

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Jackie</i>	DATE <i>2/11/11</i>
---------------------	------------------------

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER <i>100351</i>	<input type="checkbox"/> I Prepare reply for the Director's signature DATE DUE _____		
2. DATE SIGNED BY DIRECTOR <i>Cleared 2/17/11, see attached e-mail.</i>	<input checked="" type="checkbox"/> I Prepare reply for appropriate signature DATE DUE <i>2/23/11</i> <input type="checkbox"/> I FOIA DATE DUE _____ <input type="checkbox"/> I Necessary Action		

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE * (Note reason for disapproval and return to preparer.)	COMMENT
1.			<i>Note: Not in envelope - 10-4-10 Data stamped in Cont. Log 2/10/11</i>
2.			
3.			
4.			

Gwendolyn B. Bobo

9422 Ayescough Rd., Summerville, SC 29485

Home Phone (843)771-0542 E-mail: gwenbobob@hotmail.com

October 4, 2010

RECEIVED

FEB 10 2011

**CENTRAL ELIGIBILITY
PROCESSING**

Ms. J. Wright
DHHS Region VIII
PO Box 13748
Charleston, SC 29422-3748

Re: Eartha Stevens

Dear Ms. Wright:

The purpose of this letter is to register a formal complaint against and to request immediate removal of case worker E. Lee from my cousin's case.

I feel that Ms. Lee has made the handling of Eartha's case a personal vendetta against me because of my response in a memo that I sent to her dated 9/24/10 (enclosure #1). I have complied with her requests in a timely manner and answered as many questions that I could about Eartha.

On 9/20/10 (encl. #2), I received a notice from Ms. Lee regarding Eartha's benefits being discontinued as of 9/30/10 because of Ms. Lee not receiving information on an insurance policy. I have called repeatedly and also written this company to get the information, but the only information that I have gotten is that her deceased husband is the beneficiary. I immediately sent a faxed request to the insurance company when this information was requested (encl. #3). I found out about this policy through one of my cousins who was paying the premium and could no longer pay it. She told me about this so I could pay it to keep it in force. She gave me the company's contact information and the monthly payment which is \$22.85 (encl. #3). I sent the company my power-of-attorney and informed them that I would be paying the premiums and requested the statements be sent to me. I also inquired as to the amount and beneficiary of the policy. I was informed that the beneficiary is her husband, S. Braction, who was deceased at the time of my inquiry.

I spent thousands of my own money trying to keep my cousin safe and to get her the medical care/treatment that she needed while I fought to get her benefits. I explained to Ms. Lee the difficulties that I encountered getting benefits for a cousin who is 25 years older, has Alzheimer's disease, never lived with me, and cannot help with completion of paperwork.

The "Notice of Proposed Action" (encl. #2) stated that one could request a fair hearing with a signed written request within ten days of the date of the notice. The notice is dated 9/10/10 and my request was fax and mailed on 9/24/10. I did not hear from Ms. Lee concerning the request so I called. Ms. Lee told me that I have to complete a form to request a hearing. I told her that there was no mention of another form to be completed on the notice. I asked her what was on the form that I have not included in my request (encl. #1). Her exact words were, "**You have to check the box requesting the hearing.**" I asked her if she could fax the form to me because sometimes mail is delayed and I didn't want to miss the deadline. She said she could not because she would have no way of knowing who signed the form. She said she mailed it.

I reminded her that we were dealing with a discontinuance of benefits date of 9/30/10 which was few days away. I asked her what would happen if I did not get the form and could not return it by the

October 4, 2010

deadline. Ms. Lee said that, “**Nothing is final until after the hearing.**” I told her that the notice stated definite dates for discontinuance and the nursing home received the same notice. It seemed like a final decision to not only me but to Ms. Susy. I told Ms. Lee that Ms. Susy from Mt. Pleasant Manor called me very concerned about the notice and wanted to know about the problem. Ms. Lee was silent and finally said that Eartha’s benefits would be discontinued as of the dates on the notice. Ms. Lee was not forthright. She deliberately tried to mislead me. You may ask for what reason. My answer is “she is rancorous” and she knows that she can use her position to “make or break” people. People from whom you probably never will receive complaints because they are so afraid of not getting their benefits.

