DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Ries	11/2/06

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 060337	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ Ref. Log # 4487 ✓	[✓] Prepare reply for appropriate signature DATE DUE 11/13/06 [ ] 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. Letter dated attached.	11/2/06		
2. cleared 11/13/06			
3. Letter Attached			
4.			

Ref. Log # 1487

Holli Josette Tindal
Post Office Box 354
Pelion, South Carolina 29123
(803) 894-6133

Log to Alicia

RECEIVED
OCT 31 2006
Department of Health & Human Services
OFFICE OF THE DIRECTOR

October 27, 2006

VIA FACSIMILE (803) 741-9475
ATTN: Ms. Emily Nicholson
State of South Carolina Department
of Health and Human Services
Division of Medicaid Eligibility,
Region IV Office
Post Office Box 8206
Columbia, South Carolina 29202-8206

Dary, 741-1165 x164
We were mly copied - want to just file with previous log??
lw 10/31

RE: Holli Tindal
Social Security No.: 247-65-1942
Medicaid No.: 4780420409

Dear Ms. Nicholson:

I am in receipt of your letter dated October 18, 2006. I wish to respond to your resolution of my inquiry relative to the receipt of retroactive benefits on my behalf beginning December 2004.

Granted I was employed during the majority of December 2004. The accident which left me disabled was on December 29, 2004. As previously stated I had insurance coverage through my employer with Blue Cross and Blue Shield of South Carolina through and until February 1, 2005. I have requested retroactive Medicaid benefit coverage from December 29, 2004, through February 2005.

For February 2005, I did not have resources that exceeded $ 4,000.00. I provided you with the statement for my accounts with Universal One Credit Union. None of the information I provided to you reflected resources that exceeded $4,000.00. I would request that you further review this matter and make an eligible determination for retroactive benefits for February 2005. Should you need any additional information from me with regard to this matter I will be happy to provide it to you.

I also wish to know the status as to my various requests for continued coverage for Medicaid benefits which was initially made to my purported caseworker, Ms. Martha Taylor on June 5, 2005, through the Lexington County Department of Health and Human Services. My various requests and communications were ignored and not responded to.

In addition, I would also like to know what actions are being taken with regard to the negligence of the caseworkers, Ms. Martha Taylor, Ms. Lesley Shealy, and lastly Ms. Michelle Foster (I have never spoken with the last two ladies although I was informed they were my caseworkers), of the Lexington County Department of Health and Human Services. I am not satisfied that my various requests, telephone calls, and correspondence for assistance were not responded to but were blatantly ignored.

Throughout the course of an investigation by your office I have been unable to have necessary prescriptions filled and uncertain as to how to respond to providers about future payment for medical treatment. I am disabled and live on a fixed income. I now have outstanding medical expenses which have hindered my credit rating. This matter has become quite lengthy and stressful.

I cannot believe the neglect that is shown by the agencies of this state in helping those who need and require assistance at a difficult time. I am shocked at the lack of concern and the inability of those who are obviously not qualified to do the jobs in which they have been placed.

I do appreciate your assistance throughout this matter. With regards, I am,

Respectfully,

Holli J. Tindal

Holli J. Tindal

cc: Mr. Robert M. Kerr
Ms. Patricia McWhite
Governor Mark Sanford

Ref Log # 1487

COPY

Holli Josette Tindal
Post Office Box 354
Pelion, South Carolina 29123
(803) 894-6133

October 27, 2006

RECEIVED
OCT 31 2006
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OFFICE OF THE DIRECTOR

VIA FACSIMILE (803) 741-9475
ATTN: Ms. Emily Nicholson
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Post Office Box 8206
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Respectfully,

Holli J. Tindal

Holli J. Tindal

cc: Mr. Robert M. Kerr
Ms. Patricia McWhite
Governor Mark Sanford

Log #1487

COPY

Holli Josette Tindal
Post Office Box 354
Pelion, South Carolina 29123
(803) 894-6133

October 27, 2006

RECEIVED
OCT 3 1 2006
Department of Health & Human Services
OFFICE OF THE DIRECTOR

VIA FACSIMILE (803) 741-9475
ATTN: Ms. Emily Nicholson
State of South Carolina Department
of Health and Human Services
Division of Medicaid Eligibility,
Region IV Office
Post Office Box 8206
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RE: Holli Tindal
Social Security No.: 247-65-1942
Medicaid No.: 4780420409

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VIA FACSIMILE (803) 741-9475
ATTN: Ms. Emily Nicholson
State of South Carolina Department
of Health and Human Services
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Region IV Office
RE: Holli Tindal
Social Security No.: 247-65-1942
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October 27, 2006
Page Two

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Respectfully,

Holli J. Tindal

Holli J. Tindal

cc: Mr. Robert M. Kerr
Ms. Patricia McWhite
Governor Mark Sanford

Gary - Copy of 18th letter as requested - Thx! Jan

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

FAX COVER SHEET

"CONFIDENTIAL INFORMATION ENCLOSED"

DATE: 11/1/06

TO: Jan Polatty
Telephone #: 898-2502
Fax #: 255-8235

FROM: Emily Nicholson

Total Number of Pages Transmitted: 4 (Including Cover Sheet)

COMMENTS: Requested information. The second notice is one I also sent

Thank you in advance for your cooperation and assistance!!

DHHS- Medicaid Eligibility Region IV Office
PO Box 155 State Park SC 29147-0155
(803) 741-1165 • Fax (803) 741-9475

Rev: 01/04

COPY

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

October 18, 2006

Ms. Tindal
cc. Mrs. Mc White

Ms. Tindal,

My name is Emily Nicholson and I am a Medicaid worker who has been working with Mrs. Mc White to resolve your inquiry about receiving retro benefits beginning December 2004- February 2005. Below you will find an explanation of why you were eligible or ineligible for the above listed times.

December 2004
Income: You received $52,340 during the entire year of 2004. This roughly equates to about $1,090 /week. The income limit is 776.00 / month .
Resources: Under the 4000 limit
Outcome: Ineligible for retro benefits due to income

January 2005
Income: No income received .
Resources: Under the 4000 limit
Outcome: You are eligible for retro benefits this month

DHHS-Region IV Medicaid
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 741-1165 Fax (803) 741-9475

(continued)

February 2005
Income: No income received
Resources: Over the 4000 limit (This is based on the Universal Checking, Savings, IRA and Life insurance Cash Value amount)
Conclusion: Ineligible due to resources

I have sent a correction request for retro benefits effective 01/01/2005. If you have any other questions please do not hesitate to call us at 741-1165. Thank you for your patience, assistance and cooperation during this ordeal.

Emily Nicholson
Human Service Specialist II

South Carolina Department of Health and Human Services

Verification of Retroactive Medicaid

Date: 10/26/2006

To: Holli Tindal
PO Box 354
Pelion, SC 29123

Re: Holli Tindal

Medicaid Number: 4780420409

Retroactive Medicaid coverage was entered into the Department of Health and Human Services computer system for the above-named individual on the following date: 10/18/2006.

The retroactive period began on the following date: 1/1/05.

The retroactive period ended on the following date: 2/1/05.

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.

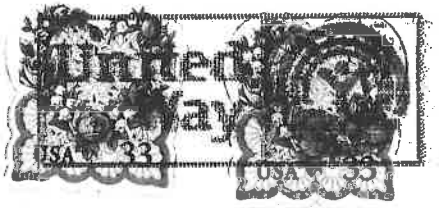
Emily Nicholson
Medicaid Eligibility Worker

(803)741-1165 ext 164
Telephone Number

DHHS Form 945 (May 2004)

H. Tindal
Post Office Box 354
Pelion, South Carolina 29123

COLUMBIA SC 292
27 OCT 2006PM 3 T



ATTN: Ms. Emily Nicholson
Mr. Robert M. Kerr
Ms. Patricia McWhite
SC Department of Health and Human Services
Division of Medicaid Eligibility, Region IV Office
Post Office Box 8206
Columbia, South Carolina 29202-8206

29202+8206

LOS #337
#1487

Holli Josette Tindal
Post Office Box 354
Pelion, South Carolina 29123
(803) 894-6133

November 2, 2006

VIA FACSIMILE (803) 741-9475
ATTN: Ms. Emily Nicholson
State of South Carolina Department
of Health and Human Services
Division of Medicaid Eligibility,
Region IV Office
Post Office Box 8206
Columbia, South Carolina 29202-8206

RE: Holli Tindal
Social Security No.: 247-65-1942
Medicaid No.: 4780420409

Dear Ms. Nicholson:

Relative to your telephone call to me on October 30, 2006, and to further respond to the information you relayed relative to your letter of October 18, 2006, and October 26, 2006, I wish to make the additional reply and appeal to the matter pertaining to the retroactive period of February 2005.

