners for Health 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 me and my family 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.

Tell us where you obtained this application Spartanburg Regional Hospital

Primary Individual: lisa martin HH#: 101064729 BG#: 98728261 Application Date: 8/25/05

Budget Group Information

Instructions

	Budget Group Members	Relationship	Income: Wages	Self Employment	SSA	VA	Pension	UCI Benefits	Child Support	Contribution	Interest Dividends	Other Unearned	Disregards: Childcare Paid
	1	Primary											
	2												
Children	3	c											
Children	4												
Children	5												
Children	6												
Children	7												
Children	8												
		Totals	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

	Aid Group Members (Adults)	Resources: Auto, truck	Life Insurance	Checking	Savings	Pre-need Burial	Real Property	Personal Needs	Other Resource
	1								
	2								
	Totals	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Income Calculator

		Check 1	Check 2	Check 3	Check 4	Total	Average per Period	FI Monthly Average	SSI Monthly Average
0	Weekly					0.00	0.000	0.00	0.00
	Bi-Weekly					0.00	0.000	0.00	0.00
	Semi-Monthly					0.00	0.000	0.00	0.00

		Check 1	Check 2	Check 3	Check 4	Total	Average per Period	FI Monthly Average	SSI Monthly Average
0	Weekly					0.00	0.000	0.00	0.00
	Bi-Weekly					0.00	0.000	0.00	0.00
	Semi-Monthly					0.00	0.000	0.00	0.00

Notes and Documentation

Betsy's 2005 budget workbook.xls

lisa martin

BG#: _____

Partners for Healthy Children

Section 1: Computation of Income				
Type of Income	Income of AG Members			
Earned Income	**I**	**O**	**Children**	**Totals**
1 Gross Earned Income	0.00	0.00		0.00
2 Earned Income Disregard	0.00	0.00		0.00
4 Incapacitated Adult Care Paid				0.00
5 Total Disregards	0.00	0.00		0.00
6 Subtotal	0.00	0.00		0.00
Unearned Income				
7 Child Support Payments			0.00	0.00
8 SSA Benefits	0.00	0.00	0.00	0.00
9 VA Benefits	0.00	0.00	0.00	0.00
10 Pension	0.00	0.00	0.00	0.00
11 UCI Benefits	0.00	0.00	0.00	0.00
12 Contributions	0.00	0.00	0.00	0.00
13 Other	0.00	0.00	0.00	0.00
14 Gross Unearned Income	0.00	0.00	0.00	0.00
3 Child Care Deduction	0.00	0.00		0.00
	Net Income			0.00

PHC Eligible

Aid Group	**2**	**Action:**	**Application**
Income Limit	**1,604.00**	**Decision:**	**Approval**
		Eligibility Month:	**August-05**

Eligibility Worker's Signature: B. Caudill

Decision Date: 8/29/05

Processing Time: 4 Day(s)

lisa martin

BG#: _____

Pregnant Woman

Section 1: Computation of Income				
Type of Income	Income of AG Members			
Earned Income	I	O	Children	Totals
1 Gross Earned Income	0.00	0.00		0.00
2 Earned Income Disregard	0.00	0.00		0.00
3 Incapacitated Adult Care Paid				0.00
4 Total Disregards	0.00	0.00		0.00
5 Subtotal	0.00	0.00		0.00
Unearned Income				
6 Child Support Payments			0.00	0.00
7 SSA Benefits	0.00	0.00	0.00	0.00
8 VA Benefits	0.00	0.00	0.00	0.00
9 Pension	0.00	0.00	0.00	0.00
10 UCI Benefits	0.00	0.00	0.00	0.00
11 Contributions	0.00	0.00	0.00	0.00
12 Other	0.00	0.00	0.00	0.00
13 Gross Unearned Income	0.00	0.00	0.00	0.00
14 Child Care Deduction	0.00	0.00		0.00
	Net Income			0.00

Budget Group 3
Income Limit 2,481.00

PW Eligible

BG#: _____

Baby Under 1 (PB)/Family Planning

Section 1: Computation of Income				
Type of Income	Income of AG Members			
Earned Income	I	O	Children	Totals
1 Gross Earned Income	0.00	0.00		0.00
2 Earned Income Disregard	0.00	0.00		0.00
3 Incapacitated Adult Care Paid				0.00
4 Total Disregards	0.00	0.00		0.00
5 Subtotal	0.00	0.00		0.00
Unearned Income				
6 Child Support Payments			0.00	0.00
7 SSA Benefits	0.00	0.00	0.00	0.00
8 VA Benefits	0.00	0.00	0.00	0.00
9 Pension	0.00	0.00	0.00	0.00
10 UCI Benefits	0.00	0.00	0.00	0.00
11 Contributions	0.00	0.00	0.00	0.00
12 Other	0.00	0.00	0.00	0.00
13 Gross Unearned Income	0.00	0.00	0.00	0.00
14 Child Care Deduction	0.00	0.00		0.00
	Net Income			0.00

Budget Group 2
Income Limit 1,978.00

PB Eligible

Action: Application
Retroactive Medicaid: _____

EDC: 12/16/05
Month of Eligibility: August-05

Eligibility Worker's Signature: B. Cavell

Decision Date: 8/29/05
Processing Time: 4 Day(s)

entered the country after 8/22/96.
not eligible.

```
MEDELD01 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 08/29/05
MEDSPROD                MEDICAID ELIGIBILITY DECISION             ACTION:
                  DATES-FROM: 08 / 2005 THRU: __ / ____           PAGE: 2 OF 3
HH NAME:   LISA J MARTIN                                  HH NUMBER: 101064729
BG NUMBER: 98728258          CATEGORY: OCWIPW          ACTION TYPE: MAINTENANC
BG: D  BGP: D                  WORKER: BARTH           ACTION DATE: 08/29/05
   COUNTABLE BG MEMBERS:  2
   COUNTABLE INCOME:          0.00      COUNTABLE RESOURCES:          0.00
       INCOME LIMIT:          0.00      RESOURCE LIMIT:               0.00
            POV-LVL:          +.00 %     HLTH INS PREM:               0.00
   RECURRING INC:      0.00   TOTAL ALLOC:      0.00   OSS AWARD:     0.00
MEETS NON-FINANCIAL?    (Y/N): _      ACT ON DECISION COMPLETE? (Y/N): Y
MEETS INCOME?           (Y/N): _      DECISION ACCEPTED DATE:    08/29/05
MEETS RESOURCES?        (Y/N): _      NEXT REVIEW DATE:          ________
MEETS OTHER CONDITIONS? (Y/N): Y      ANTICIPATED CLOSURE DATE:  08/30/06
REASON(S) FOR DENIAL/CLOSURE/CHANGE:
054 You have not met eligibility rules.
___ ____________________________________________________________________
ELIGIBILITY DECISION APPEALED? (Y/N) _     CONTINUE BENEFITS?       (Y/N): _
APPEAL REQUEST DATE: ________              COUNTY DECISION UPHELD? (Y/N): _
UPDATED: USER ID: BARTH     DATE: 08/29/05  SYSTEM ID: ELD3000  DATE: 08/29/05
ME903071 ACT ON DECISION IS COMPLETE
 1-HELP  3-NEXT SCR  6-RETURN  10-MENU  13-FLD HELP  15-MAKE DECISION
 16-HMS BG DETER  21-PREV HIST  22-NEXT HIST  24-ACT ON DECISION
```

MEDELD02 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 08/29/05
MEDSPROD MEDICAID ELIGIBILITY DECISION ACTION:
DATES-FROM: 08 / 2005 THRU: __ / ____ PAGE: 3 OF 3

HH NAME: LISA J MARTIN HH NUMBER: 101064729
BG NUMBER: 98728258 CATEGORY: OCWIPW ACTION TYPE: MAINTENANC
BG: D BGP: D WORKER: BARTH ACTION DATE: 08/29/05
RCP NAME: LISA J MARTIN RCP NUMBER: 9780275057
PREVIOUS BG: _____ NEW BG: _____ CORRECT RCP NUMBER: _____
IT: _ PING-PONG: _ RETRO: N EXPARTE: N QMB: _ PROT PER DATE: _____

ACTUAL ELIGIBILITY DATES

MEDICAID ---BENEFIT DATES--- BEGIN	END	--MEDICAID+QMB DATES-- BEGIN	END	SERVICE TYPE	REASON CODE 1	REASON CODE 2
					054	

UPDATED: USER ID: BARTH DATE: 08/29/05 SYSTEM ID: ELD3000 DATE: 08/29/05
ME900115 BUDGET GROUP PERIOD INFORMATION FOUND
1-HELP 2-PREV MBR 3-NEXT MBR 5-HMS DET 6-RETURN 10-PREV 11- HH MBRS
15-MD 16-HMS BG DETER 18-HMS INQ 21-HIST- 22-HIST+ 24-AOD

```
MEDELD01 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 08/29/05
MEDSPROD                MEDICAID ELIGIBILITY DECISION             ACTION:
                  DATES-FROM: 08 / 2005 THRU: __ / ____           PAGE: 2 OF 3
HH NAME:   LISA J MARTIN                                  HH NUMBER: 101064729
BG NUMBER: 98728261          CATEGORY: PHC              ACTION TYPE: MAINTENANC
BG: A  BGP: A                  WORKER: BARTH            ACTION DATE: 08/29/05
   COUNTABLE BG MEMBERS:  2
   COUNTABLE INCOME:          0.00      COUNTABLE RESOURCES:          0.00
       INCOME LIMIT:       1604.00      RESOURCE LIMIT:               0.00
            POV-LVL:         +.00 %      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): Y      DECISION ACCEPTED DATE:    08/29/05
MEETS RESOURCES?        (Y/N): Y      NEXT REVIEW DATE:          08/30/06
MEETS OTHER CONDITIONS? (Y/N): Y      ANTICIPATED CLOSURE DATE:  ________
REASON(S) FOR DENIAL/CLOSURE/CHANGE:
___ ____________________________________________________________________
___ ____________________________________________________________________
ELIGIBILITY DECISION APPEALED? (Y/N) _     CONTINUE BENEFITS?      (Y/N): _
APPEAL REQUEST DATE: ________              COUNTY DECISION UPHELD? (Y/N): _
UPDATED: USER ID: BARTH     DATE: 08/29/05  SYSTEM ID: ELD3000  DATE: 08/29/05
ME900115 BUDGET GROUP PERIOD INFORMATION FOUND
 1-HELP  3-NEXT SCR  6-RETURN  10-MENU  13-FLD HELP  15-MAKE DECISION
 16-HMS BG DETER  21-PREV HIST  22-NEXT HIST  24-ACT ON DECISION
```

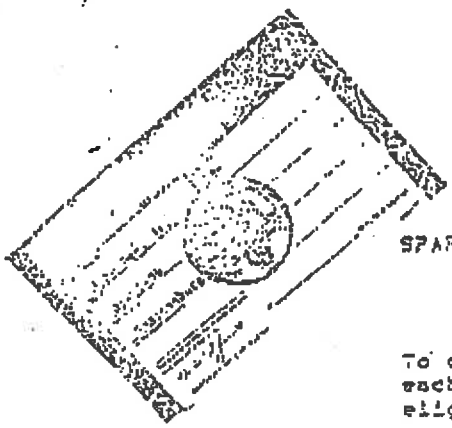
MEDELD02 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 08/29/05
MEDSPROD MEDICAID ELIGIBILITY DECISION ACTION:
DATES-FROM: 08 / 2005 THRU: __ / ____ PAGE: 3 OF 3

HH NAME: LISA J MARTIN HH NUMBER: 101064729
BG NUMBER: 98728261 CATEGORY: PHC ACTION TYPE: MAINTENANC
BG: A BGP: A WORKER: BARTH ACTION DATE: 08/29/05
RCP NAME: CIARA J TAYLOR RCP NUMBER: 9780275061
PREVIOUS BG: _____ NEW BG: _____ CORRECT RCP NUMBER: _____
IT: _ PING-PONG: _ RETRO: N EXPARTE: N QMB: N PROT PER DATE: 08/29/2006

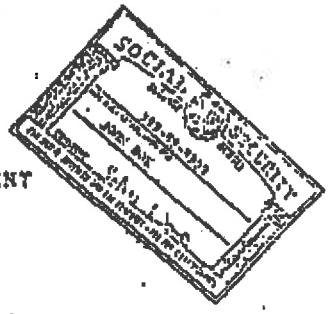
ACTUAL ELIGIBILITY DATES

MEDICAID ---BENEFIT DATES--- BEGIN	END	--MEDICAID+QMB DATES-- BEGIN	END	SERVICE TYPE	REASON CODE 1	REASON CODE 2
08/01/2005	_____	_____	_____	_____	___	___
07/01/2005	08/01/2005	_____	_____	_____	___	___
06/01/2005	07/01/2005	_____	_____	_____	___	___
05/01/2005	06/01/2005	_____	_____	_____	___	___
_____	_____	_____	_____	_____	___	___
_____	_____	_____	_____	_____	___	___
_____	_____	_____	_____	_____	___	___

UPDATED: USER ID: BARTH DATE: 08/29/05 SYSTEM ID: ELD3000 DATE: 08/29/05
ME900115 BUDGET GROUP PERIOD INFORMATION FOUND
1-HELP 2-PREV MBR 3-NEXT MBR 5-HMS DET 6-RETURN 10-PREV 11- HH MBRS
15-MD 16-HMS BG DETER 18-HMS INQ 21-HIST- 22-HIST+ 24-AOD



South Carolina DHEC
Department of Health and Environmental Control

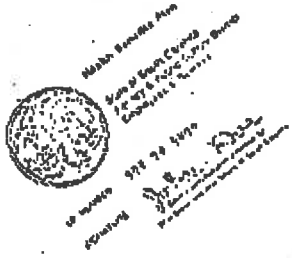


SPARTANBURG COUNTY HEALTH DEPARTMENT

To qualify for Medical Assistance each family **must** meet certain eligibility requirements.

