DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Bowling/Inhaldrop/FOIA	9-11-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000142	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Singleton, Stenoland	[ ] Prepare reply for appropriate signature DATE DUE _____ [X] FOIA DATE DUE 9-25-07 [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. Cleared 9/20/07, letter attached.			
2.			
3.			
4.			

take original to 11th flr & keep copy

From: Patsy Knotts
To: Brenda James; Margarete Keller
Date: 9/27/2007 9:33 AM
Subject: Log 0142

Are you both already aware of the logistical changes on this one? It was due 9/25 and when I pulled it to remind staff, etc., I was told Rick Hepfer said it should not have been designated an FOIA. Also, I learned his area prepared the response, dated 9/20, and it went out over his signature. I have copy of his letter if neither of you do. I can bring up at lunch if needed.

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

September 20, 2007

Ms. Anne Denbow
WESTAT
9274 Gaither Road, GA48
Gaithersburg, MD 20877-1420

Re: Attached Request

Dear Ms. Denbow:

The attached request was forwarded to this Office for review. I am sorry that Caring Angels of Manning was unable to comply with your request, and I regret that we, also, must decline. We cannot tell from the enclosed that Ms. Griffin or an authorized representative has consented for the Department to disclose the information requested (if any is available).

Please contact me if we have misunderstood your request or if you have any questions about this letter. My direct is (803) 898-2791.

Sincerely,

Richard G. Hepfer
Deputy General Counsel

cc: Caring Angels of Manning
Debora Carter, LTC Services

Office of General Counsel
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2795 Fax (803) 255-8210

From: Debora Carter
To: Patsy Knotts
Date: 9/25/2007 10:47 AM
Subject: Fwd: Log Letter

Patsy, per the below email, the log letter was passed on to legal for response. I received Rick Hepfer's response to the letter this week. I think it is out of our hands. Let me know if you need anything else.

Thanks.

>>> Daryle Doyle 09/17/07 4:42 PM >>> — I wasn't copied in on D. Doyle's msg/Patsy
CLTC is passing on to Legal Council Log Number 000142. It will be given to Rick Hepfer. Thanks.

Daryle B. Doyle, Dept. Head
SC Dept. of Health & Human Services
Division of CLTC Waiver Management
Phone: (803) 898-2705
Fax: (803) 255-8209

9/17/07
Legal determined this should not have been an FOIA and said they would handle the response. I only became aware today, 9-25-07, after sending msg (see below) to Debora Carter. Patsy Knotts

Copy of legal's response, dated 9/20/07 is attached.

From: Patsy Knotts
To: Debora Carter
Date: 9/25/2007 10:24 AM
Subject: FOIA - due today

Is there anything I can do to help with this? The legal folks take due dates on FOIA very serious so I hope you can soon pass it to me, to format, whatever, and get to Sam, legal dept and on upstairs. Thanks, Debora

From: Bryan Kost
To: Brenda James; Jan Polatty
Date: 9/10/2007 2:59 pm
Subject: FOIA ...Fwd: Incoming Fax Message

CC: Debora Carter
please log, thanks,

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

>>> Debora Carter 9/10/2007 11:18 AM >>>

Bryan, we received this fax request on Friday, and was told by Byron Roberts this morning that this needs to be an FOIA request. Please forward to appropriate person(s) for FOIA, and we will respond accordingly.

Thanks, Debora

>>> SHHSFC.faxapi."-" 09/07/07 11:27 AM >>>

-------Reception Fax Report-------
TSI Received:
Pages Received: 005
Connect Time: 00130
Receive Time: 09/07/07 11:25
DID Received: 8209
Caller ID:
Fax Port: 01
Error Code: 0000
Job ID: 6254
Faxcom: 1 at 10.57.2.82

OMB #: 0935-0118

Medical Provider Component

MEDICAL EXPENDITURE PANEL SURVEY

HOME CARE

Cover Sheet Plus _____ Page(s)

TO attn: Debora Carter & Tony Matthews

PROVIDER Caring Angels of Manning

FAX NUMBER 803-255-8209 DATE 9/7/07

FROM Lynn Horne

PHONE NUMBER: 800-792-3656 DIRECT LINE Ext # 23603
06 billing

ITEMS SENT:
- ☑ Authorization Form(s)
- ☐ Letter
- ☑ Fax/Mail Return Form
- ☑ Client List
- ☑ Brochure

Record File Number: _____ Account File Number: _____

If faxing material, please fax to:
1-800-792-3670

If mailing material, please send to:
Anne Denbow
WESTAT
9274 Gaither Road, GA48
Gaithersburg, MD 20877-1420

Thank you for participating in this important study!
If you do not receive all pages or transmission is unclear, please call 800-792-3656.