Although you stated in your telephone call on October 30, 2006, and your letter of October 30, 2006, that I am not entitled to retroactive coverage for February 2005, I disagree on the following basis.

Although you state my assets exceed a limit over $4,000.00 (utilizing your figures as to: life insurance $1,913.75, Universal One Check Account $1,513.02, Universal One IRA $1,061.67, and Universal One Savings Account $48.05, and a negative balance for Bank of America Check Account approximately $558.00), I disagree. If this is the computation that is utilized the negative balance from the Bank of America Checking Account should be noted and factored in to the total asset amount of $4,036.49, therefore the balance is approximately $3,978.00.

It should further be noted that I utilized the monies in my Universal One checking account, Universal One IRA, and life insurance account, as hardship money to provide for my living expenses and utilize toward my past due bills since I became unemployed (and disabled) effective December 29, 2004, as per the Social Security Administration.

I wish to appeal this matter and would appreciate an additional review. Your result is not satisfactory and if necessary I can provide documentation to show that these monies were utilized as stated above.

If it is necessary for me to contact an attorney to litigate this matter I will do so. I do not understand why that would be necessary when the matter is not complex. I am and have been a citizen of South Carolina since being born here. I have paid taxes and unfortunately for me I am in a situation wherein I require the necessary assistance such as drawing disability and needing the benefit of Medicaid. I should not have to jump through hoops and constantly debate issues whereby it is clear that I am in need of this assistance now.

By way of your telephone call to me on October 30, 2006, you indicated that I would have to seek assistance from Ms. Patricia McWhite as to the other issues outlined in my letter of October 27, 2006. I indicated to you that I copied, by courtesy copy, to Ms. McWhite and Mr. Kerr, a copy of the same letter which outlined my concerns.

I am again copying Mr. Robert Kerr, Ms. McWhite, and Governor Sanford with this letter. I hope for some action to be taken relative to my concerns and would appreciate a response from Ms. McWhite and Mr. Kerr. I do not feel that this matter has been given the proper attention. It would appear that my concerns have once more been dribbled to someone else for handling. I wish for these matters to be taken seriously and handled appropriately.

You have been quite helpful in your assistance but I am not satisfied with the manner in which this matter is being treated.

I would request that you further review this matter and make an eligible determination for retroactive benefits for February 2005.

Once more I also wish to know the status as to my various requests for continued coverage for Medicaid benefits which was initially made on June 5, 2005, through the Lexington County Department of Health and Human Services. My various requests and communications were ignored and not responded to just as they are being ignored now.

In addition, I would also like to know what actions are being taken with regard to the negligence of the caseworkers, Ms. Martha Taylor, Ms. Lesley Shealy, and lastly Ms. Michelle Foster, of the Lexington County Department of Health and Human Services. I am not satisfied that my various requests, telephone calls, and correspondence for assistance were not responded to and were blatantly ignored.

I wish to receive a response from Mr. Kerr and Ms. McWhite with regard to these matters and therefore I am copying them with this letter in effort to receive their response.

I do appreciate your continued assistance with this matter. With regards, I am,

Respectfully,

Holli J. Tindal

cc: Mr. Robert M. Kerr
Ms. Patricia McWhite
Governor Mark Sanford

337

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

November 13, 2006

Ms. Holli J. Tindal
Post Office Box 354
Pelion, SC 29123

Dear Ms. Tindal:

Thank you for your letter regarding retroactive Medicaid coverage and your concerns about the inadequate service you received from our Lexington County Medicaid Office.

I apologize for any difficulty you experienced when trying to reach a Medicaid eligibility worker. Good customer service is important to us, and we will take appropriate action as needed. Ms. Pat McWhite has been in contact with you regarding your problems during the eligibility process. Ms. McWhite is the Regional Administrator who oversees our Fairfield, Kershaw, Richland and Lexington County Offices. She may be reached at (803) 741-1165, Ext. 132.

Your Supplemental Security Income Medicaid coverage ended on August 1, 2006. Our Lexington County Office received your requests for continued Medicaid benefits; however, when you began receiving Social Security disability, your income was above the allowable limit.

Ms. Jennifer Dabbs in Constituent Services has been in contact with you regarding your retroactive Medicaid coverage. You are not eligible for Medicaid for December 2004 due to excess income. After further review of your case, we have determined that you may be eligible for retroactive Medicaid benefits during the month of February 2005. We faxed a Burial Exclusion form to the fax number you provided, but it has not been returned. We also tried to contact you by phone to assist you in completing the form, but were unable to reach you. If this form is not returned, you are not eligible for February 2005. If you have any questions, please contact Mr. Jimmy Hampton at (803) 714-7561, supervisor, Richland County Medicaid Office, and will be glad to assist you.

We mailed you information on a number of programs that can provide medical and prescription help to people with limited incomes. We hope this information is helpful in addressing your healthcare needs. Please contact Jennifer Dabbs in Constituent Services at (803) 898- 3965 if you have any questions.

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

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

Ms. Holli J. Tindal
Post Office Box 354
Pelion, SC 29123

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You are not eligible for Medicaid for December, 2004 due to excess income

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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

Free Medical Clinics in South Carolina

Free medical clinics in South Carolina provide indigent residents with basic medical care, including prescription medicines, wellness education and, in some cases, dental or chiropractic care and psychological counseling. The clinics are as diverse as the communities that support them. One operates in a homeless shelter, another operates within a university school of nursing, and several are closely associated with congregations or multi-denominational religious organizations, or community hospitals. Please contact the nearest facility by telephone and make an advance appointment prior to visiting any clinic.

Name of Clinic	Address	Telephone No.
Free Medical Clinic of Aiken Cty.	PO Box 1294, **Aiken** 29802	803-641-2827
Anderson Free Clinic	PO Box 728, **Anderson** 29622	864-226-1294
Kershaw County Medical Clinic	110 E. DeKalb St., **Camden** 29020	803-713-0806
Crisis Ministries Health Clinic	573 Meeting St., **Charleston** 29403	843-723-9477
Good Samaritan Medical Center	962 McCandless Rd., **Chester** 29706	803-385-6332
Clemson Free Clinic	PO Box 941, **Clemson** 29633	864-723-6077
Good Shepherd/ Laurens Cty. Free Medical Clinic	PO Box 1535, **Clinton** 29325	864-833-0017
Free Medical Clinic, Inc.	PO Box 1452, **Columbia** 29240	803-765-1503
Friendship Medical Clinic	1396 Highway 544, **Conway** 29526	843-347-7178
Darlington Cty. Free Medical Clinic	203 Grove St., **Darlington** 29532	843-398-0060
Mercy Medicine Clinic	514-E S. Dargan St., **Florence** 29506	843-667-9947
Greenville Free Medical Clinic	PO Box 8993, **Greenville** 29604	864-232-1470
Greenwood Free Clinic	1404 Edgefield St., **Greenwood** 29646	864-942-0500
Volunteers in Medicine Clinic	15 Northridge Dr., **Hilton Head** 29926	843-681-6612
Helping Hands Free Medical Clinic	518 S. Main St., **Mullins** 29574	843-464-8211
Newberry County Free Clinic	2568 Kinard St., **Newberry** 29108	803-276-6665
First Baptist Medical Clinic & St. Matthew Dental Clinic	4217 Rivers Ave., **N Charleston** 29406	843-744-4269
Harvest Free Medical Clinic	2427 Midland Park Rd., **N Charleston** 29406	843-225-7572
Smith Medical Clinic at Baskerville	PO Box 1740, **Pawleys Island** 29585	843-237-2672
Pickens Cty. Free Medical Clinic	PO Box 1452, **Pickens** 29671	864-855-0853
Rosa Clark Medical Center	210 S. Oak St., **Seneca** 29678	864-882-4664
St. Luke's Free Medical Clinic	PO Box 3466, **Spartanburg** 29304	864-542-2273
Woodruff Free Medical Clinic	340 Woodruff St., **Woodruff** 29388	864-476-8191

6/14/05

The Medically Indigent Assistance Program in South Carolina

Established in July 1989, the Medically Indigent Assistance Program (MIAP) is authorized to offer help to low-income individuals throughout South Carolina who may need to be hospitalized. This specialized program is only available to needy citizens who are not eligible for Medicaid or any other form of government assistance. The program provides coverage for a wide degree of hospitalization expenses for all eligible recipients.