Ms. Susy from the Business Office of Mt. Pleasant Manor where Eartha resides called me to inquire about any changes in Eartha’s status. I told her that I was complying with Ms. Lee’s request, but I did not have the insurance information. I told her that Ms. Lee could not get the information.

On 9/30/10, I called Ms. Lee several times with the intention of speaking to her about “options”, but I got her voicemail. I also wanted to let her know that I had not received the form (DHHS form 3260). In the meantime, Ms. Susy called me. I told her that I could not reach Ms. Lee. Ms. Susy said that she would call and leave a message for Ms. Lee to contact me.

Ms. Lee finally called back around 3:00 pm on 9/30/10 and said there was absolutely nothing that could be done until the box on the form was checked and the form signed and returned to her.

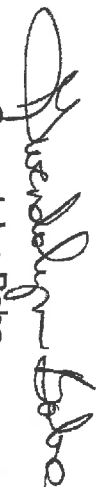
As of today, 10/4/10, I have not spoken with Ms. Lee.

On Saturday, 10/2/10, I finally received the form (#3260) which was the prerequisite for securing a “fair hearing”. After reading the form, it states clearly under Part II that “**A signed letter from the applicant/beneficiary/authorized representative requesting a fair hearing may be attached instead of the signed statement below.**” (encl. #4) For this reason, I am not mailing back this form – Ms. Lee has my written request since 9/24/10 (encl. #1).

I feel that Ms. Lee is abusing her authority and making this case more difficult that it has to be simply because she did not like my response to her dated 9/24/10. She is being vindictive as she knew or should have known that form #3260 was not necessary to request a hearing. She has lost her objectivity, impartiality, sensibility, and reasoning abilities in this case; and frankly, I do not want to deal with her anymore.

In summary, this entire case should be centered on the care and welfare of Eartha Stevens – an 83 year old woman who worked, paid taxes, and expects (just like the rest of us) that those in charge would use our tax dollars to take care of us as was the intent of laws for social security and medicare taxes.

Your prompt attention to this matter would be appreciated.


Gwendolyn Bobo
Legal Guardian of Eartha Stevens

Enclosures (4)

Cc Ms. Lee – DHHS Region VIII
State Director – Dept. of Social Services
Director – SC Dept. of Health & Human Services

Gwendolyn B. Bobo

9422 Ayseough Rd., Summerville, SC 29485

Home Phone (843)771-0542 E-mail: gwenbobob@hotmail.com

September 24, 2010

Fax/Memo

TO:

E. Lee
DHHS Region VIII
Charleston, SC
FAX: (843)740-5962

RE:

Eartha Stevens

No. of Pages: 6 (total)

This memo is in reference to your notice dated 9/20/10 regarding loss of financial eligibility for Eartha Stevens because of lack of information concerning an insurance policy.

I am enclosing a copy of my fax to the insurance company requesting that the information be sent to your office as well as to me. I would like to know the answers to your question as well. The only information that I have gotten from them is that her deceased husband, S. Braction, is the beneficiary of the policy.

I did not fight over a year to get Eartha's benefits started for this piece of information to stop it. In case you don't know Eartha has late stage Alzheimer's disease. I exhausted my funds caring for her because of a system that was not designed to help people such as her. She cannot help with this information. I have done what I can do to help facilitate the gathering of this information.

You have all of the resources at your disposal to get this information from the insurance company. I am not going to spend one more dime or time that I don't have to help you do your job. I have given you what you requested. If the company doesn't respond to you, you can make them release the information – even if by legal means.

In the meantime, you do not have the right to discontinue her benefits because of a situation regarding lack of insurance information that we do not have and even you are having difficulty obtaining.