Help establish your eligibility by bringing the following information to your interview:

1. Driver's License
2. Birth Certificate / Voter Registration
3. Social Security Card
4. Check Stubs
5. Insurance Cards and/or Policies
6. Unpaid Medical Bills
7. Note from R.N. or Physician with due date

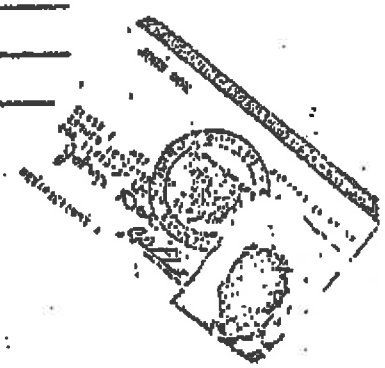


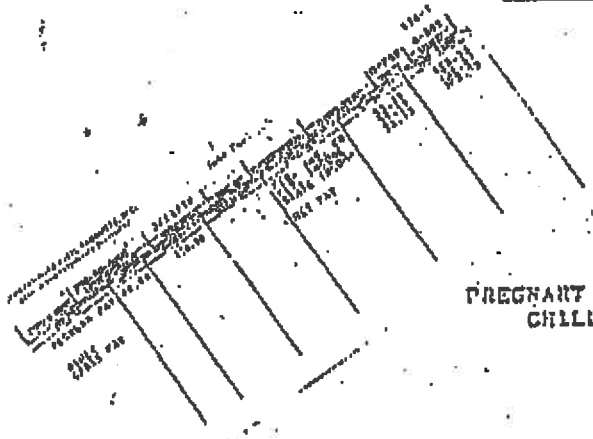
YOU HAVE AN APPOINTMENT:

WITH _____

ON _____

AT _____





ATTENTION

PREGNANT WOMEN AND PARENTS OF CHILDREN UNDER SEVEN

TO WHOM IT MAY CONCERN OR MEDICAID ELIGIBILITY WORKER

Lisa Martin IS PREGNANT, EDC 12-16-05

If possible, please begin her Medicaid eligibility to include date of service 7-25-05.

Bill Williams RN 7-28-05

SIGNATURE & TITLE _____ DATE _____

Help Us Keep Your Earnings Record Accurate

You, your employer and Social Security share responsibility for the accuracy of your earnings record. Since you began working, we recorded your reported earnings under your name and Social Security number. We have updated your record each time your employer (or you, if you're self-employed) reported your earnings.

Remember, it's your earnings, not the amount of taxes you paid or the number of credits you've earned, that determine your benefit amount. When we figure that amount, we base it on your average earnings over your lifetime. If our records are wrong, you may not receive all the benefits to which you are entitled.

▼ **Review this chart carefully** using your own records to make sure our information is correct and that we've recorded each year you worked. You're the only person who can look at the earnings chart and know whether it is complete and correct.

Some or all of your earnings from **last year** may not be shown on your *Statement*. It could be that we still were processing last year's earnings reports when your *Statement* was prepared. Your complete earnings for last year will be shown on next year's *Statement*. **Note:** If you worked for more than one employer during any year, or if you had both earnings and self-employment income, we combined your earnings for the year.

▼ **There's a limit on the amount of earnings on which you pay Social Security taxes each year.** The limit increases yearly. Earnings above the limit will not appear on your earnings chart as Social Security earnings. (For Medicare taxes, the maximum earnings amount began rising in 1991. Since 1994, **all** of your earnings are taxed for Medicare.)

▼ **Call us right away** at **1-800-772-1213** (7 a.m.–7 p.m. your local time) if any earnings for years **before last year** are shown incorrectly. If possible, have your W-2 or tax return for those years available. (If you live outside the U.S., follow the directions at the bottom of Page 4.)

Your Earnings Record at a Glance

Years You Worked	Your Taxed Social Security Earnings	Your Taxed Medicare Earnings
2000	$ 17,550	$ 17,550
2001	13,920	13,920
2002	16,583	16,583
2003	Not yet recorded	

Did you know... Social Security is more than just a retirement program? It's here to help you when you need it most.

You and your family may be eligible for valuable benefits:

▼When you die, your family may be eligible to receive survivors benefits.

▼Social Security may help you if you become disabled — even at a young age.

▼It is possible for a young person who has worked and paid Social Security taxes in as few as two years to become eligible for disability benefits.

Social Security credits you earn move with you from job to job throughout your career.

Total Social Security and Medicare taxes paid over your working career through the last year reported on the chart above:

Estimated taxes paid for Social Security:		Estimated taxes paid for Medicare:	
You paid:	$2,979	You paid:	$695
Your employers paid:	$2,979	Your employers paid:	$695

Note: You currently pay 6.2 percent of your salary, up to $87,900, in Social Security taxes and 1.45 percent in Medicare taxes on your entire salary. Your employer also pays 6.2 percent in Social Security taxes and 1.45 percent in Medicare taxes for you. If you are self-employed, you pay the combined employee and employer amount of 12.4 percent in Social Security taxes and 2.9 percent in Medicare taxes on your net earnings.

Prevent identity theft—protect your Social Security number

Your Social Security Statement

Prepared especially for Lisa J. Martin

March 3, 2004

80190 000220518 01 AV 0.278
LISA J. MARTIN
7636 DOLPHIN ST
DETROIT MI 48239-1013

See inside for your personal information →

What's inside ...

What Social Security Means to You

This *Social Security Statement* will help you understand what Social Security means to you and your family. This *Statement* can help you better plan for your financial future. It gives you estimates of your Social Security benefits under current law. Each year, we will send you an updated *Statement* including your latest reported earnings.

Be sure to read this *Statement* carefully. If you think there may be a mistake, please let us know. That's important because your benefits will be based on our record of your lifetime earnings. We recommend you keep a copy of this *Statement* with your financial records.

Social Security is for people of all ages ...
It can help you whether you're young or old, male or female, single or with a family. It's there for you when you retire, but it's more than a retirement program. Social Security also can provide benefits if you become disabled and help support your family when you die.

Work to build a secure future ...
Social Security is the largest source of income for most elderly Americans today. It is very important to remember that Social Security was never intended to be your only source of income when you retire. Social Security can't do it all. You also will need other savings, investments, pensions or retirement accounts to make sure you have enough money to live comfortably when you retire.

About Social Security's future ...
Social Security is a compact between generations. For more than 60 years, America has kept the promise of security for its workers and their families. But now, the Social Security system is facing serious future financial problems, and action is needed soon to make sure that the system is sound when today's younger workers are ready for retirement.

Today there are almost 36 million Americans age 65 or older. Their Social Security retirement benefits are funded by today's workers and their employers who jointly pay Social Security taxes — just as the money they paid into Social Security was used to pay benefits to those who retired before them. Unless action is taken soon to strengthen Social Security, in just 15 years we will begin paying more in benefits than we collect in taxes. Without changes, by 2042 the Social Security Trust Fund will be exhausted.* By then, the number of Americans 65 or older is expected to have doubled. There won't be enough younger people working to pay all of the benefits owed to those who are retiring. At that point, there will be enough money to pay only about 73 cents for each dollar of scheduled benefits. We will need to resolve these issues soon to make sure Social Security continues to provide a foundation of protection for future generations as it has done in the past.

Social Security On The Net ...
Visit *www.socialsecurity.gov* on the Internet to learn more about Social Security. You can read our publications, use the *Social Security Benefit Calculators* to calculate future benefits, apply for retirement, spouse's or disability benefits, or subscribe to *eNews* for up-to-date information about Social Security.

Jo Anne B. Barnhart
Commissioner

* These estimates of the future financial status of the Social Security program were produced by the actuaries at the Social Security Administration based on the intermediate assumptions from the Social Security Trustees' Annual Report to the Congress.

ICP4304E 035 107

Department of the Treasury -- Internal Revenue Service

Form 1040 U.S. Individual Income Tax Return 2001

(99) IRS Use Only -- Do not write or staple in this space.

OMB No. 1545-0074

For the year Jan. 1-Dec. 31, 2001, or other tax year beginning , 2001, ending , 20

Use the IRS label. Otherwise, please print or type.

LABEL HERE

LISA J MARTIN

11062 CLOVERLAWN
Detroit MI 48204-

Your social security number: 368-25-0542

Spouse's social security no.

▲ You must enter your SSN(s) above. ▲

Presidential Election Campaign — Note. Checking "Yes" will not change your tax or reduce your refund. Do you, or your spouse if filing a joint return, want $3 to go to this fund? ▶ You: ☐ Yes ☒ No Spouse: ☐ Yes ☐ No

Filing Status

Check only one box.

1 ☐ Single

2 ☐ Married filing joint return (even if only one had income)

3 ☐ Married filing separate return. Enter spouse's SSN above & full name here. ▶

4 ☒ Head of household (with qualifying person). (See instructions.) If the qualifying person is a child but not your dependent, enter child's name here. ▶

5 ☐ Qualifying widow(er) with dependent child (yr. spouse died ▶). (See instructions.)

Exemptions

6a ☒ Yourself. If your parent (or someone else) can claim you as a dependent on his or her tax return, do not check box 6a

b ☐ Spouse

No. of boxes checked on 6a and 6b: 1

No. of your children on 6c who: ● lived with you: 1 ● did not live with you due to divorce or separation (see inst.): 0

Dependents on 6c not entered above: 0

Add numbers entered on lines above ▶: 2

c Dependents: If more than six dependents, see instructions.

(1) First name Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if qualifying child for child tax credit (see inst.)
CIARA TAYLOR	376-19-5992	DAUGHTER	☒

d Total number of exemptions claimed: 2

Income

Attach Forms W-2 and W-2G here. Also attach Form(s) 1099-R if tax was withheld.

If you did not get a W-2, see instructions.

Enclose, but do not attach, any payment. Also, please use Form 1040-V.

7	Wages, salaries, tips, etc. Attach Form(s) W-2	7	12,467.
8a	Taxable interest. Attach Schedule B if required	8a	
b	Tax-exempt interest. Do not include on line 8a (8b)		
9	Ordinary dividends. Attach Schedule B if required	9	
10	Taxable refunds, credits, or offsets of state and local income taxes (see instructions)	10	
11	Alimony received	11	
12	Business income or (loss). Attach Schedule C or C-EZ	12	1,573.
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ ☐	13	
14	Other gains or (losses). Attach Form 4797	14	
15a	Total IRA distributions (15a) b Taxable amount (see inst.)	15b	
16a	Total pensions and annuities (16a) b Taxable amount (see inst.)	16b	
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E	17	
18	Farm income or (loss). Attach Schedule F	18	
19	Unemployment compensation	19	
20a	Social security benefits (20a) b Taxable amount (see inst.)	20b	
21	Other income	21	
22	Add the amounts in the far right column for lines 7 through 21. This is your total income ▶	22	14,040.