In order to qualify for aid under the statewide program, an individual cannot have income exceeding 200 % of the federal poverty guidelines and must be a United States citizen or legal alien. Patients must be a legal resident or state their intent to be a legal resident of South Carolina.

Eligibility considers an individual's financial resources as follows:

Primary Residence:

- A family farm of 50 acres or less on which the applicant or their family has lived at least 25 years is excluded from countable resources.
- All other property is allowed an exclusion up to $35,000 on equity value.

Equity Interest in all other real property and taxable personal property, such as motor vehicles, cannot exceed a combined total value of $6,000.

All liquid assets such as cash, notes and financial instruments convertible into cash within 20 working days cannot exceed $500.

Applicants with excess liquid assets may establish eligibility by spending the excess amount on valid debts, such as rent, mortgage, utilities and medical expenses.

(County MIAP Contact Information List on Reverse Side)

South Carolina Community Health Centers

First established in 1964, Community Health Centers are community-based, non-profit organizations that provide comprehensive, high-quality, patient-focused health care services in a culturally appropriate manner. With a focus on primary care, prevention, education and case management, health centers accept most health insurance plans including Medicare and Medicaid. For those patients without insurance, services are provided on a sliding fee scale based on the patient's income. Community Health Centers receive federal grants through the United States Department of Health and Human Services' Bureau of Primary Health Care to partially support the cost of providing health care to the nation's growing uninsured population.

Community Health Centers offer core health care services, either directly or through cooperative arrangements, to include:

- Preventive and primary care
- Diagnostic services (lab and x-ray)
- Family planning
- Prenatal and perinatal care
- Well child care and immunizations
- Screening for elevated blood lead levels, communicable diseases, and cholesterol
- Eye, ear and dental screening for children
- Preventive dental services
- Emergency medical and dental services
- Hospitalization
- Pharmacy services

In addition, Community Health Centers provide services to help ensure access to care and continuity of care. These services include: outreach, transportation, communication assistance (interpreters), case management and social services. Some Community Health Centers may offer additional services such as mental and behavioral counseling and specialty care.

Community Health Centers are governed by a community and consumer based Board of Directors and the location, hours of operation, staff and programs of each health center are tailored to meet the specific needs of the community in which it is located. All Community Health Centers must adhere to national, state and local licensure requirements and quality standards. Community Health Centers are held accountable by the Bureau of Primary Health Care for specific program expectations. As a result, a health center's standard of quality is among the highest in the health care industry.

Community Health Centers are models of community-based care. They represent partnerships of people, governments and communities working together to improve the health status of their respective communities.

(List of South Carolina Community Health Centers on Reverse Side)

Prescription Assistance Programs Available for South Carolinians

There are several specialized programs sponsored by pharmaceutical companies, business associations or non-profit organizations to assist low-income or needy individuals in obtaining necessary prescription medicines at little or a substantially reduced cost. The following is a list of some of these programs and contact information for those who may want to apply for assistance:

Together RX Access

1-800-444-4106
www.TogetherRxAccess.com
Savings of 25-40% on some 275 brand-name prescriptions. Must meet specific income levels, have no private or public prescription insurance coverage, be a legal US resident and not be eligible for Medicare.

Partnership for Prescription Assistance

1-888-477-2669
www.pparx.com
Combined efforts of major pharmaceutical companies, doctors, health care providers, patient groups and community organizations to assist qualified patients without access to prescription medications obtain them at little or no cost. Recipients must lack any form of prescription insurance coverage and must meet specific income and other eligibility requirements of some 150 drug assistance programs nationwide.

Pfizer Helpful Answers

1-866-706-2400
www.pfizerhelpfulanswers.com
Pharmaceutical company program offering several options for free or reduced cost prescriptions of their products through doctors and community health centers for low-income patients. Must meet set income limits and have no private or public prescription coverage.

From: Jimmy Hampton
To: Jennifer Dabbs
Date: 11/8/2006 10:38 AM
Subject: Re: Holli Tindall

CC: Pat McWhite

Yes, it is okay to provide my phone number in your response.

>>> Jennifer Dabbs 11/08/06 10:25 AM >>>
Good morning! I still have not heard back from Ms. Tindall. I have left her 2 messages regarding the burial exclusion form that must be completed for retro coverage. If I don't hear from her today, or if you don't receive the fax, I am going to have to alter my response in the log letter. If this is necessary, would it be okay for me to put in the letter your phone number, if she has questions about the form before faxing? Not sure why she hasn't returned my calls or faxed the form. I made it clear when I spoke to her on Friday that the only way we can give retro coverage is if the form is completed. Thanks!!

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

From: Vastine Crouch
To: Jennifer Dabbs
Date: 11/6/2006 1:36 PM
Subject: Re: Holli Tindal 247-65-1942

CC: Jimmy Hampton; Pat McWhite

you are correct, this was an adopted SSA decision. Our Order of Dismissal was mailed on 8/25/05. Christine Asmond signed for Pat McWhite's copy of the OD on 8/29. Ms. Tindall's copy of the OD was returned by the post office on 8/31 marked "NMR", I think that's what it says. I'm guessing that stands for No Mail Receptacle. It was remailed on 9/22/05. That's all we know.

>>> Jennifer Dabbs 11/6/2006 1:11 PM >>>
Hello,

We received a log letter from the above constituent in regards to her past Medicaid eligibility. It appears that the caseworker sent an appeal request to your area on August 10, 2005. There is no further correspondence in regards to the appeal. This is actually one where the SSA decision was adopted, however I just want to check and see if a letter was ever sent to the caseworker or client in regards to the appeal request. Any information you can give will be greatly appreciated. I just want to be sure correct procedures were followed in Ms. Tindals Medicaid application. Thanks for your help!!

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

From: Pat McWhite
To: LYNCHJEN@scdhhs.gov,HamptonJ@scdhhs.gov
Date: 11/3/2006 3:50 PM
Subject: Re: Holli Tindall

Thanks Jennifer. Also, please let me know if there is anything else that we need to do regarding her concerns with the Lexington Office. While I certainly can't discuss any specifics, its important that she knows the matter is being assessed. I don't want her to feel like her concerns were not addressed.

Also, please fax the info to the Regional Office at 741-9475 to Mr. Hampton's attention.

>>> Jennifer Dabbs 11/03/06 3:34 PM >>>
I checked with Carolyn on the retro coverage. She agreed with your thoughts on using the burial exclusion for the month of February 05. I also had her review the self-employment income for the month of December 04 and she said the worker is correct, she is ineligible during this month.

So at this point we just need to have Ms. Tindall complete the 1766. I will contact her and see if there is any way to fax her this form. I'll have her return it to you, to complete the budget sheets and do a MEDS correction. Is your fax # 714-7301 in case I can get her to fax it?

Thanks for your help!

