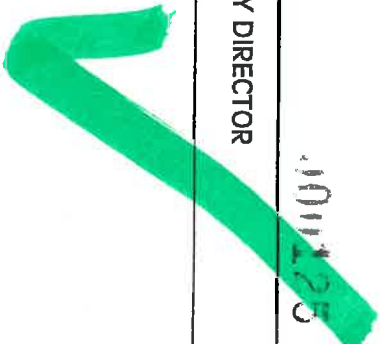


DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Wells</i>	DATE <i>9-8-09</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>100125</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR 	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>9-17-09</i> <input type="checkbox"/> FOIA DATE DUE _____ <input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

LINDSEY O. GRAHAM
SOUTH CAROLINA



290 RUSSELL SENATE OFFICE BUILDING
WASHINGTON, DC 20510
(202) 224-5972

UNITED STATES SENATE

September 3, 2009

RECEIVED

SEP 08 2009

Ms. Emma Forkner
Director
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Dear Ms. Forkner:

The attached letter concerns an issue outside my official jurisdiction. Therefore, as a courtesy to my constituent, Michael Ponder, I am sending this correspondence to your attention.

Thank you for your attention to this matter, and I ask that you please respond directly to the individual.

Sincerely,

A handwritten signature in dark ink, appearing to read "L. Graham".

Lindsey O. Graham
United States Senator

LOG/tt

Enclosure

508 HAMPTON STREET
SUITE 202
COLUMBIA, SC 29201
(803) 933-0112

401 WEST EVANS STREET
SUITE 228B
FLORENCE, SC 29501
(843) 669-1505

101 EAST WASHINGTON STREET
SUITE 220
GREENVILLE, SC 29601
(864) 250-1417

530 JOHNNIE DODDS BOULEVARD
SUITE 202
MOUNT PLEASANT, SC 29464
(843) 849-3887

140 EAST MAIN STREET
SUITE 110
ROCK HILL, SC 29730
(803) 366-2828

135 EAGLES NEST DRIVE
SUITE B
SENECA, SC 29678
(864) 888-3330

AUG 24 2009

Michael S. Ponder
209 Coach Hill Dr
Gaffney SC 29340

August 21, 2009

Senator Lindsey Graham
Midlands Region Office
Columbia SC 29201

RE: Shon W Ponder – Medicaid ID # 2780361962

Dear Sir:

I am writing to you because we need your help regarding our son's Medicaid coverage. Shon has severe Type A hemophilia. He's had this condition since birth. He has been in and out of the hospital his whole life due to his condition. Shon is now five years old. He will begin school on August 24, 2009.

A representative from Medicaid visited our home to evaluate Shon. She was only there approximately 10 minutes. She did not look at his bruises, his port that is used for his medication or anything of that nature. A few days later, we received a letter in the mail stated that he no longer qualified for Medicaid and that effective September 1, 2009 he would no longer have Medicaid benefits.

Without the Medicaid benefits, we can not afford the medication necessary for Shon to live. The medication is very expensive. My wife does not work. She stays at home to care for Shon and our two daughters.

We have requested a "fair hearing" with Medicaid regarding the reasons for Shon's termination of Medicaid benefits. We have all his medical records together to take with us to the hearing.

I would very much appreciate any help you can offer. I will be glad to talk with you and answer any questions you may have. I can be reached at (864)-480-9944 or (704)-689-0397. If I am not available, my wife, Lisa, will be glad to talk with you.

Thanking you in advance,

Michael Ponder

Cc: copies of letter to Medicaid requesting hearing

August 10, 2009

STATE OFFICE COUNTY DHHS
PO Box 100101
Columbia, SC 29202-0000
ATT: Monica Williams

RE: Shon W. Ponder – Medicaid ID# 2780361962

Please be advised that we would like to request a fair hearing regarding the termination of Medicaid benefits for our son. We would like to know the reasons for his disqualification. We would also like to request the Medicaid continue until the hearing takes place.

Shon has Hemophilia – Type A- Severe. Without Medicaid, we are not able to afford the necessary medication he needs in order to live. Medical records from the pediatrician and the Greenville Hospital can be provided.

We greatly appreciate your immediate attention to this. Please contact me at 704-689-0397 or 864-480-9944 with any questions. Thank you.

Sincerely,

Michael Ponder

Notice that Medicaid Coverage Will End

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

LISA A PONDER
C/O LISA A PONDER
209 COACH HILL DR
GAFFNEY SC 29340

Date: 08/07/2009
Worker Name:
MONICA WILLIAMS
Telephone: 803 898-9662
BG #: 79435122
HH #: 101004620
47 MONIW

Medicaid coverage for the people listed below will end on: 09/01/2009

Beneficiary name:
SHON W. PONDER

Beneficiary Medicaid ID#:
2780361962

Reasons: Medicaid coverage will end because:
You do not meet the disability criteria.

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: 102.06.02A

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.