Adjusted Gross Income

23	IRA deduction (see instructions)	23	
24	Student loan interest deduction (see instructions)	24	
25	Archer MSA deduction. Attach Form 8853	25	
26	Moving expenses. Attach Form 3903	26	
27	One-half of self-employment tax. Attach Schedule SE	27	111.
28	Self-employed health insurance deduction (see instructions)	28	
29	Self-employed SEP, SIMPLE, and qualified plans	29	
30	Penalty on early withdrawal of savings	30	
31a	Alimony paid b Recipient's SSN ▶	31a	
32	Add lines 23 through 31a	32	111.
33	Subtract line 32 from line 22. This is your adjusted gross income ▶	33	13,929.

INTERFACE DOCUMENTATION CHECKLIST

Primary Individual: L. Martin **BG#:** 98728258

Date Checked: 8/29/05

SCREEN NAME MEDS Screen	NO INFORMATION FOUND	INFORMATION FOUND; SEE PRINT-OUT	OTHER
ESC Wage Match (MEDESC01)	✓		
ESC Unemployment Compensation (MEDESC02)	✓		
SDX Inquiry (MEDSDX01)	✓		
BENDEX (MEDIEV01)	✓		
Work Number (TALX) www.theworknumber.com *(As needed basis)*			

***Please include the printouts in case file in which information is found.**

MEDS SCREEN REQUIRED IN CASE FILE

***Place a check by each screen included in the case file for documentation.**

✓ **ELD01: Medicaid Eligibility Decision**

✓ **ELD02: Medicaid Eligibility Decision**

Prepared by Rosetta K. Evans 6/1/05 3:36 PM

From: Romie Bostick
To: Jennifer Dabbs
Date: 10/17/2006 6:28 AM
Subject: Lisa Martin BG28958914

CC: Betsy Carroll; Juanita L Tobin; Tamara Douglas

Jenny,
I have faxed the MEDS correction sheet this morning (255-8213) so hopefully this will resolve this case. I apologize for the confusion on this particular case but Betsy, Tammy, and Janelle and I were all involved in the decision to deny since the client did state that she was not a citizen and then we learned she had not been in the US for the required length of time to qualify. As you know from working in eligibility this is not the first time we have given eligibility to a client only to have to deny at a later date - depending on our findings and/or information furnished.
I pray this is the last time we will have to deal with this case.
Thanks and hope you have a great day!

10/14: Per Betty Moses we need to give her eligibility for 9/1/05 through 1/1/06 b/c error was found in 11/05, in order for 10 day notice to be sent - Closure should be effective 1/1/06. When the error was found - they took away all the eligibility.

10/16: left message for MS. Martin.

1EDHMS54 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 10/18/06
MEDSPROD RECIPIENT INFORMATION ACTION:
MEMBER PERIOD START: 01/23/06 END: PAGE: 0001

NAME: MARTIN LISA J HH NAME: MARTIN LISA J
RCP NUMBER: 9780275057 HH NUMBER: 101064729 ACTION TYPE: MAINTENANCE
SSN: 368-25-0542 VC: V APL STATUS: ACTION DATE: 01/24/06
PRIMARY INDIVIDUAL: APL CO: 42 WORKER ID: BARTH LOCATION: 055
201 POWELL MILL RD SSCN: 368250542A RRN:
APT G-201 RACE: 02 SEX: F MARITAL STATUS: S
TPL INSURANCE: N RELATION: SELF
SPARTANBURG SC 29301- DOB: 06/18/1968 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	CHIP NUMBER
_	28958914	09/01/2005	01/01/2006	55	30	LIMITED	N	Y	.00	
_	09087814	08/01/2005	09/01/2005	87	30	EMERGENCY	N	N	.00	
_	89035830	09/01/1981	09/01/1981	87	30		N	Y	.00	

UPDATED: USER ID: BARTH DATE: 11/28/05 SYSTEM ID: TTR1004 DATE: 11/12/05
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

MEDELD02 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 10/16/06
MEDSPROD MEDICAID ELIGIBILITY DECISION ACTION:
DATES-FROM: 09 / 2005 THRU: __ / ____ PAGE: 3 OF 3

HH NAME: LISA J MARTIN HH NUMBER: 101076312
BG NUMBER: 8958914 CATEGORY: FP ACTION TYPE: MAINTENANCE
BG: C BGP: C WKR: RBOST ROMIE BOSTICK ACTION DATE: 11/29/05
RCP NAME: LISA J MARTIN RCP NUMBER: 9780275057
PREVIOUS BG: _____ NEW BG: _____ CORRECT RCP NUMBER: _____
IT: _ PING-PONG: _ RETRO: N EXPARTE: N QMB: N PROT PER DATE: _____

ACTUAL ELIGIBILITY DATES

LIMITED ---BENEFIT DATES--- BEGIN	END	--MEDICAID+QMB DATES-- BEGIN	END	SERVICE TYPE	REASON CODE 1	REASON CODE 2
08/01/1981	08/01/1981				054	

UPDATED: USER ID: BARTH DATE: 11/28/05 SYSTEM ID: ELD3000 DATE: 11/29/05
ME900115 BUDGET GROUP PERIOD INFORMATION FOUND
PF1-HELP PF2-PREV MBR PF3-NEXT MBR PF5-HH MBR DTL PF6-RETURN PF10-MENU
PF11-HH MBRS PF15-MD PF16-BG DET PF18-RCP INFO PF21-HIST- PF22-HIST+ PF24-AOD

10/14: left message for Avis Newton about the BG eligibility 8-2994

10/14: left message for Margaret Riley w/ Hos. Services to inquire about bills from 8/1/05-9/1/05. She called back & said she shows the submitted bills have been paid. Called her back to let her know where the other bills are from.

0/16: Spoke with Chris Lykes from Physician Services & he looked up the bills in question. They had all paid the full amount that Medicaid would pay. He said the remainder the Doctors office would have to write off. He said once Medicaid pays in full the patient is not responsible for the remainder. I told him there were several from bill collectors. He said MS. Martin would have to have the doctors contact him directly to take care of any unpaid bills.

```
MEDELD02 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 01/05/06
 MEDSPROD                  MEDICAID ELIGIBILITY DECISION            ACTION:
                      DATES-FROM: 09 / 2005 THRU: __ / ____         PAGE: 3 OF 3
 HH NAME:   LISA J MARTIN                                    HH NUMBER: 101064729
 BG NUMBER: 89035830          CATEGORY: OCWIPW             ACTION TYPE: MAINTENANC
 BG: D  BGP: D      WKR: BARTH    BETSY CARROLL             ACTION DATE: 11/28/05
 RCP NAME:  LISA J MARTIN                                    RCP NUMBER: 9780275057
 PREVIOUS BG: ________     NEW BG: ________      CORRECT RCP NUMBER: __________
 IT: _  PING-PONG: _  RETRO: N  EXPARTE: N  QMB: _     PROT PER DATE: __________
             ACTUAL ELIGIBILITY DATES
    MEDICAID
  ---BENEFIT DATES---     --MEDICAID+QMB DATES--     SERVICE     REASON    REASON
    BEGIN       END         BEGIN       END          TYPE       CODE 1    CODE 2
 __________ __________  __________ __________     EMERGENCY     077        ___
 __________ __________  __________ __________     __________    ___        ___
 __________ __________  __________ __________     __________    ___        ___
 __________ __________  __________ __________     __________    ___        ___
 __________ __________  __________ __________     __________    ___        ___
 __________ __________  __________ __________     __________    ___        ___
 __________ __________  __________ __________     __________    ___        ___
 UPDATED: USER ID: BARTH     DATE: 11/28/05  SYSTEM ID: ELD3000  DATE: 11/28/05
ME900115 BUDGET GROUP PERIOD INFORMATION FOUND
  PF1-HELP  PF2-PREV MBR  PF3-NEXT MBR  PF5-HH MBR DTL  PF6-RETURN  PF10-MENU
 PF11-HH MBRS PF15-MD PF16-BG DET PF18-RCP INFO PF21-HIST- PF22-HIST+ PF24-AOD
```

MEDHMS49 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 11/28/05
MEDSPROD HOUSEHOLD BUDGET GROUPS
PAGE: 0001
HH NAME: MARTIN LISA J ACTION TYPE: MAINTENANCE
HH NUMBER: 101064729 APL STATUS: _____ ACTION DATE: 11/28/05

S	BG NUMBER	CATEGORY	WORKER	CNTY	LOC	NEXT REVIEW	LAST REVIEW	BG STATUS
_	98728261	PHC	BARTH	47	077	08/30/2006	_____	ACTIVE
_	89035830	OCWIPW	BARTH	47	077	_____	_____	DENIED
_	18953116	FP	FHARR	47	077	11/13/2005	_____	DENIED
_	98728258	OCWIPW	BARTH	47	077	_____	_____	DENIED
_	68933704	FP	FHARR	47	077	08/24/2006	_____	DENIED
_	28902696	FP	TAKES	47	077	07/28/2006	_____	DENIED
_	78899769	PHC	PHURS	42	003	07/26/2006	_____	DENIED
_	78899755	OCWIPW	PHURS	42	003	_____	_____	DENIED

UPDATED: USER ID: BARTH DATE: 11/28/05 SYSTEM ID: HMS5000 DATE: 11/28/05
ME904675 HOUSEHOLD BUDGET GROUPS FOUND
PF1->HELP PF3->HH MEMBERS PF5->BG DETERMINATION
PF6->RETURN PF7->PREV PF8->NEXT PF10->PREV MENU PF17->ELD00

555-0089719
Family Plan MARTIN, LISA J
6/18/1968

- DHHS USE ONLY -
FAMILY SIZE
INCOME LIMIT
FAMILY INCOME

1. Tell us who you are and where you live:
   Your Name ___ LISA J MARTIN
   Middle Last Telephone: 468 314-8577 Area Code 42
   Home Address _ 201 POWELL MILL RD APTG201
   SPARTANBURG, SC 29301-
   State Zip Code County: _____

2. Tell us information about yourself first and then about the family members who live with you:
   (You only need to provide Social Security Number or citizenship information for yourself. If you are not a U.S. Citizen, please provide a copy of your Immigration and Naturalization Service (INS) documents.)

NAME	RELATIONSHIP	BIRTHDATE	SEX	RACE	US CITIZEN	SC RESIDENT	MARITAL STATUS	SOCIAL SECURITY NUMBER
Lisa J Martin	(APPLICANT)	6/18/68	F	B	[redacted]	YES	S	368233752
2.								
3.								
4.								
5.								

3. Do you or anyone in your family have income from work or any other source? [ ] YES [X] NO If yes, complete the following:

NAME OF PERSON WHO GETS THE INCOME	SOURCE OF INCOME	GROSS MONTHLY INCOME
1.		
2.		

DHEC USE ONLY
Gross Earned Income
Standard Deduction
Child Care Deduction
Net Earned Income
Gross Other Income
Family Size

4. Do you or your parents pay for child care? [ ] YES [X] NO If yes, complete the following:

NAME OF CHILD(REN) RECEIVING CARE		
1.	2.	3.

5. Do you have health insurance that pays for Family Planning? [ ] YES [X] NO If yes, give:
   Name of Company _____, Policy Number _____ and Insured's Name _____

6. Have you received Family Planning services during the last three months? [X] YES [ ] NO If yes, which months 9/98 - 1/99
   If yes, was your income the same those months as it is now? [X] YES [ ] NO If no, what was it? _____

7. Do you have a *Partners for Health* Medicaid card in your possession? [ ] YES [X] NO

8. Have you had a permanent sterilization procedure? [ ] YES [X] NO
   If you have had a permanent sterilization procedure, you are not eligible for Family Planning Services.