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

From: Pat McWhite
To: LYNCHJEN@scdhhs.gov,NICHOLED@scdhhs.gov,TateF@scdhhs.gov
Date: 11/3/2006 9:47 AM
Subject: Re: Holli Tindal 4780420409

CC: FULLERB@scdhhs.gov,Asmond@scdhhs.gov,HamptonJ@scdhhs.gov

Thanks Jennier. I do have a copy of the letter. I forwared a copy to SO, as well once I received it. I have spoken with Ms. Tindal more than once and did assured that the matter would be looked into, with appropriate actions taken if warranted. Ms. Tindal wants to know specifically what action will be taken against the staff. However, I don't feel like this is information that I need to or have the right to discuss with Ms. Tindal. I will more than willing to call her again.

Emily, assisted with the file, after I requested it from Lexington for a review. Emily do fax all requested information to Jennifer this morning.

Thanks

>>> Jennifer Dabbs 11/03/06 9:02 AM >>>
Good morning!

We received a letter from Ms. Tindal in regards to retroactive medicaid coverage for December 2004 and February 2005. She was eligible for the month of January. I have a letter that Ms. Nicholson faxed to Jan on Wednesday (11/1). Could I please get a copy of everything in the case record regarding income/resources for the month of December 04 and February 05 and all budget sheets used in the determination? I would like for policy to take a look.

She also states in her letter she wants to know the status of her request for continued coverage for Medicaid benefits which were initially made to Martha Taylor on June 5, 2005. Is there any documentation in the case file in regards to a conversation on this date?

The final issue addressed in her letter is her dissatisfaction with the Lexington County office. She goes into detail on this matter, and would like to know what "actions" have been taken for the negligence of the caseworkers. Pat, Ms. Tindal copied you on this letter, so you may already be familiar with this case. If you don't mind, I thought maybe you could call Ms. Tindal and address this issue. I will of course do a response in writing and address all issues in the letter.

Thanks in advance for everyone's help on this matter. Could the appropriate person please fax the budgeting information to me as soon as possible so policy can begin reviewing? Thanks again!

Ms. Tindal's phone number is 803-894-6133.

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

```
MEDELD02 P          S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 11/03/06
 MEDSPROD                    MEDICAID ELIGIBILITY DECISION            ACTION:
                      DATES-FROM: 05 / 2006 THRU: __ / ____           PAGE: 3 OF 3
 HH NAME:   HOLLI J TINDAL                                  HH NUMBER: 101033594
 BG NUMBER: 09222127          CATEGORY: ABD                 ACTION TYPE: MAINTENANCE
 BG: C  BGP: C      WKR: MTAYL    MARTHA TAYLOR              ACTION DATE: 05/05/06
 RCP NAME:  HOLLI J TINDAL                                   RCP NUMBER: 4780420409
 PREVIOUS BG: _________     NEW BG: _________     CORRECT RCP NUMBER: __________
 IT: _  PING-PONG: _  RETRO: _  EXPARTE: _  QMB: N   PROT PER DATE: __________
                ACTUAL ELIGIBILITY DATES
    MEDICAID
  ---BENEFIT DATES---     --MEDICAID+QMB DATES--     SERVICE    REASON   REASON
    BEGIN       END         BEGIN       END          TYPE      CODE 1   CODE 2
 03/01/2005 04/01/2005                                                    S99
 01/01/2005 02/01/2005
 __________ __________
 __________ __________
 __________ __________
 __________ __________
 __________ __________
 UPDATED: USER ID: _________  DATE: _________  SYSTEM ID: SDX1000  DATE: 05/05/06
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-ACD
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4EDHMS54 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 11/03/06
 MEDSPROD                      RECIPIENT INFORMATION                ACTION:
                    MEMBER PERIOD START: 06/27/06  END:            PAGE: 0001
 NAME: TINDAL HOLLI J                              HH NAME: TINDAL HOLLI J
 RCP NUMBER: 4780420409      HH NUMBER: 101033594  ACTION TYPE: MAINTENANCE
 SSN: 247-65-1942  VC: V     APL STATUS:           ACTION DATE: 02/22/05
 PRIMARY INDIVIDUAL:         APL CO: 32      WORKER ID: TLEWI    LOCATION: 444
 P O BOX 354                                 SSCN: 247651942A    RRN:
                                             RACE: 01   SEX: F   MARITAL STATUS: S
                                             TPL INSURANCE: N    RELATION: SELF
 PELION                      SC 29123-0354   DOB: 12/30/1969     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
_ 09222144 04/01/2005 08/01/2006 80   50    FULL       N              .00
_ 09222127 03/01/2005 04/01/2005 32   50               N              .00
_          01/01/2005 02/01/2005 32         FULL       N              .00


 UPDATED: USER ID: ________ DATE: _________ SYSTEM ID: TTR1001  DATE: 05/05/06
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
```

"CONFIDENTIAL INFORMATION ENCLOSED"

DATE: 11/3/06

TO: Holli Tindal
Telephone #:
Fax #: 894-6133

FROM: Jenny Dabbs

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

COMMENTS:
Please complete and return to Mr. Hampton at fax # 803-741-9475. I will update you when everything is complete.

Confidentiality Note

This message is intended for the use of the person or entity to which it is addressed and may contain information, including health information, that is privileged, confidential, and the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this in error, please notify us immediately and destroy the related message. Thank you.

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

TX DATE/TIME	DESTINATION	DURATION	PGS.	RESULT	MODE
933 NOV. 3 16:34	803 894 6133	0° 00' 34"	002	OK	N ECM

NOV. -03' 06 (FRI) 16:35 CLTC SUMTER TEL:803 905 1987 P. 001

South Carolina Department of Health and Human Services

DEVELOPMENT OF BURIAL EXCLUSION

NAME OF APPLICANT/BENEFICIARY:	HOUSEHOLD NUMBER:

1. NAME(S) OF PERSON(S) TO BE BURIED (Applicant/Beneficiary and/or Spouse):_____

2. AMOUNT OF FUNDS SET ASIDE IN A PRE-NEED BURIAL CONTRACT AND LOCATION OF SUCH CONTRACT:

A COPY OF THE CONTRACT MUST BE SUBMITTED IN ORDER TO DETERMINE IF ANY PORTION OF THE CONTRACT CAN BE EXCLUDED.

3. AMOUNT OF OTHER FUNDS SET ASIDE FOR BURIAL: _____. FORM IN WHICH THE FUNDS ARE SET UP - NAME OF BANK OR FINANCIAL INSTITUTION, TYPE OF ACCOUNT, ACCOUNT NUMBER, NAME OF LIFE INSURANCE COMPANY AND POLICY NUMBER(S), ETC:

4. BURIAL SPACE(S) – NAME OF CEMETERY, PLOT NUMBER, FOR WHOSE USE ANY SPACES ARE INTENDED:

I UNDERSTAND THAT IF ANY EXCLUDED BURIAL FUNDS ARE USED FOR ANY PURPOSE EXCEPT BURIAL, AN AMOUNT EQUAL TO THE AMOUNT USED FOR SOME OTHER PURPOSE WILL BE COUNTED AS A RESOURCE IN DETERMINING ELIGIBILITY FOR ASSISTANCE.

I CERTIFY 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.