For additional information log on to http://www.MEPS.AHRQ.gov.

OFFICE USE ONLY

Provider Name Caring Angels of Manning

ID/W 40155902 w-1

U.S. PUBLIC HEALTH SERVICE 1798

Notice - Public reporting burden for this collection of information is estimated to average 5 minutes per patient. Any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden should be sent to: AHRQ/MEPS Reports Clearance Officer, John M. Eisenberg Building, Room 5036, 540 Gaither Road, Rockville, MD 20850, Attention: PRA Paperwork Reduction Project (0935-0118). (Please do not send patient data to this address as it will delay data processing.)

OMB #: 0935-0118

FAX/Mail Return Form

Medical Provider Component

MEDICAL EXPENDITURE PANEL SURVEY

HOME CARE

If faxing material, please use this as your cover sheet.

Cover Sheet Plus _____ Page(s)

TO Lynn Y. M.L.
Data Collection Specialist

FAX NUMBER 1-800-792-3670 PHONE NUMBER 1-800-792-3656

FROM _____

_____

DATE _____

If mailing material, please include this cover sheet in your envelope.

Please send to:

Anne Denbow
WESTAT
9274 Gaither Road, GA48
Gaithersburg, MD 20877-1420

OFFICE USE ONLY

Provider Name Caring Angels of manning

ID/W 40155902 WI

Connected Case Y _____ N ✓

C372489V

OMB #: 0935 - 0104 PANEL 10

AUTHORIZATION TO OBTAIN INFORMATION FROM MEDICAL AND BILLING RECORDS
MEDICAL EXPENDITURE PANEL SURVEY - U.S. PUBLIC HEALTH SERVICE

A. Provider Name: Caring Angels of Manning

Street Address: 318 Mill Street Ste A

City: Manning State: SC Zip: 29102

Telephone: (803) 435-5160
Area Code

B. I am voluntarily participating in the Medical Expenditure Panel Survey (MEPS), a study of health care use and expenses being conducted by the U.S. Public Health Service. I authorize and request that you provide the U.S. Public Health Service and its contractors with medical and financial information they request about all health services provided to me during the period January 1, 2005 to December 31, 2006. This authorization form covers any care I received at your facility during this period, including treatment for mental health, alcohol, drug abuse, STD, HIV, or AIDS. It also covers care I received during this period from any medical provider associated with your facility or who provided care to me in your facility.

I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA)(1) prohibits you from releasing my information without my authorization. This form (or a photocopy of this form) gives you my authorization. I have signed this form voluntarily, with the understanding that my decision to sign or not to sign the form will have no effect on my eligibility for treatment, payment, enrollment, or eligibility for any benefits to which I am entitled.

I understand that the Public Health Service and its contractors will use this information to supplement the information I have already given for MEPS research on health care use and expenditures. I also understand that once my information is released to the study, it is no longer covered by HIPAA but is covered by the Public Health Service Act(2), which prohibits the release of information that would identify me or my medical providers outside the sponsoring agency and its contractors without my permission or that of my medical providers.

I authorize the study to use information I have given in the survey to help you identify my records. I also understand that I can revoke this authorization at any time by contacting a study representative in writing or by telephone. Otherwise, this authorization expires 30 months from the date of signature.

C. 1. Patient Name: Grace Griffin

2. Date of Birth 06 / 28 / 1934
Month Day Year

3. Other Names Under Which Records May be Filed

3A. Social Security Number(3) 215 - 18 - 7619

D. 4. _____
Patient's Signature - 14 and over sign

5. Date Signed _____

IF PATIENT IS 14-17, BOTH PATIENT AND PARENT/GUARDIAN MUST SIGN AND DATE.

E. 6. Hail Carter
Grace Griffin
Parent, Guardian, Witness or Proxy's Signature

7. Date Signed 10-10-06

8. daughter
Signer's Relationship to Patient

9. Reason for Parent, Guardian, Witness or Proxy's Signature:
- ☐ Patient 13 or Younger
- ☐ Patient 14-17 Years Old
- ☑ Patient Disabled
- ☐ Patient Deceased

FIELD USE ONLY: RU ID: 116772A PROVID: 0098 PID: 019 (P10,R4)

(1) Health Insurance Portability and Accountability Act: 42 U.S.C. 1320d-2 and 1320d-4 and the implementing regulation, 45 CFR 164.508, require a detailed authorization for your health care provider to disclose health information from your records for research purposes.