SEP 1998 25 04:3

9. What is your primary language? [X] ENGLISH [ ] SPANISH [ ] KOREAN [ ] OTHER ____________________

THE FOLLOWING STATEMENTS EXPLAIN YOUR RIGHTS AND RESPONSIBILITIES. IF YOU DO NOT UNDERSTAND SOME OF THE STATEMENTS, YOU SHOULD DISCUSS THE STATEMENT(S) WITH THE WORKER DURING THE INTERVIEW. YOU ARE RESPONSIBLE FOR GIVING COMPLETE AND ACCURATE INFORMATION.

- I UNDERSTAND THAT I MUST REPORT ANY AND ALL CHANGES IN MY INCOME, LIVING ARRANGEMENTS OR OTHER INFORMATION WHICH WILL AFFECT MY FAMILY PLANNING SERVICES WITHIN TEN (10) DAYS OF THE DATE OF THE CHANGE(S). I UNDERSTAND THAT FAILURE TO REPORT PROMPTLY IS A CRIME UNDER STATE LAW FOR WHICH I CAN BE TAKEN TO COURT.
- I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION ON ME TO DHHS. A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
- I UNDERSTAND THAT I SHALL FURNISH MY SOCIAL SECURITY NUMBER TO THE DHHS OR APPLY FOR A SOCIAL SECURITY NUMBER IF I DO NOT HAVE ONE.
- I UNDERSTAND THAT MY CASE RECORD IS CONFIDENTIAL AND NO INFORMATION WILL BE RELEASED FROM IT UNLESS PROPERLY AUTHORIZED BY ME OR AS PROVIDED FOR UNDER STATE/FEDERAL LAWS. HOWEVER, INFORMATION ABOUT MY ELIGIBILITY MAY BE SHARED TO HELP ME GET OTHER BENEFITS.
- I UNDERSTAND THAT ANY INFORMATION I HAVE GIVEN IS SUBJECT TO BEING REVIEWED AND VERIFIED BY DHHS AND DHEC. ALSO, I UNDERSTAND THAT I MUST COOPERATE FULLY WITH STATE AND FEDERAL WORKERS IF MY CASE IS SELECTED FOR A COMPLETE REVIEW.
- I UNDERSTAND THAT THIS APPLICATION WILL BE CONSIDERED WITHOUT REGARD TO RACE, COLOR, SEX, AGE, HANDICAP, RELIGION, NATIONAL ORIGIN OR POLITICAL BELIEF.
- TO FILE A COMPLAINT OF DISCRIMINATION, CONTACT USDA OR HHS. WRITE USDA, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 326-W, WHITTEN BUILDING, 1400 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20250-9410 OR CALL (202) 720-5964 (VOICE AND TDD). WRITE HHS, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 506-F, 200 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20201 OR CALL (202) 619-0403 (VOICE) OR (202) 619-3257 (TDD). USDA AND HSS ARE EQUAL OPPORTUNITY PROVIDERS AND EMPLOYERS.
- I UNDERSTAND THAT I MAY REQUEST A HEARING IF I AM NOT SATISFIED WITH THE ACTION TAKEN ON MY CASE OR IF I FEEL THAT I HAVE BEEN DISCRIMINATED AGAINST.
- I UNDERSTAND THAT BY APPLYING FOR FAMILY PLANNING I AM ASSIGNING MY RIGHTS TO ANY PAYMENTS FOR FAMILY PLANNING SERVICES TO THE STATE.

I CERTIFY THAT I HAVE READ OR HAD READ TO ME ALL THE STATEMENTS ON THIS FORM AND THAT THE INFORMATION GIVEN IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF I HAVE DELIBERATELY GIVEN ANY FALSE INFORMATION OR HAVE WITHHELD ANY INFORMATION REGARDING MY SITUATION, I AM LIABLE FOR PROSECUTION FOR FRAUD AND/OR PERJURY.

DHEC USE ONLY: CERTIFICATION
I request that payment of Medicare/Medicaid or other Third Party Insurance benefits be made on behalf of the [illegible] services provided me. DHEC may exchange medical or other confidential information [illegible] these benefits for related services. I also agree to participate in treatment plans, assignment of [illegible] in payment for services is determined by specific program guidelines.

APPLICANT'S SIGNATURE [redacted] Date [redacted]

PARENT'S (OR GUARDIAN) SIGNATURE (required if applicant is under 16) ______________________ Date ____________

I have reviewed the statements on this form, a listing of community health centers, and discussed the importance of getting primary care services with the applicant/recipient.

Worker's signature Michelle E Caty Location 4201 Telephone (864) 596-2227 Date 9/4/08

MAIL APPLICATIONS TO: DHHS Division of Central Eligibility Processing
P.O. Box 100101 Columbia, South Carolina 29202-3101
Questions: 1-888-549-0820

DHHS FORM 400 (012/04)

1010647 29

09/23/2005 09:56AM

SPARTANBURG REGIONAL MEDICAL CENTER
1001 NORTH PINE STREET
SPARTANBURG, SC 29303

P/C:PS P/T:IP

MARTIN,LISA J 0522101371 08/09/05 08/10/05 1

MARY HADDAD

LISA JOY MARTIN
201 POWELL MILL RD
G201
SPARTANBURG SC 29301

502002 PENDING SPONSOR INPAT

999 360250542 08/19/05

CODE	DESCRIPTION	QTY
110	ROOM-BOARD/PVT	650.00
250	PHARMACY	682.58
258	IV SOLUTIONS	713.06
259	DRGS/OTHER	106.16
300	LABORATORY	1,294.00
636	DRUGS/DETAIL CODE	1,292.57
964	PRO FEE/ANES CRNA	588.00
	TOTAL CHARGES	5,326.37
	TOTAL PAYMENTS/ADJUSTMENTS	0.00

369.6068
Kelly M

BENEFITS ASSIGNED

5,326.37

5,326.37

5,326.37

Encounter #304410459 08/03/2005 DETAIL 11/03/2005

05 307 18 56 23 000810 RPT-ORILL780

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
CYCLE	11/03/05	
INS.		

PAGE NO. 1

REF.NO. 00176

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	
5 E MARTIN ,LISA	304410459	F	37	08/03/05			OUT PATIENT

GUARANTOR NAME AND ADDRESS

LISA MARTIN
201 POWELL APT G201
SPARTANEURG,SC 29301-1567

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
F MEDICAID OUT OF		9780275057

PHY: ADAMS T GARD MD

AMOUNT OF PAYMENT $

DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS

DATE OF SERVICE	DESCRIPTION HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
08/03	ED LEVEL 3 001	6841003	551.00	551.00				
08/03	US OB FETUS LI001	2044114	177.00	177.00				

SUMMARY OF CURRENT CHARGES

RADIOLOGY	177.00	177.00
EMERGENCY ROOM	551.00	551.00
SUB-TOTAL OF CURR. CHARGES	728.00	728.00

GUAR RELATIONSHIP: S SEX: F GUAR NO: 368250542
ACC DATE: 08/03/05 TYPE: S TIME: 3:41 PM PLACE: EMPL REL:
DIAGNOSIS: 632
625.9

PATIENT NUMBER

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE/GUARANTOR.

ANNAPOLIS HOSPITAL**
DETROIT, MI

09/23/2005 09:56AM

Patient Name
LISA J MARTIN

Spartanburg Pathology Associates, PA

Your Pathology Service Provider

[redacted] GWD- 8010671-4

Statement Date
08/26/05

Please contact our billing agent, PSA, to submit payment, update information, or speak with a billing representative.

[redacted] 09/15/05

Amount Due
345.00

IMPORTANT MESSAGE

FIRST NOTICE, PLEASE REMIT PROMPTLY.

In order to process your insurance, PSA needs complete insurance information. Please send your payment or contact us with any insurance, Medicaid or Medicare information. Thank You!

www.pathologybilling.com

Servicio en espanol, por favor llame.

TOLL FREE: 1-877-835-0598
TOLL FREE FAX: 1-877-288-1254

Office hours:
Mon-Thur 8am-10pm EST
Fri 8am-8pm, Sat 10am-4pm

Referring Physician:
MICHAEL R WATKINS MD

DATE	PROC. CODE	DESCRIPTION	Number of Specimens	AMOUNT
08/10/05	8830926	MICROSCOPIC ANALYSIS, VI	1	345.00

These charges are not included in any other hospital or physician statement. For more information or to update insurance information, see the back of this statement or visit www.pathologybilling.com.

BILLING OFFICE ADDRESS:

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

Patient Name: LISA J MARTIN

☐ Please check box if address or insurance information is incorrect and indicate change(s) on reverse side.

ADDRESSEE:

LISA J MARTIN
G201
201 POWELL MILL RD
SPARTANBURG SC 29301-1526

STATEMENT DATE	[redacted]	ACCOUNT #
08/26/05		GWD- 8010671-4

Check # _____
(please do not staple)

AMOUNT DUE
$ 345.00

AMOUNT ENCLOSED $

Do Not Mail Credit Card Information.
To pay by Credit Card, visit us at: www.pathologybilling.com
or call: 1-877-835-0598

MAKE CHECKS PAYABLE TO & REMIT TO:

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

09/23/2005 09:56AM

LISA J MARTIN

Spartanburg Pathology Associates, PA

Your Pathology Service Provider

[redacted]	Statement Date
GWD- 8006137-4	08/25/05
Due Date	Amount Due
09/14/05	110.00

Please contact our billing agent, PSA, to submit payment, update information, or speak with a billing representative.

IMPORTANT MESSAGE

FIRST NOTICE, PLEASE REMIT PROMPTLY.

In order to process your insurance, PSA needs complete insurance information. Please send your payment or contact us with any insurance, Medicaid or Medicare information. Thank You!

www.pathologybilling.com

Servicio en espanol, por favor llame.

TOLL FREE: 1-877-835-0598
TOLL FREE FAX: 1-877-268-1254

Office hours:
Mon-Thur 8am-10pm EST
Fri 8am-6pm, Sat 10am-4pm

Referring Physician:
MARY HADDAD MD

DATE	PROC. CODE	DESCRIPTION	Number of Specimens	AMOUNT
08/09/05	8834226	IMMUNOCYTOCHEMISTRY	1	110.00

These charges are not included in any other hospital or physician statement. For more information or to update insurance information, see the back of this statement or visit www.pathologybilling.com.

BILLING OFFICE ADDRESS:

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

STATEMENT DATE	[redacted]	ACCOUNT #
08/25/05		GWD- 8006137-4

AMOUNT DUE
$ 110.00

Check # _____
(please do not staple)

AMOUNT ENCLOSED $

Patient Name: LISA J MARTIN

☐ Please check box if address or insurance information is incorrect and indicate change(s) on reverse side.

Do Not Mail Credit Card Information.
To pay by Credit Card, visit us at: www.pathologybilling.com
or call: 1-877-835-0598

ADDRESSEE:

LISA J MARTIN
G201
201 POWELL MILL RD
SPARTANBURG SC 29301-1526

MAKE CHECKS PAYABLE TO & REMIT TO:

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

09/23/2005 09:56AM

PATIENT STATEMENT OF ACCOUNT

ACCOUNT NO.	CODE	STATEMENT DATE
0522101371	FP363	9/12/05

☐ CHECK HERE FOR ADDRESS CHANGE.USE REVERSE SIDE FOR CORRECTIONS
www.kam2000.com/pa

** PAYMENT PROCESSED BY
ANESTHESIOLOGY SERVICES
AUGUSTA, GA **

CHECK CARD USING FOR PAYMENT
MASTERCARD VISA DISCOVER AMEX
CARD NUMBER | 4 DIGIT CID | EXP. DATE
SIGNATURE (REQUIRED)
PRINT NAME ON CARD | PAY THIS AMOUNT $ $1,800.00
SHOW AMOUNT PAID HERE $

ADDRESSEE

LISA MARTIN
G201
201 POWELL MILL RD
SPARTANBURG SC 29301-1526

REMIT TO

Foothills Anesthesia Consultan
PO BOX 4391
SPARTANBURG SC 29305-4391

DETACH AND RETURN TOP PORTION WITH PAYMENT

STATEMENT OF SERVICES RENDERED

SERVICE DATE	CASE NUMBER	CPT CODE	DESCRIPTION OF PROCEDURE OR SERVICE	CHARGES / PAYMENT & ADJ. PATIENT	INSURANCE
8 10 05	3310308	01967	Anesthesiology Services by Dr. D. SHANTHA for Dr. M.Haddad Billed To Patient	$1,800.00	

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	NEW BALANCE	PATIENT	INSURANCE
$1,800.00	$0.00	$0.00	$0.00	$0.00		$1,800.00	$0.00

ACCOUT NO.	STATEMENT DATE	
0522101371	9/12/05	PATIENT IS RESPONSIBLE FOR "PATIENT NEW BALANCE" PAYMENT IS DUE WITHIN 15 DAYS OF RECEIPT OF STATEMENT.