SIGNATURE OF APPLICANT/BENEFICIARY:		DATE:
SIGNATURE OF RESPONSIBLE PERSON/AUTHORIZED REPRESENTATIVE		DATE:
WITNESS: DATE:	WITNESS:	DATE:
SIGNATURE OF MEDICAID ELIGIBILITY WORKER :		DATE:

LEGISLATIVE LOG #	0337
LEGISLATOR/INQUIRER	ltr cc to: Kerr/Sanford
CONSTITUENT	Holli Tindal - Previously Logged #1487
SSN	247-65-1942
BC ASSIGNED LOG	Jacobs
DATE REC'D BY AGENCY	10/31/2006
DATE DRAFT DUE GR	11/10/2006
LOG LETTER DUE DATE	11/13/2006
DATE REFERRED TO BC	11/2/2006

Brief Description of Issue/Problem	Date	Staff Person	Phone #	Action Taken
Requested retro coverage and denied for 2 months due to income/resources. States her appeal/retro coverage requests were not acknowledged. Complains of Lex. County office.	11/2/2006	Jan	8-2502	To Alicia per Gary.
	11/2/2006	Jill	8-3936	Gave to Jenny to distribute (2:30pm)
	11/2/2006	Jenny	8-3965	I will handle. Located old log. Began research.
	11/3/2006	Jenny	8-3965	Spoke with Ms. Tindal and told her we were looking into her case. She said Pat McWhite assisted her as far as the caseworkers and her dissatisfaction with Lex. County. I told her to call me if she thought of any questions. She said if more information is needed to call her anytime.
	11/3/2006	Jenny	8-3965	Discussed case with Carolyn and she said we could submit a burial exclusion form to get the retro for Feb. 05. She reviewed the income budget for December 04 and said it was done correctly and she is ineglible. I faxed Ms. Tindal the form and she said she would complete and fax to Mr. Hampton on Monday.
	11/6/2006	Jenny	8-3965	Left a message with Ms. Tindal to be sure she received the fax and that she was faxing to Mr. Hampton. Mr. Hampton emailed me and let me know he was looking in file for any info on an appeal request.
	11/6/2006	Jenny	8-3965	Emailed Jimmy. He has not received fax. Called Ms. Tindal, left message for her to call me back.
	11/8/2006	Jenny	8-3965	If I do not hear from Ms. Tindal today, I will alter my response letter to include Mr. Hampton's phone number in regards to the form she needs to fax to him. Retro can not be given if we do not have cooperation with Ms. Tindal.
	11/8/2006	Jenny	8-3965	To Mark (5:00)
	11/9/2006	Jenny	8-3965	To Alicia.

CHECKLIST ***Programs:***

CuwKR
47

Holli Josette Tindal
Post Office Box 354
Pelion, South Carolina 29123

Received
SEP 2 5 2006
Region IV LEP Office

MEDICAID
JUN 07 2006
ELIGIBILITY

June 5, 2006

Lexington County DHHS
605 West Main Street
Lexington, South Carolina 29072-0000

RE: Holli J. Tindal
Medicaid Number: 4780420409

To Whom It May Concern:

I have attempted to contact my assigned caseworker, Ms. Martha Taylor, by telephone and have left voice mail messages for her as well as write a letter on May 12, 2006. I have not received the courtesy of a response. I am not certain as to whom the correct person is that I should contact to answer questions.

I previously requested a retroactive determination be made to December 29, 2004, by my letter to Ms. Taylor dated May 12, 2006. I have not been notified as to the status of this request. I do not know what I am to do if anything else.

In addition I received the attached Medicaid Benefit Changes notice dated May 30, 2006.

I am receiving a monthly Social Security disability check as of June 2, 2006. I am still undergoing medical care and from indication by my physician it will continue. *I am therefore requesting an eligibility determination to continue receiving Medicaid benefits due to the necessity of continued medical care.*

The total monthly amount of Social Security disability is $1,413.00. I can forward a copy of the Notice of Award letter should a copy be needed as proof of this income. I receive no other income. I am single with no dependents.

Please advise. With kindest regards, I am,

Respectfully yours,
Holli J. Tindal
Holli J. Tindal

Enclosure

Holli Josette Tindal
Post Office Box 354
Pelion, South Carolina 29123
Phone: (803) 894-6133
Email: HTindal@aol.com

September 29, 2006

VIA FACSIMILE (803) 741-9475
Ms. Patricia McWhite
State of South Carolina Department
of Health and Human Services
Division of Medicaid Eligibility,
Region IV Office
Post Office Box 8206
Columbia, South Carolina 29202-8206

RE: Holli Tindal
Social Security No.: 247-65-1942
Medicaid No.: 4780420409

Dear Ms. McWhite:

In addition to my request for a retroactive determination for Medicaid benefits, please also remember that I am inquiring as to why my requests for continued coverage for Medicaid benefits has been ignored by the Lexington County Department of Health and Human Services office. My initial request was made by letter to the LCDHHS office on May 12, 2006, and a follow up request for continued coverage was made by letter and telephone calls on June 5, 2006. I have since made several attempts to contact someone for assistance with regard to Medicaid benefits.

I am disabled and I have to continue undergoing medical treatment for my disability. I am living on a fixed income and I am unable to get prescriptions filled that I need as of this date.

Any assistance and inquiry you can give to this matter will be greatly appreciated.

Respectfully,

Holli J. Tindal

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

May 11, 2005

To Whom It May Concern:

Ms. Holli Tindal, SS# 247-65-1942 has applied for Medical Services with the Department of Health and Human Services. Her application is still in a pending status as of now. We must get a decision from our State Office before we can complete the process for Ms. Tindal.

If you have any questions or concerns you may reach me at (803) 741-1165 ext. 142.

Thank you,
Mrs. Lewis

Division of Medicaid Eligibility Region IV Office
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 741-1165 Fax (803) 741-9475

Holli Josette Tindal
Post Office Box 354
Pelion, South Carolina 29123
Phone: (803) 894-6133
Email: HTindal@aol.com

August 9, 2005

VIA FACSIMILE (803) 741-9475
Mrs. Toya Lewis
State of South Carolina Department
of Health and Human Services
Division of Medicaid Eligibility,
Region IV Office
Post Office Box 8206
Columbia, South Carolina 29202-8206

RE: Holli Tindal
Social Security No.: 247-65-1942
Recipient ID No.: 4780420409

Dear Mrs. Lewis:

Please accept this letter as an appeal and/or request for hearing in regard to the determination that I received dated August 4, 2005 (a copy is attached hereto). I request a review of the determination based on the attached statement received from my attending physician, Dr. Coleman D. Fowble. A copy of this statement has been provided to Mr. Robert M. Kerr.

Please advise. With kindest regards, I am,

Respectfully yours,

Holli J. Tindal

Holli J. Tindal

Enclosure

cc: Governor Mark Sanford
Mr. Robert M. Kerr, Director

Medicaid Letter of Action

From: RICHLAND COUNTY DHHS
P. O. Box 183
State Park SC 29147-0183

To: HOLLI TINDAL
P O BOX 354
PELION SC 29123

Date: 08/04/2005
Worker Name:
TOYA LEWIS
Telephone: 803 741-1165
BG #: 48724884
HH #: 101033594
40 TLEWI

COPY

Recipient Name: HOLLI TINDAL

Recipient ID: 4780420409

RECEIVED
AUG 17 2005
DHHS
COLUMBIA REGIONAL OFFICE

Your application has been denied for: AGED, BLIND, DISABLED (ABD)

Reason for denial:
Recipient has not reached age 65 or is not disabled
Failure to meet disability criteria

Denied for the month(s) of: 02/2005

Manual/policy reference supporting this action: 2.06
2.06.02

X You may ask for a fair hearing before the Department of Health and Human Services if you believe an error was made in processing your application.

To Request A Hearing from the Department of Health and Human Services

- Ask your Medicaid worker in writing within 30 days of this letter. Attach a copy of this letter to your request.

To Get Help with Your Hearing

- You may hire an attorney to help you
- You may have someone you know come to the hearing and speak for you
- Contact your Medicaid worker in person or by phone to get help in asking for a hearing

ELD007 - Revison Date 07/2004 - 40 TLEWI

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

Petitioner: Holli Tindal
Category: 32/ABD

On February 14, 2005, Holli Tindal's application was received by the Department of Health and Human Services. The application was assigned the receipt number 48724884 for processing.

Eligibility was determined once I received the disability determination from Regina Brown on August 2, 2005. Ms. Brown's department adopted that Ms. Tindal did not meet disability criteria (see attachments). Therefore, Ms. Tindal's application was denied for failure to meet the required disability criteria for the ABD program. Retroactive medical services were also denied because the applicant did not meet the disability criteria.