(2) Public Health Service (PHS) Act: Sections 924(c) and 308(d) [42 U.S.C. 299c-3(c), and 42 U.S.C. 242m(d)] protect the confidentiality of data collected under the research authorities of the Agency for Healthcare Research and Quality and the National Center for Health Statistics in the U.S. Public Health Service. Section 543 of the PHS Act [42 U.S.C. 290dd-2.] and regulations at 42 CFR Part 2, provide additional confidentiality restrictions on records of alcohol and substance abuse patients. This research project will be carried out in compliance with all these provisions.

(3) Your Social Security Number is requested to allow the addressee to accurately identify and help locate your records. Providing this information is voluntary. It is collected under the authority of Title IX of the Public Health Service Act Section 902(a) (42 USC 299a). Refusal to provide the number will have no effect on your rights, benefits or privileges under law.

CODE SCAN: ☑ Yes ☐ No 6670 FIID

PROVIDER ID: 40155902 W 1 Page 1 of 1	OMB# 0935-0118
PROVIDER NAME: CARING ANGELS OF MANNING	

MEDICAL PROVIDER COMPONENT

PATIENT LIST

The patient(s) listed below have given permission to contact you and request information from their records. Copies of the signed Authorization Forms are attached.

Each patient's name, date of birth, and gender are provided to help you to locate the patient in your records.

For each patient, we will be asking about health care services received between January 1, 2006 and December 31, 2006. For each date of service we will need information about diagnosis, services provided, charges, and payments

A data collection coordinator will be calling you shortly after you have received these materials to collect the information over the telephone.

1 Patient Name: GRACE GRIFFIN Date of Birth: 6/28/1934 Sex: F

OMB #: 0935-0118

Medical Provider Component

MEDICAL EXPENDITURE PANEL SURVEY

HOME CARE

What is the Medical Expenditure Panel Survey (MEPS)?

MEPS is a nationwide research study conducted to learn more about the health care services people use, the charges for those services and the sources that pay for them. MEPS is conducted annually by the U.S. Public Health Service through the Agency for Healthcare Research and Quality and the Centers for Disease Control and Prevention. Major components of MEPS include surveys of:

- A nationally representative sample of households;
- Home care providers, hospitals, physicians, and pharmacies reported by the household participants; and
- Providers of health insurance.

MEPS is the most complete source of data available on health care use and expenses in the United States and is used by government policymakers and private researchers.

How are providers chosen?

Home care providers were named by respondents in the household data collection as sources of care during 2006. The clients we are asking about signed HIPAA-compliant forms authorizing and requesting you to release the information sought by the study.

Why should this provider participate?

The services and associated expenditures provided by home care agencies are critical to MEPS. The information that you supply will supplement that given by your client and help us build a more complete picture of health care expenditures for respondents in our study. Your clients have asked specifically for your help by signing the authorization form.

What information is needed?

For each of the clients on the enclosed list, we need information about their services. For each month of service in 2006, we need:

- Visit dates
- Services provided (revenue code, HPCPS, CPT-4, or description)
- Total charge
- Payment sources and amounts
- Diagnoses/conditions

How do I know the information will be kept confidential?

The confidentiality of data collected for MEPS is protected by Federal law under Sections 924(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 242m(d)]. Identifying information collected for the study cannot be released without the permission of the individuals or establishments who provided the information.

Personal identifying information such as names or addresses are removed before information from the study is made available to researchers. Findings are published in statistical summaries and tables and micro-data is released on "public use" data files.

Who is collecting this data?

The U.S. Public Health Service has chosen Westat, a national research company, to administer the study. A professionally trained data collection specialist from Westat will contact each home care agency.

What questions will the data collected answer?

MEPS data provide answers to many important questions. For example:

- How much of home care costs are covered by insurance?
- How much do people pay out of pocket for their home care?
- What conditions are being treated by home care providers?
- What types of services are people receiving from home care providers?

Any further questions?

Please call toll-free, at **1-800-792-3656.**

For direct access to information about MEPS, go to **http://www.meps.ahrq.gov.**

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

TO:

FROM:

SUBJECT: Cost of Processing FOIA Request #

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

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

Please remit the above amount to the following address:

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

Please contact _____ should you have any questions.