The Governor's Office was responsible for getting this started; and if Eartha's benefits end, they will be the first one to know. If she is released from the place where she is, I will personally take her to the Governor's Office and call a news conference to show the world what

September 24, 2010

happens to citizens who have this disease and the lack of empathy from those who are put in charge of seeing that they receive what they have worked for, paid for, and deserve.

I am not asking for anything that she has not paid for and earned by all of her years of hard work. This is the reason we pay taxes.

I am tired of people making quick decisions to "discontinue" benefits for people who are totally helpless such as Eartha. My cousin doesn't know that she is in this world. But the "system" chooses not handle the cases of Alzheimer's sufferers (mental disability) differently from others who have physical disabilities.

I am telling you like I told everyone during my year+ fight to get her benefits started, "If you find something later that Eartha owns - you can start proceedings to take it if you are entitled to it. But, as long as I am breathing, you will not deny her benefits because she can't answer your questions or complete her paperwork. She worked all her life and she deserves to leave this life with dignity. I will not have her homeless.

So in summary, handle this case in the same manner that you would if a person like Eartha was brought to you and you had no information and no one to provide information - just her medical condition. What would you do with her?

You can reach me at work (843)722-2585, 8:00 am - 4:00 pm, Mon. - Friday, cell number 843-367-6802 after 4:30 pm and weekends.

I am responding within ten days, and I am requesting a fair hearing before the SC DHHS and requesting that Eartha's coverage continue until a decision is made. This request is being faxed and mailed.



Gwendolyn Bobo
Eartha Stevens Guardian

Enclosures (4)

- 1) Contact information for Continental Ins. Co.
- 2) My fax to Continental Ins. Co.
- 3) Copy of your request to me dated 9/7/10
- 4) Copy of your "Notice of Proposed Action" dated 9/20/10

2

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PROPOSED ACTION – MEDICAL ASSISTANCE ONLY

FROM: DHHS Region VIII
PO Box 13748
Charleston, SC 29422-3748

DATE: 9/20/10
BUDGET GROUP NUMBER: 77839038

TO: Ms. Gwendolyn Bobo
9422 Ayscough Rd
Summerville, SC 29485

E. Lee
TELEPHONE NUMBER: 843.740.5968

PLEASE READ THE STATEMENTS CHECKED "X" BELOW FOR INFORMATION ABOUT YOUR ASSISTANCE.

TYPE OF ASSISTANCE RECEIVED: Eartha Stevens - NH

NOTICE: If your circumstances change, you have an increase or decrease in income or you have new or additional information that would affect your case, it is your responsibility to notify the Department of Health and Human Services within ten (10) days.

- ☐ The monthly amount you pay to the medical facility will change from \$ _____ to \$ _____ beginning _____.
- ☐ The monthly amount you pay to the medical facility will be \$ _____ beginning _____.
- ☐ Community Long Term Care (CLTC) has informed the Department that your level of nursing care will be changed from _____ to _____. The nursing care facility in which you reside does not provide both skilled and intermediate level care in the same area. Therefore, you should be sure that you are transferred promptly to the area of your present facility or to a different nursing care facility that will provide you with the level of care appropriate to your needs. The Department will terminate its Medicare coinsurance or Medicaid vendor payment on _____ unless you are placed in the proper level of care.
- ☐ CLTC has informed the Department that you will be eligible for _____ level nursing care upon termination of your Medicare benefits; therefore, a Medicaid vendor payment will be made to the nursing care facility in your behalf.
- ☒ Your eligibility for a vendor payment made to a medical provider in your behalf, by the department, will be discontinued beginning 9/30/10 and Medicaid ends 11/1/10.

Reason for Action: In order to redetermine financial eligible, we must have proof face value of Continental insurance policy with policy number, owner, and 2010 cash value.

MANUAL/POLICY REFERENCE SUPPORTING THIS ACTION (A copy of the referenced material is available upon request from the county department):

MPPM 101.11.01



FAIR HEARING:

If you feel that DHHS has made an error in processing your case, 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 signed, written request (along with a copy of this letter) within 30 days to your Medicaid eligibility 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 was correct, you will be required to pay back any Medicaid benefits you received while your case was being reviewed.