OFFICE HOURS: 8:00AM-4:15PM EST PHONE NO:888 850 6304

THIS IS A BILL FOR SERVICES NOT INCLUDED ON YOUR HOSPITAL BILL.
PLEASE CALL OUR OFFICE WITH QUESTIONS CONCERNING YOUR BILL.
IF PAYMENT HAS BEEN MADE PLEASE DISREGARD THIS BILL. THANK YOU.

** PAYMENT PROCESSED BY
ANESTHESIOLOGY SERVICES
AUGUSTA, GA **

09/23/2005 09:56AM

Oakwood

OAKWOOD ANNAPOLIS
P.O. BOX 2905
DEARBORN, MI 48123-2905

9261-7614

ADDRESS SERVICE REQUESTED

FOR BILLING INQUIRIES, CALL: 800-858-9503
OFFICE HOURS 8:00am - 4:30pm, MON - FRI

Please check box if your address is incorrect or insurance information has changed, please indicate change(s) on reverse side.

ADDRESSEE:

304410459
LISA MARTIN
201 POWELL APT G201
SPARTANBURG, SC 29301

IF PAYING BY MASTERCARD, DISCOVER OR VISA, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA

CARD NUMBER	AMOUNT PAID
SIGNATURE	EXP. DATE

DATE DUE	PATIENT BALANCE DUE	ACCT.#
09/28/05	$728.00	304410459

PATIENT NAME
MARTIN ,LISA

SEND TO:

DEPARTMENT 249001
OAKWOOD HEALTHCARE SYSTEM PP
PO BOX 67000
DETROIT, MI 48267-2490

00000000000000007080002490010000000000304410459000007280008

PLEASE DETACH AT PERF AND RETURN TOP PORTION WITH YOUR PAYMENT.

STATEMENT

PATIENT NAME: MARTIN ,LISA SERVICE DATE: 08/03/05 PAGE NO. 1

DATE	DESCRIPTION	AMOUNT
08/03/05	EMERGENCY ROOM	551.00
08/03/05	RADIOLOGY	177.00

ACCOUNT BALANCE	ESTIMATED INSURANCE DUE	ACCOUNT NUMBER
728.00	0.00	304410459

MESSAGES:
PLEASE INCLUDE ACCOUNT NUMBER(S) ON YOUR CHECK OR MONEY ORDER.
THERE WILL BE A $25 FEE FOR RETURNED CHECKS.

YOUR INSURANCE CO. HAS BEEN BILLED. THE PATIENT BALANCE DUE IS YOUR RESPONSIBILITY. PLEASE SEND PAYMENT TODAY.

PATIENT BALANCE DUE
▸▸▸▸ $728.00

PAYMENT DUE BY:
▸▸▸▸ 09/28/05

BILL DATE: 09/10/05

FOR BILLING INQUIRIES, CALL: 800-858-9503 OFFICE HOURS 8:00am - 4:30pm, MON - FRI

9261-7614-1M10BLOTA000048 SEE REVERSE SIDE FOR IMPORTANT INFORMATION

09/23/2005 09:56AM

BON SECOURS COTTAGE HEALTH SERVICES

468 Cadieux Rd * Grosse Pointe, MI 48230

auto**mixed aadc 605
LISA J MARTIN
201 POWELL MILL RD APT G201
SPARTANBURG, SC 29301-1567

COT
15 (2292)

August 15, 2005

Patient: Lisa J Martin
Account #: 3679669-O
Community Svc. Adjustment: -708.53
Balance: 1062.80
Service Date: 08/01/2005

Dear Lisa J Martin:

Thank you for choosing Bon Secours Health System. We value our community's use of Bon Secours Cottage Health Services facilities.

There is a balance due on this account, as indicated above. Your payment is important to the efficiency of the hospital and our attempts to hold down costs. Payment may be made either by phone or mail by using your credit card or checking account. If that is not convenient budget wise for you, kindly call our Customer Service Center. They will explain our extended payment options including our financial assistance program to you. Please be advised if you do not contact customer service to establish a monthly payment plan the balance is due and payable.

Please note that Bon Secours Health System has applied a Community Service Adjustment to your account, which reflects an offset to the cost of healthcare to our uninsured patients and families.

If you have any questions regarding the balance of this account or if you have additional insurance information which you have not previously given, please call the number shown below.

We look forward to your response to this letter within the next 15 days.

Payment of balance can be made by phone or mail, If payment of balance due is received within 30 days from receipt of this letter, you may take a 10% prompt pay discount

PLEASE RETURN LOWER PORTION WITH YOUR PAYMENT

CHECK ( ) VISA ( ) MC ( ) DISC ( ) AMEX ( )

CARD #: _____

CID #: _____ EXPIRATION DATE: _____

CID is the three digit number on the credit card back, usually in the signature block.

SIGNATURE: _____

PAYMENT AMOUNT: _____

BILLING ADDRESS: _____

CITY, STATE, ZIP CODE: _____

(Address information needs to be for the primary credit card holder and should be the same address information where the credit card bills are sent.)

Date: August 15, 2005
Patient: Lisa J Martin
Account #: 3679669-O
Balance: 1062.80
Service Date: 08/01/2005

Bon Secours Cottage Health Services
PO Box 77000 Dept 771144
Detroit MI 48277-1144

Calls / inquiries may be monitored for quality control

Customer Service Center
Toll Free: 1-877-342-1500
8:30 AM to 1:00 PM
2:00 PM to 5:00 PM
Monday through Friday

LT01Z

10/10/2005 03:07PM

To: Betsy Carroll (803)255-8223 fax ~~Sept 23, 2005~~ 10/10/05

From: Lisa J. Martin Ph# 864-574-8577

re: Unpaid hospitals due to stillborn pregnancy and complications

3 pages
~~3 pgs~~ incl cover

S. Mrs. Carroll could you please contact me regarding the current situation about my bills that are being paid for. I am not clear what bills are being paid and if these bill have been paid. Thank you Lisa Martin (864) 574-8577

LISA J MARTIN

Spartanburg Pathology Associates, PA

Your Pathology Service Provider

	Statement Date
GWD- 8010671-4	10/05/05
10/25/05	345.00

Please contact our billing agent, PSA, to submit payment, update information, or speak with a billing representative.

www.pathologybilling.com

Servicio en espanol, por favor llame.

TOLL FREE: 1-877-835-0598
TOLL FREE FAX: 1-877-268-1254

Office hours:
Mon-Thur 8am-10pm EST
Fri 8am-8pm, Sat 10am-4pm

SECOND NOTICE, PLEASE REMIT PROMPTLY.
YOUR PROMPT ATTENTION IS NEEDED. SEND BALANCE SHOWN BY DUE DATE. THANK YOU.

Referring Physician:
MICHAEL R WATKINS MD

1

DATE	PROC. CODE	DESCRIPTION	Number of Specimens	AMOUNT
08/10/05	8830926	MICROSCOPIC ANALYSIS, VI	1	345.00

These charges are not included in any other hospital or physician statement. For more information or to update insurance information, see the back of this statement or visit www.pathologybilling.com.

BILLING OFFICE ADDRESS:

843 3

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

STATEMENT DATE	ACCOUNT #
10/05/05	GWD- 8010671-4

AMOUNT DUE
$ 345.00

Check # _____
(please do not staple)

AMOUNT ENCLOSED $

Patient Name: LISA J MARTIN

☐ Please check box if address or insurance information is incorrect and indicate change(s) on reverse side.

Do Not Mail Credit Card Information.
To pay by Credit Card , visit us at: www.pathologybilling.com
or call: 1-877-835-0598

ADDRESSEE:

LISA J MARTIN

201 POWELL MILL RD # G
SPARTANBURG SC 29301-1526

MAKE CHECKS PAYABLE TO & REMIT TO:

SPARTANBURG PATHOLOGY ASSOCIATES, PA
PO BOX 52990
GREENWOOD SC 29649-0048

10/10/2005 03:07PM

51 4927 491

$59.00

DATE PRINTED: 09/28/05 **DATE DUE: 10/18/05**

From LAKEPOINTE RADIOLOGY, P.C. for XRAY SERVICES
by ARU PATEL MD, a RADIOLOGIST, at BON SECOURS HOSPITAL
for LISA MARTIN (DOB: 06/18/68) on 08/01/05
for LISA MARTIN (DOB: 06/18/68) on 08/01/05

#BWNGFXX
#51492749111#

LISA J MARTIN
201 Powell Mill Rd Apt G201
Spartanburg SC 29301-1567

LAKEPOINTE RADIOLOGY, P.C.
BOX 77000 D 771336
DETROIT MI 48277-1336

INSURANCE ASSISTANCE

► IF YOU HAVE ADDITIONAL INSURANCE - SEND THEM THIS BILL ◄

PAYMENTS CREDITED

► NO PAYMENTS HAVE BEEN RECEIVED. ◄

► FULL PAYMENT IS YOUR RESPONSIBILITY ◄

YOUR ACCOUNT STATUS WITH LAKEPOINTE RADIOLOGY, P.C.

WHEN	WHERE	WHAT	CPT	ICD9	ORIGINAL CHARGE	APPROVED AMOUNT	PROCEDURE PAYMENTS	DUE NOW
08/01/05	EMR RM	LIMITED OB US ONE	76815	64683	$59.00	$59.00	<NONE>	$59.00

equals AMOUNT BILLED..... $59.00
less TOTAL PAID..... ■ NO PAYMENTS ■

==> EMERGENCY <== < US FUNDS ONLY > **AMOUNT DUE: $59.00**

IMPORTANT INFORMATION *More info is on back.*

1 - Please **WRITE YOUR ACCOUNT NUMBER** *(51 4927 491)* on your check.
2 - If you want to notify us by telephone, then call: ***800.765.0428<== TELEPHONE NUMBER***
(Please have your ACCOUNT NUMBER and INSURANCE INFO ready when calling).
Or notify us via email: *update@pmgpays.com<========== email updates*
--> We now accept VISA, MASTERCARD and AMERICAN EXPRESS PAYMENTS - Call us <--

YOUR ACCOUNT NUMBER: 51 4927 491

SPARTANBURG PATHOLOGY ASSOC
PO BOX 52990
GREENWOOD SC 29649-0048

(877) 835-0598

PSA PSR DEPARTMENT

LISA J MARTIN
30976 SPRINGLAKE BLV
APT 19205
NOVI MI 48377

ACCOUNT NO. 8010671
STATEMENT DATE 11/04/05
BALANCE DUE 345.00

DATE	PROCEDURE	DESCRIPTION OF SERVICE	AMOUNT	UNITS
08/10/05	88309	MICROSCOPIC ANALYSIS, VI	345.00	1
10/26/05		MEDICAID ADJUSTMENTS NOT ENROLLED OR ELIGIBLE FAMILY PLANNING COVERAGE ONLY	.00	

SPARTANBURG PATHOLOGY ASSOC
PO BOX 52990
GREENWOOD SC 29649-0048

(877) 835-0598

LISA J MARTIN
30976 SPRINGLAKE BLV
APT 19205
NOVI MI 48377

ACCOUNT NO.	8006137
STATEMENT DATE	11/04/05
BALANCE DUE	110.00

PSA FSR DEPARTMENT

DATE	PROCEDURE	DESCRIPTION OF SERVICE	AMOUNT	UNITS
08/09/05	88342	IMMUNOCYTOCHEMISTRY	110.00	1
10/26/05		MEDICAID ADJUSTMENTS NOT ENROLLED OR ELIGIBLE	.00	

The Following Document(s) is/are of Poor Quality and May not scan well

[redacted] Encounter #304410459 08/03/2005 DETAIL 11/03/2005
05 307 18 56 23 000810 RPT=OBILL780