The application met all non-financial criteria such as SC residency, US citizenship, Social Security number furnished, he agreed to assign rights to medical support, and not an inmate of the public institution. All of the above actions taken were based on Medicaid policies and procedures found in the Medicaid Policy Manual (see attachments).

Prepared by Toya Lewis
Date: August 10, 2005

Divisionof Medicaid Eligibility Region IV Office
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 741-1165 Fax (803) 741-9475

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR FAIR HEARING FOR MEDICAID APPLICANT/BENEFICIARY

PART I: To be Completed by the Eligibility Worker

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.

Name of Applicant/Beneficiary: Holli Tindal	Household Number: 101033594
Complete Address of Applicant/Beneficiary: 633 Lawson Rd. Leesville, SC 29070	Payment Category: ABD/32
Telephone Number of Applicant/Beneficiary: (803) 894-6133	County 32
Race of Applicant/Beneficiary (for Statistical Purposes Only): ☒ White ☐ Black ☐ Other:	Name of Eligibility Worker: T. Lewis
Applicant/Beneficiary's Authorized Representative:	Telephone Number of Eligibility Worker: (803) 741-1165
Address of Authorized Representative:	Reason for Action Being Appealed: ☐ Resource ☐ Income ☒ Disability **Note: If disability, please submit disability decision notification letter.** ☐ Level of Care ☐ Other:
Specify which category: ☐ TEFRA ☐ NH ☐ HCBWS ☐ GH ☒ ABD ☐ SLMB ☐ LIF ☐ PHC ☐ OCWI ☐ OSS ☐ Pass-Along ☐ WD ☐ BCCP ☐ FP ☐ Other:	
Type of Action Being Appealed: ☐ Case Closed ☒ Case Denied ☐ Other Action:	
When was the applicant/beneficiary/authorized representative notified of the action he wishes to appeal? Notices sent on: 08/05/05	On what date does (or did) the action go into effect? Effective Date: 08/03/05

PART II: To be Completed by the Applicant/Beneficiary/Authorized Representative

A signed letter from the applicant/beneficiary/authorized representative requesting a fair hearing may be attached instead of the signed statement below.

I request a fair hearing from the Department of Health and Human Services because:

- ☐ Action has not been taken on my application within a reasonable time.
- ☐ My application has been turned down.
- ☐ My service has been stopped.
- ☐ My service has been reduced or changed.
- ☐ I have been charged with an overpayment.
- ☐ Other: (Explain)

Attach additional sheets of paper if more space is needed.

If I am given a fair hearing,

- ☐ I want at least 30 days advance written notice of my hearing date as offered by state law.
- ☐ 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,

- ☐ 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.
- ☐ I do not wish to receive continued benefits.

When complete, please return this form to the Medicaid Eligibility Worker. The Medicaid Eligibility Worker will forward this request to the Division of Appeals.	Signature of Applicant/Beneficiary/Authorized Representative:
	Date:

DHHS Form 3260ME (May 2003)

MEDICAID DISABILITY DETERMINATION

Claim Level and Type				Filing Date	SSN
IN MA01				02/14/05	247-65-1942
Name and Address of Claimant HOLLI TINDAL PO BOX 354 PELION SC 29123				S/A Receipt Date 04/06/05	Date of Birth 12/30/69
Claimant Disabled	B. Onset		C. Diary		
			Type	Mo/Yr	Reason
Claimant Not Disabled DENIED	Primary Diagnosis Fractures of Lower Limb	Body Sys 01	Code 8270	Secondary Diagnosis Anxiety Related Disorders	Body Sys 12	Code 3000
B. Disability Ceased	Basis Code ADC			Reason SSA DENIAL ADOPTED-COORDINATED		
Med List No.	VR Action A. ☐		B. Screen Out ☒		C. Prev Ref ☐	

Remarks

Disability Examiner

Date:
07/26/05

Cindia D Kirby

CDK/810
Claim No: E06345
MAO 99 (7/04)

RECEIVED
AUG - 2 2005
DHHS
COLUMBIA REGIONAL OFFICE

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

August 1, 2005

Memorandum

To:	Justin Rozier	Medicaid Supervisor	Richland	County

From:	Nancy A. Bigelow	Department of Disability Determination

Subject: **Special Attention for Disability Determination Decisions**

Applicant:	Holli Tindal	SS#	247-65-1942
EW:	Toya Lewis	County:	Richland

Please forward the attached disability decision(s) to the appropriate eligibility worker.

If you have any questions, call me at (803) 898-4562.

/b

attachment(s)

COPY

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

October 18, 2006

Ms. Tindal
cc. Mrs. Mc White

Ms. Tindal,

My name is Emily Nicholson and I am a Medicaid worker who has been working with Mrs. Mc White to resolve your inquiry about receiving retro benefits beginning December 2004- February 2005. Below you will find an explanation of why you were eligible or ineligible for the above listed times.

December 2004
Income: You received $52,340 during the entire year of 2004. This roughly equates to about $1,090 /week. The income limit is 776.00 / month .
Resources: Under the 4000 limit
Outcome: Ineligible for retro benefits due to income

January 2005
Income: No income received
Resources: Under the 4000 limit
Outcome: You are eligible for retro benefits this month

DHHS-Region IV Medicaid
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 741-1165 Fax (803) 741-9475

(continued)

February 2005
Income: No income received
Resources: Over the 4000 limit (This is based on the Universal Checking, Savings, IRA and Life insurance Cash Value amount)
Conclusion: Ineligible due to resources

I have sent a correction request for retro benefits effective 01/01/2005. If you have any other questions please do not hesitate to call us at 741-1165. Thank you for your patience, assistance and cooperation during this ordeal.

Emily Nicholson
Human Service Specialist II

South Carolina Department of Health and Human Services

Verification of Retroactive Medicaid

Date: 10/26/2006

To: Holli Tindal
PO Box 354
Pelion, SC 29123

Re: Holli Tindal

Medicaid Number: 4780420409

Retroactive Medicaid coverage was entered into the Department of Health and Human Services computer system for the above-named individual on the following date: 10/18/2006.

The retroactive period began on the following date: 1/1/05.

The retroactive period ended on the following date: 2/1/05.

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.

Emily Nicholson
Medicaid Eligibility Worker

(803)741-1165 ext 164
Telephone Number

DHHS Form 945 (May 2004)

The South Carolina Department of Health and Human Services

Welcomes your application for the
South Carolina Partners for Health Medicaid Program

Mail to:
PO BOX 805
Lexington SC 29071

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: Tindal	First Name: Holli	M.I.: J.	Phone Where We Can Reach You: 803-894-6133	
Mailing Address (Include Apartment/Lot Number): Post Office Box 354	City: Pelion	State: SC	Zip Code: 29123	County: Lexington
Street Address, if different (Include Apartment/Lot Number): 633 Lawson Road	City: Leesville	State: SC	Zip Code: 29070	

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. How 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. We will not share Social Security numbers with the Immigration and Naturalization Service (INS).

Last Name (List spouse, parent(s), and children)	First Name (List spouse, parent(s), and children)	Check if Applying for Medicaid	Social Security Number (Only if applying for Medicaid)	Marital Status	Date of Birth	M	F	Race	How is this person related to you?	Is this person pregnant? Yes	Is this person pregnant? 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 U.S. Citizen? Yes	Is this person a U.S. Citizen? 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
Tindal	Holli		247-65-1942	S	12-30-69		✓	W	Self		✓	✓			✓	✓			✓

Note 1: Date baby is due: _____ Provide proof of due date from doctor, nurse, or Health Department for each pregnant woman.
Note 2: Provide INS 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 SSN	Person 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?
Blue Cross & Blue Shield	ZCY247651942	Holli J. Tindal	247-65-1942	Holli J. Tindal	health-medical dental	$359.29	Yes (no longer as of 12-31-04 employer retiring)

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. $ −530.23 Name of bank: Bank of America
$? Name of bank: NCR Universal / Credit U

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	✓		Holli J. Tindal	$ 50,000.00
Cars/trucks		✓		$	Other (explain) *such as trusts, IRAs, CDs, lump sums, etc.* NCR Universal I.C.U.	✓		Holli J. Tindal	2,379.00 value * 1500.00
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 not in this home)
Employer Name and Phone Number (803) 216-9449 Employer retired 12-31-04 - F. Glenn Smith, attorney at law	Employer Name and Phone Number
Amount you earn each pay period before taxes: $ 595.74 ? after ☑ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly	Amount other parent earns each pay period before taxes: $ _____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly
Hours worked each pay period _____	Hours worked each pay period _____
Does this employer offer health insurance? ☑ Yes ☐ No	Does this employer offer health insurance? ☐ Yes ☐ No
How much would it cost you? ?	How much would it cost you? _____

Other Income	Amount	How often do you get this income?	Which family member gets this income?
Child Support	$ -0-		
Alimony	$ -0-		
Social Security Payment	$ -0-		
Unemployment Benefits	$ -0-		
Veterans Benefits	$ -0-		
Other (Please explain)	$ -0-		

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 which 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, et

☐ 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 INS 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. You must sign one of these statements.