NOTICE

If your circumstances change, you have an increase or decrease in income or you have new or additional information that would affect your case, it is your responsibility to notify your Department of Health and Human Services within ten (10) days.



STATE RETIREMENT

If your Medicaid is being terminated because you have been discharged from a nursing home and you receive State Retirement benefits, you must contact the South Carolina State Retirement System at the end of six (6) months from your date of discharge if:

1. You have not been admitted to a nursing facility or,
2. You have not been admitted to a hospital. You may be eligible to receive an increase in your State Retirement check.

(3)

Gwendolyn B. Bobo
9422 Ayscough Road
Summerville, SC 29485
Phone: (843)771-0542 E-mail: gwenbobob@hotmail.com

September 13, 2010

F A X

TO: Bradley N. Stanton II
Continental Life Insurance Company
Upper Darby, PA
FAX: (610)853-2107

RE: Eartha Lee Braction
Acct. 03-0410-04540

No. of Pages: 3 (including cover page)

Please see the attached request from the Medicaid Office for information concerning Eartha Lee Stevens Braction. It is urgent that this information is furnished in the next few days to them unless Eartha will be disqualified for assistance. I have been paying for Eartha's insurance and I don't have any information on this policy. I also need to know the policy number and the amount of insurance. I do know that the beneficiary of the policy is her deceased husband, S. Braction. Since Eartha is unable to change her beneficiary because of Alzheimer's disease, how can I change it as her legal guardian? I need to know if the beneficiary can be changed to a funeral home to cover her burial expenses rather than to a specific person. A copy of my power-of-attorney should be in her file. I faxed it and mailed it previously trying to get the same information. Now this information is critical for her continued care. Your prompt response to the Medicaid request as well as mine would be greatly appreciated. Please fax to Medicaid at the phone number on the form. Attn: Ms. Lee. Send information to me at the above home or e-mail address.

Thank you.

gfb

(3)

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

Applicant/Beneficiary: Eartha Stevens Date: 9/7/10

Authorized Representative: Gwendolyn Bobo

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

- ☐ Complete the Attached Review Form
- ☐ Power of Attorney, Guardianship, or Conservator Papers
- ☐ Verification of ☐ Citizenship ☐ Identity ☐ Original Documents Required.
- ☐ The income limit for institutional care is \$_____ for _____. The applicant's income is over this amount. To possibly qualify for Medicaid assistance for long-term care services, an income trust must be established. You will find the forms needed to complete this process attached.
- ☐ Proof of gross income received by _____. This may be a copy of an itemized check-stub, award letter, PRINTOUT, or statement on letterhead from the company or agency.
- ☐ For all accounts, copies of entire bank statements, not account summaries, for February 2006, February 2007, February 2008, February 2009 and the following month(s): _____

- ☐ Designate or establish a bank account for income to flow through. Return verification of this account.
- ☐ Proof of assets sold, transferred, or given away on or after **February 8, 2006** to the present. _____ benefits on the applicant's behalf.
- ☐ Verification you have applied for _____
- ☐ Burial Assets: Copies of the applicant/spouse's ☐ Pre-need burial contract(s) ☐ burial plot deed(s) or other verification of ownership such as a statement on letterhead. If the contract or plot is not paid for, we also need verification of the payoff amount.
- ☒ Copies of all life insurance policies owned by the applicant/spouse. If the policy is not on hand, a letter from the agent showing the policy number, name of owner, face value, and current cash value of the policy can be provided. If this is not possible, give the name and address of the insurance company, and the policy number for each policy. The owner of the policy needs to sign and date DHHS Form 1280 ME, Verification of Insurance Value, to let us verify current cash values directly from the insurance company.