[redacted]

TYPE OF BILL	DATE OF BILL	DATE OF PREV. BILL
CYCLE	11/03/05	
INS.	[redacted]	

PAGE NO. 1

BIRTH DATE [redacted]

EMPT. NO. 00176

	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	
5 E	MARTIN ,LISA	304410459	F	37	08/03/05			OUT PATIENT

[redacted]

GUARANTOR NAME AND ADDRESS:
LISA MARTIN
201 POWELL APT G201
SPARTANBURG,SC 29301-1567

INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
F MEDICAID OUT OF		9780275057

ADAMS T GARD MD

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
	DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS							
08/03	ED LEVEL 3	001 6841003	551.00	551.00				
08/03	US OB FETUS LI	001 2044114	177.00	177.00				
	SUMMARY OF CURRENT CHARGES							
	RADIOLOGY		177.00	177.00				
	EMERGENCY ROOM		551.00	551.00				
	SUB-TOTAL OF CURR. CHARGES		728.00	728.00				

GUAR RELATIONSHIP: S SEX: F GUAR NO: 368250542
ACC DATE: 08/03/05 TYPE: S TIME: 3:41 PM PLACE: EMPL REL:
DIAGNOSIS: 632
625.9

[redacted]

PATIENT NUMBER [redacted]

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

ANNAPOLIS HOSPITAL**
DETROIT, MI

Nov. 22. 2005 2:29PM Patient Acct No. 6448 P. 2/2

BON SECOURS COTTAGE HEAL
468 CADIEUX ROAD
GROSSE POINTE MI 482301
5864984960

2					3 PATIENT CONTROL NO. 3679669Z				4 TYPE OF BILL 131
5 FED. TAX NO. 383404533	6 STATEMENT COVERS PERIOD FROM 080105	THRU 080105	7 COV'D	8 N-COV'D	9 COV'D	10 L-R'D	11 MED		

12 PATIENT NAME: MARTIN, LISA
13 PATIENT ADDRESS: 201 POWELL MILL RD APT 201 SPARTANBURG, SC 29301

14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24-30 CONDITION CODES	31
06181968	F		080105	15		7		01	01280250		

32-35 OCCURRENCE CODE / DATE; 36 OCCURRENCE SPAN CODE / FROM / THROUGH; A B C

Z01 SELF PAY
468 CADIEUX ROAD

GROSSE POIN, MI 48230

	39 CODE	39 VALUE CODES AMOUNT	40	41 CODE	41 VALUE CODES AMOUNT
a	D3	177133			
b					
c					
d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0258	IV SOLUTIONS		080105	0	72.53	72.53	
2	0272	STERILE SUPPLY		080105	0	45.80	45.80	
3	0301	LAB/CHEMISTRY	80048	080105	1	120.00	120.00	
4	0301	LAB/CHEMISTRY	84702	080105	1	165.00	165.00	
5	0301	LAB/CHEMISTRY	84703	080105	1	68.00	68.00	
6	0305	LAB/HEMATOLOGY	85025	080105	1	62.00	62.00	
7	0307	LAB/UROLOGY	81001	080105	1	52.00	52.00	
8	0402	ULTRASOUND	76856	080105	1	497.00	497.00	
9	0450	EMERGENCY ROOM	90784	080105	1	54.00	54.00	
10	0450	EMERGENCY ROOM	99284	080105	1	635.00	635.00	
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	0001	TOTAL CHARGES				1771.33	1771.33	

50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A Z01 SELF PAY	383404533	Y	Y			
B						
C						
57	DUE FROM PATIENT ▶					

58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A MARTIN, LISA	01		UNKNOWN	
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 ES	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A	9		
B			
C			

67 PRIN. DIAG. CD.	68	69	70	71	72	73	74	75	76 ADM. DIAG. CD.	77 E-CODE	78
64003									V7240		

79 P.C.	80	81	82
	PRINCIPAL PROCEDURE CODE / DATE	A OTHER PROCEDURE CODE / DATE	B OTHER PROCEDURE CODE / DATE
	C OTHER PROCEDURE CODE / DATE	D OTHER PROCEDURE CODE / DATE	E OTHER PROCEDURE CODE / DATE

83 ATTENDING PHYS ID: MI43053686
382801815 COURTNEY, LAVELL
84 OTHER PHYS ID: A
OTHER PHYS ID: MI43053686 B
382801815 COURTNEY, LAVELL

a 84 REMARKS MED201
b
c
d

UB-92 HCFA-1450 OCR/ORIGINAL 1 CERTIFY THE CERTIFICATIONS ON THE REVERSE 11/22/2005 02:43PM

The Following Document(s) is/are of Poor Quality and May not scan well

PSA

111 East Evans Street · Suite 301 · Florence, SC 29506
P.O. Box 100559 · Florence, SC 29501-0559

843-664-4300 · 800-432-5270 · Fax 843-664-4322
psa@psapath.com · www.psapath.com

FAX TRANSMITTAL SHEET

Date: 11-04-05

Pages Including Cover: 5

To: Betsy Carroll (DHHS) From: Mary Crutcher, Secretary

CC: Email:

Fax: 803-255-8223 Fax: 877-268-1254

Phone: Phone:

RE: 2 itemized bills for Lisa Joy Martin

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Recycle

SPARTANBURG PATHOLOGY ASSOC
PO BOX 52990
GREENWOOD SC 29649-0048

(877) 835-0598

PAGE 1

PSA PSR DEPARTMENT

LISA J MARTIN
30976 SPRINGLAKE BLV
APT 19205
NOVI MI 48377

ACCOUNT NO. 8010671
STATEMENT DATE 11/04/05
BALANCE DUE 345.00

DATE	PROCEDURE	DESCRIPTION OF SERVICE	AMOUNT	UNITS
08/10/05	88309	MICROSCOPIC ANALYSIS, VI	345.00	1
10/26/05		MEDICAID ADJUSTMENTS	.00	
		NOT ENROLLED OR ELIGIBLE		
		FAMILY PLANNING COVERAGE ONLY		

SPARTANBURG PATHOLOGY ASSOC
PO BOX 52990
GREENWOOD SC 29649-0048

(877) 835-0598

PAGE 1

PSA PSR DEPARTMENT

LISA J MARTIN
30976 SPRINGLAKE BLV
APT 19205
NOVI MI 48377

ACCOUNT NO. 8006137
STATEMENT DATE 11/04/05
BALANCE DUE 110.00

DATE	PROCEDURE	DESCRIPTION OF SERVICE	AMOUNT	UNITS
08/09/05	88342	IMMUNOCYTOCHEMISTRY	110.00	1
10/26/05		MEDICAID ADJUSTMENTS NOT ENROLLED OR ELIGIBLE	.00	

Oakwood Healthcare System

OAKWOOD HOSPITAL AND MEDICAL CENTER - DEARBORN
PATIENT ACCOUNTING/VILLAGE PLAZA
Phone Number: (313) 791-1200
Fax: (313) 791-4663

TELECOPIER COVER LETTER

To: Betsy Carroll

Firm/Department: DHHS

Fax Number: 803-255-8823

Senders Name: Allae + Kathy

Confirmation Number (sender's phone#) 800-858-9503

Total Number of Pages 2
(including face sheet)

Date: 11-4-05

MESSAGE:

C:\mydocuments\Fax.dot

11/03/2005 02:32PM

PATIENT STATEMENT OF ACCOUNT

PATIENT ACCOUNTS
804 Scott Nixon Memorial Drive
Augusta, GA 30907

Address Service Requested

CHECK CARD USING FOR PAYMENT
MASTERCARD VISA DISCOVER TRANSOVER AMEX

CARD NUMBER | 4 DIG CID | EXP. DATE

SIGNATURE (REQUIRED)

PRINT NAME ON CARD | PAY THIS AMOUNT $1,800.00

SHOW AMOUNT PAID HERE $

ACCOUNT NO.	CODE	STATEMENT DATE
0522101371	FP363	10/12/05

** CREDIT CARD PAYMENTS PROCESSED BY ANESTHESIOLOGY SERVICES AUGUSTA, GA **

ADDRESSEE

LISA MARTIN
G201
201 POWELL MILL RD
SPARTANBURG SC 29301-1526

☐ CHECK HERE FOR ADDRESS CHANGE. PLEASE MAKE CHANGES ON BACK
www.kam2000.com/pa

MAKE CHECK PAYABLE TO

Foothills Anesthesia Consultan
PO BOX 4391
SPARTANBURG SC 29305-4391

DETACH AND RETURN TOP PORTION WITH PAYMENT

STATEMENT OF SERVICES RENDERED

SERVICE DATE	CASE NUMBER	CPT CODE	DESCRIPTION OF PROCEDURE OR SERVICE	CHARGES / PAYMENT & ADJ. PATIENT	INSURANCE
8 10 05	3310308	01967 P3	Anesthesiology Services by Dr. D. SHANTHA for Dr. M.Haddad Billed To Patient 632 Diagnostic Code	$1,800.00	

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	NEW BALANCE	PATIENT	INSURANCE
$0.00	$1,800.00	$0.00	$0.00	$0.00		$1,800.00	$0.00

ACCOUNT NO.	STATEMENT DATE	
0522101371	10/12/05	PATIENT IS RESPONSIBLE FOR "PATIENT NEW BALANCE" PAYMENT IS DUE WITHIN 15 DAYS OF RECEIPT OF STATEMENT.

OFFICE HOURS: 8:00AM-4:15PM EST PHONE NO: 888 850 6304

THIS IS A BILL FOR SERVICES NOT INCLUDED ON YOUR HOSPITAL BILL. PLEASE CALL OUR OFFICE WITH QUESTIONS CONCERNING YOUR BILL. IF PAYMENT HAS BEEN MADE PLEASE DISREGARD THIS BILL. THANK YOU.

** CREDIT CARD PAYMENTS PROCESSED BY ANESTHESIOLOGY SERVICES AUGUSTA, GA **

11/04/2005 11:41 8436292974 PSA PSR DEPARTMENT PAGE 01/05

PSA

111 East Evans Street · Suite 301 ·Florence, SC 29506
P.O. Box 100559 ·Florence, SC 29501-0559

843-664-4300 · 800-832-5270 · Fax 843-664-4122
psa@psapath.com ·www.psapath.com

FAX TRANSMITTAI SHEET

Date: 11-04-05

Pages Including Cover: 2

To: Betsy Carroll (DHHS) **From:** Mary Crutcher, Client Services

CC: **Email:**

Fax: 803-255-8223 **Fax:** 877-268-1254

Phone: **Phone:**

RE: 2 itemized bills for Lisa Joy Martin

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Recycle

11/04/2005 10:48AM

South Carolina
Partners for Healthy Children

October 21, 2005

Lisa J Martin
~~PO Box 92~~ 201 Powell Mill Rd. Copy
~~Converse, SC 29329~~ Apt. G201
Budget Group Number: Spartanburg, SC 29301

Dear Mr/Ms Martin,

In order to determine eligibility for Partners for Healthy Children, we will need the information indicated below for the applicant, spouse and/or children under the age of 19:

Name	Information Needed
Lisa	We need the diagnosis code used for billing.

A self-addressed envelope is provided for you to return this information to me by 10/31/2005. You may want to fax this information. Our fax number is (803) 255-8223. I may be contacted at the toll free number listed below if you have any questions. Thank you for your cooperation.