US Citizens or lawful immigrant

☑ I certify that the information I have provided is true to the best of my knowledge and I give permission for the State of South Carolina to make ar necessary contacts to check my statements. I have read the list of my rights and responsibilities. I know that I could be penalized if I knowingly give fals information. I certify that all persons for whom I am applying are U.S. citizens or lawful immigrants.

Signature of applicant or authorized representative: Willie J. Tindal Date: 1-25-06
Address and phone number of authorized representative, if applicable: P.O. Box 354, Pelion, SC 29123 (803) 894-6133

Non US Citizens

☐ I am not a citizen nor lawful immigrant. However in applying for payment of an emergency service, I certify that the information I have provided is true t the best of my knowledge.

Signature of applicant or authorized representative: _____ Date: _____

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 recipients 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

11. 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
1801 Main Street
Post Office Box 100101
Columbia, South Carolina 29202-3101

Tell us where you got this application From P.O. Box 805, Lexington, SC 29071

Rights and Responsibilities

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 agree that information, including medical information, can be released only if needed to administer this program.

3. I know that any information I have given may be reviewed and verified by State of South Carolina staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission is needed to get verification or other information.

4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, the agency is prohibited from discriminating 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 I may request a hearing if I believe an error has been made by the State o South Carolina in processing my application.

6. I know that the State of South Carolina will request and use information from a computer system called the State Income and Eligibility Verification System (IEVS). This computer system compares the information about me and other members of my family with information from other agencies. Other agencies may include the Internal Revenue Service, Social Security Administration, and Employment Security Commission. The information will not be given to the Immigration and Naturalization Service (INS).

7. I know that Partners for Health does not pay medical expenses that a third party, such as a private health insurance company, is supposed to pay. I give my rights to any third party payments to the Department of Health and Human Services. These payments may include payments from hospital and health insurance policies. I also understand that, if I receive a settlement from an accident, I will repay Medicaid for care given to me due to the accident.

8. Completion of a Medical Assistance Child Support Referral Form is required on an absen parent(s) if the custodial parent/caregiver relatives want Medicaid coverage.

[✓] I have read these rights and responsibilities or had them read to me:

Applicant: Kelli J. Lindal Date: 1-25-04

Monthly Income Limits:

Family Size:	1	2	3	4	5	6	7	8	9
Families with Children	$ 369	$ 497	$ 625	$ 754	$ 882	$1,010	$1,139	$1,267	$1,395
Children Under Age 19	$1,123	$1,515	$1,908	$2,300	$2,693	$3,085	$3,478	$3,870	$4,263
Pregnant Women and/or Children Under Age 1	$1,385	$1,869	$2,353	$2,837	$3,321	$3,805	$4,289	$4,773	$5,258
Aged, Blind & Disabled (ABD)	$ 749	$1,010							

January 2006 Budget Workbook

February 2005 Retro Requested

Holly Tindal

BG#: ~~40724684~~ 09229127

ABD/SLMB Budgetsheet

Section I - Burial Assets Exclusion Computation	
1. Determine Net Burial Assets Exclusion Limit:	
A. Maximum Burial Assets Exclusion Limit	1,500.00
B. Offset	
C. Net Burial Assets Exclusion Limit (A - B)	1,500.00
2. A. Combined Value of Burial Assets	
B. Net Burial Assets Exclusion Limit	1,500.00
C. Excluded Burial Assets	0.00
Enter 2C amount in Section II Line 14 below.	

Section II - Countable Resources Computation	$ Value
1. Automobile, Truck, Etc.	0.00
2. Life Insurance (Face Value > $5000)	1,913.75
3. Cash on Hand	
4. Checking Account	1,513.02
5. Savings Account	48.05
6. U.S. Savings Bond	
7. Stocks and Bonds	
8. Trust Fund	
9. Pre-Need Burial Account (Revocable)	0.00
10. Non-Excluded Cemetary Lot(s)	
11. Real Property	0.00
12. Other	1,061.67
13. Countable Resource Subtotal	4,536.49
14. Less Burial Exclusion	0.00
Total Countable Resource Value	4,536.49
Resource Limit	4,000.00

Resource Ineligible

Section III - Income Sources	
RSDI/RR Retirement	0.00
VA Benefits	0.00
Pension/Retirement	0.00
Earned Income	0.00
Interest/Dividends/Rent	0.00
Cash Contributions	0.00
Other	0.00

If determining eligibility for a child(ren) living with his/her parent(s), complete the monthly deeming and allocation section

IV - Determination of Income Eligibility	$ Amount	SLMB/QMB Budgeting
1. Gross Unearned Income	0.00	0.00
2. General Disregard	50.00	20.00
3. Subtotal	0.00	0.00
4. Gross Earned	0.00	0.00
5. Disregards		
a. General SSI Disregard (Allow amount not used in 2)	50.00	20.00
b. Subtotal	0.00	0.00
c. Earned Income Disregard ($65)	65.00	65.00
d. Subtotal	0.00	0.00
e. Disregard 1/2 the Amount in Line 5D	0.00	0.00
f. Subtotal	0.00	0.00
6. Total	0.00	0.00
7. Allocation	0.00	0.00
8. Countable Income	0.00	0.00
9. Appropriate Poverty Level	798.00	

SLMB Countable	S1 Limit	S2 Limit
0.00	957.00	1,077.00

ABD Eligible

QMB

Allocation for Children		
	Income	Allocation
	0.00	0.00
	0.00	0.00
	0.00	0.00
	0.00	0.00
	0.00	0.00
	0.00	0.00
	Total	0.00

Retroactive: _____

Categorical Eligibility: Disabled
Action: Re-budget
Decision: Denial
Month of Eligibility: _____

Eligibility Worker's Signature: Emily Nichols

Decision Date: 10/18/2006
Processing Time: _____ Day(s)

January 2006 Budget Workbook

Primary Individual: Holly Tindal HH#: 10133594 BG#: 09229127 ~~46724884~~ Application Date:

Budget Group Information

Instructions

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

Resources

	Aid Group Members (Adults)	Auto, truck	Life Insurance	Checking	Savings	Pre-need Burial	Real Property	Personal Needs	Other Resource
1	Holly Tindal		1,913.75	1,513.02	48.05				1,061.67
2									
	Totals	0.00	1,913.75	1,513.02	48.05	0.00	0.00	0.00	1,061.67

System Matches

- ☐ Bendex
- ☐ ESC
- ☐ UCB
- ☐ SDX
- ☐ SC Retirement

. 0

Calculator

Period	1	2	3	4	Total	Average per Period	FI Monthly Average	SSI Monthly Average
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

0

Period	1	2	3	4	Total	Average per Period	FI Monthly Average	SSI Monthly Average
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

Terminated employment 12/29/04
Bank information: Bank of America checking: - 536.18
Universal Credit Union Checking: 1513.02
IRA: 1061.67
Savings: 48.05
Life Insurance: 1913.75
Total resources: 4,536.49

January 2005 Budget Workbook

January 2005 retro requested

Holli Tindal

BG#: 09222127

ABD/SLMB Budgetsheet

Section I - Burial Assets Exclusion Computation	
1. Determine Net Burial Assets Exclusion Limit:	
A. Maximum Burial Assets Exclusion Limit	1,500.00
B. Offset	
C. Net Burial Assets Exclusion Limit (A - B)	1,500.00
2. A. Combined Value of Burial Assets	
B. Net Burial Assets Exclusion Limit	1,500.00
C. Excluded Burial Assets	0.00
Enter 2C amount in Section II Line 14 below.	