- ☐ Copy of annuity for _____
- ☐ Please sign and return the form(s) indicated:
- | | |
|--|---|
| <input type="checkbox"/> DHHS 943, Release of Information | <input type="checkbox"/> DHHS 1212 ME, Verification of Veterans Information |
| <input type="checkbox"/> DHHS 1766-A, Burial Exclusion | <input type="checkbox"/> DHHS 1253 ME, Request for Financial Investigation |
| <input type="checkbox"/> DHHS 1280 ME, Verification of Insurance Value | <input type="checkbox"/> DHHS 1296 ER, Estate Recovery Notification |
| <input type="checkbox"/> DHHS 1282, Authorized Representatives Acknowledgement of Responsibilities | |
- ☐ All medical insurance policies or cards and proof of premiums
- ☒ Other: Copy of life insurance policy with owner, policy number, face value and cash value.
- ☐ Other: _____

Please provide this information by 9/17/10 If you have any questions or you need additional time to secure requested information, please call your worker listed below. Thank you for your cooperation.

Worker: E. Lee Telephone: 843.740.5968

Address: DHHS Region VIII Fax: 843.740.5962

PO Box 13748, Charleston, SC 29422-3748

CONTINENTAL LIFE INSURANCE COMPANY

8049 West Chester Pike, Upper Darby, PA 19082-1317

Phone: (610) 853 - 2100 Fax: (610) 853 - 2107

Date Printed
4/27/2010

******* PREMIUM PAYMENT STATEMENT *******

Your agent is
BRADLEY N STANTON II

Please use the following Account Number when calling : 03-0410-04540

Phone Numbers

Home (843) 771-0542
Work (843) 556-6058

If Phone number is
wrong or missing
please call the office

Payor

EARTHA LEE BRACKTON
C/O GWEN BOBO
9422 AYSCOUGH RD
SUMMERVILLE SC 29485-7606-00

Revised 10/2/10

(14)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES REQUEST FOR FAIR HEARING FOR MEDICAID APPLICANT/BENEFICIARY

INSTRUCTIONS FOR ELIGIBILITY WORKER: Complete all of Part I when an oral or written appeal request is received. If the appeal request is received in written form, complete Part I and send the written request, a case summary, and a copy of this form directly to the Division of Appeals. If the appeal request is oral, complete Part I and have the applicant/beneficiary/authorized representative complete Part II of this form, or submit a written request. The supervisor must review the record to determine if all options have been considered and that the action was appropriate. The supervisor must then sign Part III. **NOTE:** The beneficiary may be eligible to receive continued benefits pending a hearing decision if a written or oral request is made within 10 days of the decision. If the hearing decision is not in favor of the applicant or beneficiary, any Medicaid benefits received pending the decision must be repaid.