Sincerely,

Betsy Carroll
Eligibility Worker
Ext# 83010

Division of Central Eligibility Processing
Post Office Box 100101 Columbia South Carolina 29202-3101
1-888-549-0820
www.dhhs.state.sc.us

MEDHMS49 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 10/10/05
MEDSPROD HOUSEHOLD BUDGET GROUPS
PAGE: 0001

HH NAME: MARTIN LISA J ACTION TYPE: MAINTENANCE
HH NUMBER: 101076312 APL STATUS: _____ ACTION DATE: 09/16/05

S	BG NUMBER	CATEGORY	WORKER	CNTY	LOC	NEXT REVIEW	LAST REVIEW	BG STATUS
_	28958914	FP	RBOST	47	077	09/18/2006	_____	ACTIVE

UPDATED: USER ID: RBOST DATE: 09/16/05 SYSTEM ID: HMS5000 DATE: 09/16/05
ME904675 HOUSEHOLD BUDGET GROUPS FOUND
PF1->HELP PF3->HH MEMBERS PF5->BG DETERMINATION
PF6->RETURN PF7->PREV PF8->NEXT PF10->PREV MENU PF17->ELD00

N

09/23/2005 09:56AM

To: Betsy Carroll (803)255-8223 fax Sept. 23, 2005

From: Lisa J. Martin Ph# 864-574-8577

Re: Unpaid hospitals due to stillborn pregnancy and complications

8pgs incl. cover

09/23/2005 09:56AM
REGIONAL MATERNAL-FETAL MEDICINE
853 N CHURCH STR STE 610
SPARTANBURG, SC 29303

MAKE CHECKS PAYABLE TO: REG MATERNAL-FETAL MED

☐ VISA ☐ MASTERCARD ☐ DISCOVER

CARD NUMBER: _____ EXP DATE: _____

SIGNATURE: _____

PAYMENTS WILL BE POSTED TO OLDEST INVOICES FIRST UNLESS YOU INDICATE OTHERWISE HERE: _____

STATEMENT DATE	ACCT #	AMOUNT DUE	AMOUNT ENCLOSED
08/16/05	29-695931	$330.00	$

BILLING INQUIRIES: CALL 864-560-1600

LISA MARTIN
201 POWELL MILL RD
SPARTANBURG, SC 29301-1826
168 1 AV 0.270

REG MATERNAL-FETAL MED
853 N CHURCH STR STE 610
SPARTANBURG, SC 29303

PLEASE REVIEW YOUR INSURANCE INFORMATION ON THE REVERSE SIDE. IF CHANGES ARE NECESSARY, PLEASE CALL US AT THE NUMBER(S) ABOVE.

STATEMENT OF PROFESSIONAL SERVICES

(AS OF AUGUST 16, 2005)

LISA MARTIN (ACCT # 29-695931)

INVOICE NUMBER: 29-5207604

CHARGES

PROVIDER: JAMES SCARDO MD

08/09/05 76805-ECHO EXAM OF PREGNANT UTERUS - 76806	$330.00
TOTAL:	$330.00

PAYMENT ACTIVITY:

AMOUNT PAID THIS	$330.00

NOTE: NO INSURANCE CLAIM WAS FILED FOR THIS SERVICE. IF YOU HAVE INSURANCE THAT COVERS THIS SERVICE, PLEASE CONTACT OUR OFFICE AT 864-560-1600.

TOTAL AMOUNT DUE NOW: $330.00

REGIONAL MATERNAL-FETAL MEDICINE

11/03/2005 02:32PM

PATIENT STATEMENT OF ACCOUNT

PATIENT ACCOUNTS
804 Scott Nixon Memorial Drive
Augusta, GA 30907

Address Service Requested

CHECK CARD USING FOR PAYMENT

MASTERCARD VISA DISCOVER NOVUS AMEX OTHER

CARD NUMBER | 4 DIG CID | EXP. DATE

SIGNATURE (REQUIRED)

PRINT NAME ON CARD | PAY THIS AMOUNT $1,800.00

SHOW AMOUNT PAID HERE $

ACCOUNT NO.	CODE	STATEMENT DATE
0522101371	FP363	10/12/05

** CREDIT CARD PAYMENTS PROCESSED BY ANESTHESIOLOGY SERVICES AUGUSTA, GA **

ADDRESSEE

LISA MARTIN
G201
201 POWELL MILL RD
SPARTANBURG SC 29301-1526

MAKE CHECK PAYABLE TO

Foothills Anesthesia Consultan
PO BOX 4391
SPARTANBURG, SC 29305-4391

☐ CHECK HERE FOR ADDRESS CHANGE, PLEASE MAKE CHANGES ON BACK
www.kam2000.com/pa

DETACH AND RETURN TOP PORTION WITH PAYMENT

STATEMENT OF SERVICES RENDERED

SERVICE DATE	CASE NUMBER	CPT CODE	DESCRIPTION OF PROCEDURE OR SERVICE	CHARGES / PAYMENT & ADJ. PATIENT	INSURANCE
8 10 05	3310308	01967 P3	Anesthesiology Services by Dr. D. SHANTHA for Dr. M.Haddad Billed To Patient 632 Diagnostic Code	$1,800.00	

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	NEW BALANCE	PATIENT	INSURANCE
$0.00	$1,800.00	$0.00	$0.00	$0.00		$1,800.00	$0.00

ACCOUNT NO.	STATEMENT DATE	
0522101371	10/12/05	PATIENT IS RESPONSIBLE FOR "PATIENT NEW BALANCE" PAYMENT IS DUE WITHIN 15 DAYS OF RECEIPT OF STATEMENT.

OFFICE HOURS: 8:00AM-4:15PM EST PHONE NO: 888 850 6304

THIS IS A BILL FOR SERVICES NOT INCLUDED ON YOUR HOSPITAL BILL.
PLEASE CALL OUR OFFICE WITH QUESTIONS CONCERNING YOUR BILL.
IF PAYMENT HAS BEEN MADE PLEASE DISREGARD THIS BILL. THANK YOU.

** CREDIT CARD PAYMENTS PROCESSED BY ANESTHESIOLOGY SERVICES AUGUSTA, GA **

11/04/2005 11:41 8436292974 PSA PSR DEPARTMENT PAGE 01/05

PSA

161 East Evans Street · Suite 301 ·Florence, SC 29506
P.O. Box 100559 ·Florence, SC 29501-0559

843-664-4300 · 800-832-6270 · Fax 843-664-4322
psa@psapath.com ·www.psapath.com

FAX TRANSMITTAI SHEET

Date: 11-04-05

Pages Including Cover: 5

To: Betsy Carroll (DHHS) From: Mary Crutcher, Sleep Disorders

CC: Email:

Fax: 803-255-8223 Fax: 877-268-1254

Phone: Phone:

RE: 2 itemized bills for Lisa Joy Martin

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Recycle

11/04/2005 10:48AM

The Following Document(s) is/are of Poor Quality and May not scan well

Nov. 22. 2005 2:29PM Patient Acct No. 6448 P. 1/2

BON SECOURS COTTAGE HEALTH SERVICES Henry Ford Health System

CONFIDENTIAL
PATIENT HEALTH INFORMATION ENCLOSED

Health Information is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

Date: 11-22-05 # of pages sent including cover sheet: 2

Time: Fax Number: (803-265-8223

To: Betsy Carrol Recipient's Phone Number: (586-498-4952

NOTIFY BSCHS IMMEDIATELY WITH ANY CHANGES TO YOUR FAX #

FROM: Bon Secours Cottage Health Services
Patient Accounting Department
468 Cadieux Rd.
Grosse Pointe, MI 48230
(586)-498-4960

Sender: Cindy Fax Number: (586)-498-4930

Message: Please process claim.

IMPORTANT WARNING:
This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, 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 message by error, please notify us immediately and return or destroy the documents received.

11/22/2005 02:43PM

11/03/2005 02:32PM

To: Betsy Carroll

Nov 3, 2005 2pages

From: Lisa Martin
Fax # 803-255-8223
Ph# 803-898-3010.
Re: Diagnostic Codes
Stillborn Pregnancy 8/1/05 (Spartanburg Regional)

Per our conversation on the phone. Four offices will be faxing their bills with diagnostic codes to your office as you have requested. Please call me when the decision has been made by your supervisor regarding the payment of my bills. Your assistance is very much appreciated.

Lisa J. Martin

SPARTANBURG PATHOLOGY ASSOC
PO BOX 52990
GREENWOOD SC 29649-0048

(877) 835-0598

PAGE 1

PSA PSR DEPARTMENT

LISA J MARTIN
30976 SPRINGLAKE BLV
APT 19205
NOVI MI 48377

ACCOUNT NO. 8010671
STATEMENT DATE 11/04/05
BALANCE DUE 345.00

DATE	PROCEDURE	DESCRIPTION OF SERVICE	AMOUNT	UNITS
08/10/05	88309	MICROSCOPIC ANALYSIS, VI	345.00	1
10/26/05		MEDICAID ADJUSTMENTS NOT ENROLLED OR ELIGIBLE FAMILY PLANNING COVERAGE ONLY	.00	

SPARTANBURG PATHOLOGY ASSOC
PO BOX 52990
GREENWOOD SC 29649-0048

(877) 835-0598

LISA J MARTIN
30976 SPRINGLAKE BLV
APT 19205
NOVI MI 48377

ACCOUNT NO. 8006137
STATEMENT DATE 11/04/05
BALANCE DUE 110.00

DATE	PROCEDURE	DESCRIPTION OF SERVICE	AMOUNT	UNITS
08/09/05	88342	IMMUNOCYTOCHEMISTRY	110.00	1
10/26/05		MEDICAID ADJUSTMENTS NOT ENROLLED OR ELIGIBLE	.00	

SPARTANBURG PATHOLOGY ASSOC
PO BOX 52990
GREENWOOD SC 29649-0048

(877) 835-0598

PSA PSR DEPARTMENT

LISA J MARTIN
30976 SPRINGLAKE BLV
APT 19205
NOVI MI 48377

ACCOUNT NO. 8006137
STATEMENT DATE 11/04/05
BALANCE DUE 110.00

DATE	PROCEDURE	DESCRIPTION OF SERVICE	AMOUNT	UNITS
08/09/05	88342	IMMUNOCYTOCHEMISTRY	110.00	1
10/26/05		MEDICAID ADJUSTMENTS NOT ENROLLED OR ELIGIBLE	.00	

SPARTANBURG PATHOLOGY ASSOC
PO BOX 52990
GREENWOOD SC 29649-0048

(877) 835-0598

PAGE 1

LISA J MARTIN
30976 SPRINGLAKE BLV
APT 19205
NOVI MI 48377

ACCOUNT NO.	8010671
STATEMENT DATE	11/04/05
BALANCE DUE	345.00

PSA PSR DEPARTMENT

DATE	PROCEDURE	DESCRIPTION OF SERVICE	AMOUNT	UNITS
08/10/05	88309	MICROSCOPIC ANALYSIS, VI	345.00	1
10/26/05		MEDICAID ADJUSTMENTS NOT ENROLLED OR ELIGIBLE FAMILY PLANNING COVERAGE ONLY	.00	

11/04/2005 11:41 8436292974

11/04/2005 10:48AM

ACCOUNT
BALANCE
345.00

11/04/2005 10:48AM

ACCOUNT
BALANCE
110.00

```
MEDELD01 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 01/24/06
MEDSPROD                    MEDICAID ELIGIBILITY DECISION           ACTION:
                    DATES-FROM: 01 / 2006 THRU: __ / ____           PAGE: 2 OF 3
HH NAME:   LISA J MARTIN                                  HH NUMBER: 101064729
BG NUMBER: 69101522          CATEGORY: FP                 ACTION TYPE: MAINTENANCE
BG: D  BGP: D      WKR: BARTH    BETSY CARROLL             ACTION DATE: 01/24/06
   COUNTABLE BG MEMBERS:  2
   COUNTABLE INCOME:          0.00      COUNTABLE RESOURCES:          0.00
      INCOME LIMIT:           0.00      RESOURCE LIMIT:               0.00
           POV-LVL:           +.00 %     HLTH INS PREM:               0.00
   RECURRING INC:      0.00   TOTAL ALLOC:      0.00   OSS AWARD:      0.00
MEETS NON-FINANCIAL?    (Y/N): _      ACT ON DECISION COMPLETE? (Y/N): Y
MEETS INCOME?           (Y/N): _      DECISION ACCEPTED DATE:    01/24/06
MEETS RESOURCES?        (Y/N): _      NEXT REVIEW DATE:          01/25/07
MEETS OTHER CONDITIONS? (Y/N): Y      ANTICIPATED CLOSURE DATE:  ________
REASON(S) FOR DENIAL/CLOSURE/CHANGE:
054 You have not met eligibility rules.

___ ____________________________________________________________________
ELIGIBILITY DECISION APPEALED? (Y/N) _     CONTINUE BENEFITS?      (Y/N): _
APPEAL REQUEST DATE: ________              COUNTY DECISION UPHELD? (Y/N): _
UPDATED: USER ID: BARTH     DATE: 01/24/06 SYSTEM ID: ELD3000  DATE: 01/24/06
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
```