_____ _____

Signature Date:

Finance and Administration
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2503 Fax (803) 255-8235

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Bowling/Waldrep/FOIA	9-11-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000142	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Singleton, Stenoland Log passed to Rick for info, see attached e-mail	[ ] Prepare reply for appropriate signature DATE DUE _____ [X] FOIA DATE DUE 9-25-07 [ ] Necessary Action

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

From: Bryan Kost
To: Brenda James; Jan Polatty
Date: 9/10/2007 2:59 pm
Subject: FOIA ...Fwd: Incoming Fax Message

CC: Debora Carter
please log, thanks,

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

>>> Debora Carter 9/10/2007 11:18 AM >>>

Bryan, we received this fax request on Friday, and was told by Byron Roberts this morning that this needs to be an FOIA request. Please forward to appropriate person(s) for FOIA, and we will respond accordingly.

Thanks, Debora

>>> SHHSFC.faxapi."-" 09/07/07 11:27 AM >>>

-------Reception Fax Report-------
TSI Received:
Pages Received: 005
Connect Time: 00130
Receive Time: 09/07/07 11:25
DID Received: 8209
Caller ID:
Fax Port: 01
Error Code: 0000
Job ID: 6254
Faxcom: 1 at 10.57.2.82

OMB #: 0935-0118

Medical Provider Component

MEDICAL EXPENDITURE PANEL SURVEY

HOME CARE

Cover Sheet Plus _____ Page(s)

TO attn: Debora Carter & Tony Matthews

PROVIDER Caring Angels of Manning

FAX NUMBER 803-255-8209 DATE 9/7/07

FROM Lynn Korne

PHONE NUMBER: 800-792-3656 DIRECT LINE Ext # 23603

06 billing

ITEMS SENT:
- ☑ Authorization Form(s)
- ☑ Client List
- ☐ Letter
- ☑ Brochure
- ☑ Fax/Mail Return Form

Record File Number: _____ Account File Number: _____

If faxing material, please fax to:
1-800-792-3670

If mailing material, please send to:
Anne Denbow
WESTAT
9274 Gaither Road, GA48
Gaithersburg, MD 20877-1420

Thank you for participating in this important study!
If you do not receive all pages or transmission is unclear, please call 800-792-3656.

✳ **For additional information log on to http://www.MEPS.AHRQ.gov.** ✳

OFFICE USE ONLY

Provider Name Caring Angels of Manning

ID/W 40155902 W-1

U.S. PUBLIC HEALTH SERVICE 1798

Notice - Public reporting burden for this collection of information is estimated to average 5 minutes per patient. Any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden should be sent to: AHRQ/MEPS Reports Clearance Officer, John M. Eisenberg Building, Room 5036, 540 Gaither Road, Rockville, MD 20850, Attention: PRA Paperwork Reduction Project (0935-0118). (Please do not send patient data to this address as it will delay data processing.)

OMB #: 0935-0118

FAX/Mail Return Form

Medical Provider Component

MEDICAL EXPENDITURE PANEL SURVEY

HOME CARE

If faxing material, please use this as your cover sheet.

Cover Sheet Plus _____ Page(s)

TO Lynn K. M.A.
Data Collection Specialist

FAX NUMBER 1-800-792-3670 PHONE NUMBER 1-800-792-3656

FROM _____

_____

DATE _____

If mailing material, please include this cover sheet in your envelope.

Please send to:

Anne Denbow
WESTAT
9274 Gaither Road, GA48
Gaithersburg, MD 20877-1420

OFFICE USE ONLY

Provider Name Caring Angels of manning

ID/W 40155902 W1

Connected Case Y _____ N ✓

C372489V

OMB #: 0935 - 0104 PANEL 10

AUTHORIZATION TO OBTAIN INFORMATION FROM MEDICAL AND BILLING RECORDS
MEDICAL EXPENDITURE PANEL SURVEY - U.S. PUBLIC HEALTH SERVICE

A. Provider Name: Caring Angels of Manning

Street Address: 318 Mill Street Ste A

City: Manning State: SC Zip: 29102

Telephone: (803) 435 - 5160
Area Code

B. I am voluntarily participating in the Medical Expenditure Panel Survey (MEPS), a study of health care use and expenses being conducted by the U.S. Public Health Service. I authorize and request that you provide the U.S. Public Health Service and its contractors with medical and financial information they request about all health services provided to me during the period January 1, 2005 to December 31, 2006. This authorization form covers any care I received at your facility during this period, including treatment for mental health, alcohol, drug abuse, STD, HIV, or AIDS. It also covers care I received during this period from any medical provider associated with your facility or who provided care to me in your facility.