PART I -- To Be Completed by the Eligibility Worker <i>This section must be completed by the Eligibility Worker upon receipt of an oral or written request for a hearing and prior to releasing this form to the applicant/beneficiary/authorized representative, or mailing it to the Division of Appeals at the following address:</i> SCDHHS, Division of Appeals, Post Office Box 8206, Columbia, South Carolina 29202-8206.			
Name of Applicant/Beneficiary: <i>Eartha Stevens</i>		Household Number: <i>100440815</i>	Payment Category: <i>NA - 15</i>
Complete Address of Applicant/Beneficiary: <i>Mr Robert Hunter 921 Bowman Rd Mt Pleasant SC</i>		Originating Office/Unit: <i>Law/Election SC</i>	Region/Division: <i>8</i>
Telephone Number of Applicant/Beneficiary: <i>254664</i>		Name of Supervisor: <i>J. Wright</i>	
Applicant/Beneficiary's Authorized Representative: <i>Gwendolyn Bobo</i>		Name of Eligibility Worker: <i>E. Lee</i>	
Address of Authorized Representative: <i>4422 Ayscough Rd Summerville SC 29485</i>		Telephone Number of Eligibility Worker: <i>843 740 5965</i>	
Specify which category: <input type="checkbox"/> ABD <input type="checkbox"/> BCCP <input type="checkbox"/> FP <input type="checkbox"/> HCBS <input type="checkbox"/> GH <input type="checkbox"/> LIF <input checked="" type="checkbox"/> LNH <input type="checkbox"/> OCWI <input type="checkbox"/> OSS <input type="checkbox"/> PHC <input type="checkbox"/> SLMB <input type="checkbox"/> TEFRA <input type="checkbox"/> WD <input type="checkbox"/> Pass-Along <input type="checkbox"/> Other: _____		Reason for Action Being Appealed: <input checked="" type="checkbox"/> Resource <input type="checkbox"/> Income <input type="checkbox"/> Level of Care <input type="checkbox"/> Disability <input type="checkbox"/> Other: _____	
Type of Action Being Appealed: <input type="checkbox"/> Case Closed <input type="checkbox"/> Case Denied <input type="checkbox"/> Other Action:		If disability, submit disability decision notification letter.	
The notice informing the applicant/beneficiary/authorized representative of the action he/she wishes to appeal was sent on: <i>9/28/10</i>		On what date does (or did) the action go into effect? <i>9/30/10</i>	
PART II -- To Be Completed by the Applicant/Beneficiary/Authorized Representative <i>A signed letter from the applicant/beneficiary/authorized representative requesting a fair hearing may be attached instead of the signed statement below.</i>			
I request a fair hearing from the Department of Health and Human Services because: <input type="checkbox"/> Action has not been taken on my application within a reasonable time. <input type="checkbox"/> My application has been turned down. <input type="checkbox"/> My service has been stopped. <input type="checkbox"/> My service has been reduced or changed. <input type="checkbox"/> I have been charged with an overpayment. <input type="checkbox"/> Other: (Explain) _____ _____ _____			
(Attach additional sheets of paper if more space is needed.)			
If I am given a fair hearing: <input type="checkbox"/> I want at least 30 days advance written notice of my hearing date as offered by State law. <input type="checkbox"/> I want my hearing to be held as soon as possible, and I will be satisfied with at least 10 days advance written notice of my hearing date.			
If I am eligible to receive continued benefits: <input type="checkbox"/> I wish to receive benefits pending the hearing decision; however, I understand I must repay the continued benefits if the decision is not in my favor. <input type="checkbox"/> I do not wish to receive continued benefits.			
Signature of Applicant/Beneficiary/Authorized Representative:		Date:	
NOTE: When complete, please return this form to the Medicaid Eligibility Worker. The Eligibility Worker will forward this request, along with a case summary, to the DHHS Division of Appeals.			
PART III -- Supervisory Review The case record has been reviewed. All other options have been explored and the action being appealed was appropriate			
Signature:		Date:	

B

Ms. Gwendolyn Bobo
9422 Ayscough Rd.
Summerville, SC 29485



Director
SC Dept of Health & Human Services
PO Box 8206 J-11
Columbia, SC 29202-8206

29202+8206



Jennifer Lynch - Re: Log 0351

Log # 351 ✓

From: Alicia Jacobs
To: Jennifer Lynch
Date: 2/17/2011 8:53 AM
Subject: Re: Log 0351
CC: Monique Dabreu

I agree. Attach this email to it and close it out with no response necessary. Thanks

>>> Jennifer Lynch 2/16/2011 2:42 PM >>>
I'm thinking we may not need to send a letter on this one. What do you think?

The letter from the authorized representative is dated October 4, 2010 and is stamped as received on February 10, 2011 in CEP. It was logged to us on February 11, 2011. The issue was resolved on October 13, 2010 when the information needed (insurance verification) was submitted to the eligibility worker. The appeal was dismissed at that time and benefits continued. I'm thinking that our response now (4 months later) will make us appear untimely and confuse her. The same letter we received was received in the county Medicaid office in October and the issue was resolved.

Thanks.

Jennifer Lynch
Supervisor, Division of Constituent & Beneficiary Services
Department of Health and Human Services
(803) 898-3965
(803) 255-8350 FAX
lynchjen@scdhhs.gov