4EDELD02 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 01/24/06
MEDSPROD MEDICAID ELIGIBILITY DECISION ACTION:
DATES-FROM: 01 / 2006 THRU: __ / ____ PAGE: 3 OF 3

HH NAME: LISA J MARTIN HH NUMBER: 101064729
BG NUMBER: 69101522 CATEGORY: FP ACTION TYPE: MAINTENANCE
BG: D BGP: D WKR: BARTH BETSY CARROLL ACTION DATE: 01/24/06
RCP NAME: LISA J MARTIN RCP NUMBER: 9780275057
PREVIOUS BG: _____ NEW BG: _____ CORRECT RCP NUMBER: _____
IT: _ PING-PONG: _ RETRO: N EXPARTE: N QMB: N PROT PER DATE: _____

ACTUAL ELIGIBILITY DATES

LIMITED ---BENEFIT DATES--- BEGIN	END	--MEDICAID+QMB DATES-- BEGIN	END	SERVICE TYPE	REASON CODE 1	REASON CODE 2
					054	

UPDATED: USER ID: BARTH DATE: 01/24/06 SYSTEM ID: ELD3000 DATE: 01/24/06
ME900115 BUDGET GROUP PERIOD INFORMATION FOUND
PF1-HELP PF2-PREV MBR PF3-NEXT MBR PF5-HH MBR DTL PF6-RETURN PF10-MENU
PF11-HH MBRS PF15-MD PF16-BG DET PF18-RCP INFO PF21-HIST- PF22-HIST+ PF24-AOD

4EDHMS49 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 02/14/06
MEDSPROD HOUSEHOLD BUDGET GROUPS
PAGE: 0001

HH NAME: MARTIN LISA J ACTION TYPE: MAINTENANCE
HH NUMBER: 101064729 APL STATUS: ACTION DATE: 01/24/06

S	BG NUMBER	CATEGORY	WORKER	CNTY	LOC	NEXT REVIEW	LAST REVIEW	BG STATUS
_	98728261	PHC	BARTH	47	077	08/30/2006		ACTIVE
_	09087814	OCWIPW	TDOUG	47	077			CLOSED
_	69101522	FP	BARTH	47	077	01/25/2007		DENIED
_	89035830	OCWIPW	BARTH	47	077			DENIED
_	18953116	FP	FHARR	47	077	11/13/2005		DENIED
_	98728258	OCWIPW	BARTH	47	077			DENIED
_	68933704	FP	FHARR	47	077	08/24/2006		DENIED
_	28902696	FP	TAKES	47	077	07/28/2006		DENIED
_	78899769	PHC	PHURS	42	003	07/26/2006		DENIED
_	78899755	OCWIPW	PHURS	42	003			DENIED

UPDATED: USER ID: BARTH DATE: 01/24/06 SYSTEM ID: HMS5000 DATE: 01/24/06
ME904675 HOUSEHOLD BUDGET GROUPS FOUND
PF1->HELP PF3->HH MEMBERS PF5->BG DETERMINATION
PF6->RETURN PF7->PREV PF8->NEXT PF10->PREV MENU PF17->ELD00

State of South Carolina

Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

January 24, 2006

Lisa J Martin
201 Powell Mill Rd Apt G201
Spartanburg, SC 29301
Budget Group Number:

APR

Dear Ms Martin,

In order to determine eligibility for the Family Planning Waiver Program, we will need the information indicated below:

Name	Information Needed
Lisa	We need a copy of the hospital bill.

A self-addressed envelope is provided for you to return this information to me by 02/03/2006. You may want to fax this information. Our fax number is (803)255-8223. I may be contacted at our toll free number listed below if you have any questions. Thank you for your cooperation.

Sincerely,

Betsy Carroll
Eligibility Worker
Ext. 83010

11/03/2005 02:32PM

To: Betsy Carroll

Nov 3, 2005 2pages

From: Lisa Martin
Fax # 803-255-8223
Ph # 803-898-3010.

Re: Diagnostic Codes
Stillborn Pregnancy 8/10/05 (Spartanburg Regional)

Per our conversation on the phone. Four offices will be faxing their bills with diagnostic codes to your office as you have requested. Please call me when the decision has been made by your supervisor regarding the payment of my bills. Your assistance is very much appreciated.

Lisa J. Martin

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

November 28, 2005

Ms. Lisa J Martin
201 Powell Mill Road
Apartment 201 G
Spartanburg, South Carolina 29301

Dear Ms. Martin:

In order for us to update our records for your Family Planning case, we will need the following information:

Are you a citizen of the United States? Yes No Please circle one.

If you are not a citizen of the United States, we will need a copy of your green card. If you are, please send us a copy of your Social Security card, along with this letter or a copy of it. We are enclosing a self-address postage envelope for you to use in returning this information to us.

If you have any further questions, please do not hesitate to call me. Our toll free number is 1-888-549-0820 and my extension is 8-3016.

Sincerely,

Romie Bostick
Eligibility Worker
Central Eligibility Department

Encl:

Central Eligibility Processing
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 803-898-2997 Fax (803) 803-2558223

10107631Z
10085908

From: Karen Felder
To: Bostick, Romie
Date: 11/4/05 12:59:21 PM
Subject: Lisa Martin - 368-25-0542

Caller reports that this client is not a US citizen - that she came from Canada within the past 5 years.

CC: Douglas, Tamara

11-4-05

T-

I'm not sure how to handle this - please advise.

Thx!

Romie

~~Lisa is not a US citizen.~~

Romie,
Betsy is also working on a Lisa Martin who is not a US citizen. Yall need to compare notes to see if same person.
You may need to contact clt & ask her to provide proof of citizenship.

Thanks,
TD
11/16/05

[redacted]

-yes- request birth cert & or "green card." TD 11/25

```
MEDHMS54 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 11/04/
MEDSPROD                      RECIPIENT INFORMATION               ACTION:
                  MEMBER PERIOD START: 09/15/05  END:             PAGE: 0001
NAME: MARTIN LISA J                              HH NAME: MARTIN LISA J
RCP NUMBER: 9780275057     HH NUMBER: 101076312        ACTION TYPE: MAINTENA
SSN: 368-25-0542  VC: V   APL STATUS:                  ACTION DATE: 09/16/05
PRIMARY INDIVIDUAL:       APL CO: 42     WORKER ID: RBOST    LOCATION: 077
201 POWELL MILL RD                       SSCN:               RRN:
APT G201                                 RACE: 02   SEX: F   MARITAL STATUS:
                                         TPL INSURANCE: N    RELATION:
SPARTANBURG               SC 29301-      DOB: 06/18/1968     DOD:
CORRECT RCP NUMBER: _________            LIV ARRANGEMENT: HOME INCOME TRUST:
                                         PROVIDER:

     BG       BEG          END                BENEFITS QMB RETRO  % OF POV   CHI
S  NUMBER     ELIG         ELIG     PCAT QCAT  TYPE     IND  IND    LEVEL    NUMB
_ 28958914 09/01/2005              55  30    LIMITED    N    Y        .00

 UPDATED: USER ID: RBOST     DATE: 09/16/05  SYSTEM ID: TTR1001  DATE: 09/11/
ME900063 RECIPIENT RECORD FOUND
 PF2->HH BG  PF3->HH MBR DTL  PF4->REFH  PF5->ELD02  PF6->RETURN  PF7->PREV
 PF8->NEXT  PF10->PREV MENU  PF15->RCP SEARCH  PF17->ELD00  PF18->HH MBR BGS
```

State of South Carolina

Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

November 28, 2005

To: Betsy Carroll
Human Services Specialist II

From: Betsy Carroll
Eligibility Worker

Subject: **Emergency Service Decision**

Name: Lisa J Martin
Recipient ID#: 9780275057

The above non-qualified alien was determined medically eligible for emergency services for the following period(s) only:

ELIGIBLE Beginning 08/01/2005 Ending 09/01/2005

Medical claims will be paid for services related to the medical diagnosis only during the eligibility period

If you have questions please contact me at (803)898-2997 ext. 83010.

Division of Central Eligibility Processing
Post Office Box 100101 Columbia South Carolina 29202-3101
www.dhhs.state.sc.us
1-888-549-0820

1010647864

38678 8593

From: Betsy Carroll
To: Tamara Douglas
Date: 12/29/2005 10:29:23 AM
Subject: Lisa J. Martin 368-25-0542

She has called me and stated that she is receiving 4 bills so far and she wants to know what to do from here. I am researching to see what was done, because I remember approving for Emergency Services for 09-01-05. However, it's not showing in MEDS.

I'll talk to you next week about this case. Her telephone # is 864-574-1311.

Thanks,
Betsy

```
MEDSVE04 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 10/16/06
 MEDSPROD                  SVES QC 40 INQUIRY INFORMATION

 SSN: 368-25-0542 NAME: LISA J MARTIN                          RCP NUM: 9780275057
 INPUT SSN: 368-25-0542  -----QC 40 INFORMATION----------------------------------
 VERIFIED SSN: 368-25-0542   SSA NAME: LISA J MARTIN
 STATE CODE: 042    STATE DATA:                                DOB: 06/18/1968
 RAILROAD SERVICE:   0   CONDITION CODE:       MIN # QQ:  0   MAX # QQ:  0
 ------------------------------COVERAGE PATTERN---------------------------------
 1937-NNNN 1938-NNNN 1939-NNNN 1940-NNNN 1941-NNNN 1942-NNNN 1943-NNNN 1944-NNNN
 1945-NNNN 1946-NNNN 1947-NNNN 1948-NNNN 1949-NNNN 1950-NNNN 1951-NNNN 1952-NNNN
 1953-NNNN 1954-NNNN 1955-NNNN 1956-NNNN 1957-NNNN 1958-NNNN 1959-NNNN 1960-NNNN
 1961-NNNN 1962-NNNN 1963-NNNN 1964-NNNN 1965-NNNN 1966-NNNN 1967-NNNN 1968-NNNN
 1969-NNNN 1970-NNNN 1971-NNNN 1972-NNNN 1973-NNNN 1974-NNNN 1975-NNNN 1976-NNNN
 1977-NNNN 1978-NNNN 1979-NNNN 1980-NNNN 1981-NNNN 1982-NNNN 1983-NNNN 1984-NNNN
 1985-NNNN 1986-NNNN 1987-NNNN 1988-NNNN 1989-NNNN 1990-NNNN 1991-NNNN 1992-NNNN
 1993-NNNN 1994-NNNN 1995-NNNN 1996-NNNN 1997-NNNN 1998-NNNN 1999-NNNN 2000-CCCC4
 2001-CCCC4 2002-CCCC4 2003-CCCN3 2004-NNNN 2005-NNNN 2006-NNNN 2007-NNNN 2008-NNNN
 2009-NNNN 2010-NNNN 2011-NNNN 2012-NNNN 2013-NNNN 2014-NNNN 2015-NNNN 2016-NNNN
 2017-NNNN 2018-NNNN 2019-NNNN 2020-NNNN 2021-NNNN 2022-NNNN 2023-NNNN 2024-NNNN
 UPDATED: SYSTEM ID: SVE3000   DATE: 10/14/06                   2025-NNNN
DC172008 *** UNACCEPTABLE RESPONSE. PLEASE TRY AGAIN ***
 PF1->HELP  PF6->RETURN PF10->PREV MENU
```

(15) -needs 40

HID 416 240.

.292

PROCESSED FOR I-551
TEMPORARY EVIDENCE OF
LAWFUL ADMISSION FOR
PERMANENT RESIDENCE
VALID UNTIL 9/29/04
EMPLOYMENT AUTHORIZED
IR6

MARTIN
LISA J
CANADA

10 06 68
FEMALE

7636 DOLPHIN ST
DETROIT MI 48239

PERMANENT RESIDENT CARD

NAME MARTIN, LISA J

INS A# 078-470-240
Birthdate Category Sex
06/10/68 IR6 F
Country of Birth
Canada
CARD EXPIRES 06/21/14
Resident Since 01/30/01

C1USA0784702409LIN0400250635<<
6806189F1406218CAN<<<<<<<<<<<5
MARTIN<<LISA<J<<<<<<<<<<<<<<