I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA)(1) prohibits you from releasing my information without my authorization. This form (or a photocopy of this form) gives you my authorization. I have signed this form voluntarily, with the understanding that my decision to sign or not to sign the form will have no effect on my eligibility for treatment, payment, enrollment, or eligibility for any benefits to which I am entitled.

I understand that the Public Health Service and its contractors will use this information to supplement the information I have already given for MEPS research on health care use and expenditures. I also understand that once my information is released to the study, it is no longer covered by HIPAA but is covered by the Public Health Service Act(2), which prohibits the release of information that would identify me or my medical providers outside the sponsoring agency and its contractors without my permission or that of my medical providers.

I authorize the study to use information I have given in the survey to help you identify my records. I also understand that I can revoke this authorization at any time by contacting a study representative in writing or by telephone. Otherwise, this authorization expires 30 months from the date of signature.

C. 1. Patient Name: Grace Griffin

2. Date of Birth 06 / 28 / 1934
Month Day Year

3. Other Names Under Which Records May be Filed

3A. Social Security Number(3) 215 - 18 - 7619

D. 4. _____
Patient's Signature - 14 and over sign

5. Date Signed _____

IF PATIENT IS 14-17, BOTH PATIENT AND PARENT/GUARDIAN MUST SIGN AND DATE.

E. 6. Gail Carter Grace Griffin
Parent, Guardian, Witness or Proxy's Signature

7. Date Signed 10-10-06

8. daughter
Signer's Relationship to Patient

9. Reason for Parent, Guardian, Witness or Proxy's Signature:
- ☐ Patient 13 or Younger
- ☐ Patient 14-17 Years Old
- ☑ Patient Disabled
- ☐ Patient Deceased

FIELD USE ONLY: RU ID: 116772A PROVID: 0098 PID: 019 (P10,R4)

(1) Health Insurance Portability and Accountability Act: 42 U.S.C. 1320d-2 and 1320d-4 and the implementing regulation, 45 CFR 164.508, require a detailed authorization for your health care provider to disclose health information from your records for research purposes.

(2) Public Health Service (PHS) Act: Sections 924(c) and 308(d) [42 U.S.C. 299c-3(c), and 42 U.S.C. 242m(d)] protect the confidentiality of data collected under the research authorities of the Agency for Healthcare Research and Quality and the National Center for Health Statistics in the U.S. Public Health Service. Section 543 of the PHS Act [42 U.S.C. 290dd-2,] and regulations at 42 CFR Part 2, provide additional confidentiality restrictions on records of alcohol and substance abuse patients. This research project will be carried out in compliance with all these provisions.

(3) Your Social Security Number is requested to allow the addressee to accurately identify and help locate your records. Providing this information is voluntary. It is collected under the authority of Title IX of the Public Health Service Act Section 902(a) (42 USC 299a). Refusal to provide the number will have no effect on your rights, benefits or privileges under law.

CODE SCAN: ☑ Yes ☐ No 6670 FIID

PROVIDER ID: 40155902	W 1	Page 1 of 1	OMB# 0935-0118
PROVIDER NAME: CARING ANGELS OF MANNING			

MEDICAL PROVIDER COMPONENT

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1 Patient Name: GRACE GRIFFIN Date of Birth: 6/28/1934 Sex: F

OMB #: 0935-0118

Medical Provider Component

MEDICAL EXPENDITURE PANEL SURVEY

HOME CARE

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- How much do people pay out of pocket for their home care?
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- What types of services are people receiving from home care providers?

Any further questions?

Please call toll-free, at **1-800-792-3656.**

For direct access to information about MEPS, go to **http://www.meps.ahrq.gov.**

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

TO:

FROM:

SUBJECT: Cost of Processing FOIA Request #

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

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

Please remit the above amount to the following address:

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

Please contact _____ should you have any questions.

_____ _____

Signature Date:

Finance and Administration
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2503 Fax (803) 255-8235

From: Daryle Doyle
To: Brenda James
Date: 9/17/2007 4:42 pm
Subject: Log Letter

CC: Byron Roberts; Rick Hepfer

CLTC is passing on to Legal Council Log Number 000142. It will be given to Rick Hepfer. Thanks.

Daryle B. Doyle, Dept. Head
SC Dept. of Health & Human Services
Division of CLTC Waiver Management
Phone: (803) 898-2705
Fax: (803) 255-8209