Section III - Income Sources	
RSDI/RR Retirement	0.00
VA Benefits	0.00
Pension/Retirement	0.00
Earned Income	0.00
Interest/Dividends/Rent	0.00
Cash Contributions	0.00
Other	0.00
If determining eligibility for a child(ren) living with his/her parent(s), complete the monthly deeming and allocation section	

Section II - Countable Resources Computation	$ Value
1. Automobile, Truck, Etc.	0.00
2. Life Insurance (Face Value > $5000)	2,145.48
3. Cash on Hand	
4. Checking Account	515.71
5. Savings Account	48.05
6. U.S. Savings Bond	
7. Stocks and Bonds	
8. Trust Fund	
9. Pre-Need Burial Account (Revocable)	0.00
10. Non-Excluded Cemetary Lot(s)	
11. Real Property	0.00
12. Other	1,060.41
13. Countable Resource Subtotal	3,769.65
14. Less Burial Exclusion	0.00
Total Countable Resource Value	3,769.65
Resource Limit	4,000.00

Section IV - Determination of Income Eligibility	$ Amount	SLMB/QMB Budgeting
1. Gross Unearned Income	0.00	0.00
2. General Disregard	50.00	20.00
3. Subtotal	0.00	0.00
4. Gross Earned	0.00	0.00
5. Disregards		
a. General SSI Disregard (Allow amount not used in 2)	50.00	20.00
b. Subtotal	0.00	0.00
c. Earned Income Disregard ($65)	65.00	65.00
d. Subtotal	0.00	0.00
e. Disregard 1/2 the Amount in Line 5D	0.00	0.00
f. Subtotal	0.00	0.00
6. Total	0.00	0.00
7. Allocation	0.00	0.00
8. Countable Income	0.00	0.00
9. Appropriate Poverty Level	776.00	

SLMB Countable	S1 Limit	S2 Limit
0.00	931.00	1,048.00

Resource Eligible

ABD Eligible

QMB

Allocation for Children		
	Income	Allocation
	0.00	0.00
	0.00	0.00
	0.00	0.00
	0.00	0.00
	0.00	0.00
	0.00	0.00
	Total	0.00

Retroactive:

Eligibility Worker's Signature: Emily McCall

Categorical Eligibility: Disabled
Action: Re-budget
Decision: Approval
Month of Eligibility:

Decision Date: 10/13/2006
Processing Time: Day(s)

January 2005 Budget Workbook

Primary Individual: Holli Tindal HH#: 10133594 BG#: ~~48724884~~ 09222127 Application Date:

Budget Group Information

Instructions

			Income										Disregards
	Budget Group Members	Relationship	Wages	Self Employment	SSA	VA	Pension	UCI Benefits	Child Support	Cntribtion	Interest Dividends	Other Unearned	Childcare Paid
	1 Holli Tindal	Primary											
	2												
Children	3												
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

		Resources							
	Aid Group Members (Adults)	Auto, truck	Life Insurance	Checking	Savings	Pre-need Burial	Real Property	Personal Needs	Other Resource
1	Holli Tindal		2,145.48	515.71	48.05				1,060.41
2									
	Totals	0.00	2,145.48	515.71	48.05	0.00	0.00	0.00	1,060.41

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

Terminated employment 12/29/04 Life insurance policy : 2145.48
Bank information: Checking (Bank of America) : - 530.23
Universal Credit Union checking: 515.71
IRA: 1060.41
Savings:48.05 Total resources: 1624.17

DECLARATION STATEMENT

Eligibility 1/05: Client had no earned income the first quarter of 2005 so she is eligible income-wise. Her resources are under the 4,000 limit so she is eligible for retro benefits in January 2005.

02/05: Once again client had no earned income/unearned income so she is income eligible. Ms. Tindal's resources are over the 4000 resource limit so she is ineligible for services February 2005

I certify 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 any situation, I am liable for prosecution for fraud and/or perjury.

Emily Tindal
SIGNATURE

10/18/06
DATE

WITNESS

DATE

WITNESS

DATE

DHHS FORM 1766ME (JULY 2003)

DECLARATION STATEMENT

Received a call from ms. Tindal inquiring about the status of her retro benefits. I explained that I was awaiting wage verification from her former employer Mr. Smith. I was informed that he sent the requested wage form to her because he did not have record of that any longer. So I asked if a copy of her taxes could be submitted so that I can finish determining her retro eligibility.

I certify 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 any situation, I am liable for prosecution for fraud and/or perjury.

Emily Nichols — SIGNATURE

10/12/06 — DATE

WITNESS

DATE

WITNESS

DATE

DHHS FORM 1766ME (JULY 2003)

Page: 1 Document Name: untitled

EDESC01 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 10/02/06
MEDSPROD ESC WAGE INQUIRY
THIS IS CONFIDENTIAL INFORMATION PAGE 001 OF 001

ESC SSN : 247-65-1942 NAME: HJTIN
MEDS SSN: 247651942 NAME: HOLLI J TINDAL
RCP NUM : 4780420409 HH NUM: 101033594 COUNTY: 40

EMP#	NAME & ADDRESS	TRADE NAME
0102135	F GLENN SMITH ATTORNEY AT LAW	F GLENN SMITH ATTORNEY AT

2231 DEVINE ST STE 302
COLUMBIA SC 29205

QTR	AMT	QTR	AMT
06/1	.00	05/4	.00
05/3	.00	05/2	.00
05/1	.00	04/4	14,333.68

UPDATED: SYSTEM ID: ESC2100 DATE: 09/17/06
ME912002 WAGE RECORD FOUND
PF1->HELP PF5->RCP INFO PF6->PREV PF7->BACK PF8->FORWARD
PF10->PREV MENU PF11->IEV PF12->EARNED INC PF14->SDX

DECLARATION STATEMENT

Gross Income Received for 2004: 52,340

52,340 ÷ 12 = 4,361.00 per month

4,361 ÷ 4 = 1090 per week

Client is ineligible for retro benefits for 12/04 because her income is over the 776.00 limit. She is also ineligible for services under the SLMB program because she is not a medicare recipient. However, she is resource eligible because she is under 4000.

I certify 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 any situation, I am liable for prosecution for fraud and/or perjury.

Emily McClintock
SIGNATURE

10/12/06
DATE

WITNESS

DATE

WITNESS

DATE

DHHS FORM 1766ME (JULY 2003)

Department of the Treasury - Internal Revenue Service

Form 1040 U.S. Individual Income Tax Return 2004

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

OMB No. 1545-0074

For the year Jan. 1-Dec. 31, 2004, or other tax year beginning , 2004, ending , 20

Label (See instructions on page 16.) Use the IRS label. Otherwise, please print or type.

Your first name and initial	Last name	Your social security number
HOLLI J	TINDAL	247-65-1942
If a joint return, spouse's first name and initial	Last name	Spouse's social security number

Home address (number and street). If you have a P.O. box, see page 16.
PO BOX 354

City, town or post office, state, and ZIP code. If you have a foreign address, see page 18.
PELION SC 29123

TAX FILE COPY

Important! You must enter your SSN(s) above.

Presidential Election Campaign (See page 16.)
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 [X] Single
2 [ ] Married filing jointly (even if only one had income)
3 [ ] Married filing separately. Enter spouse's SSN above and full name here.
4 [ ] Head of household (with qualifying person). (See page 17.) If the qualifying person is a child but not your dependent, enter this child's name here.
5 [ ] Qualifying widow(er) with dependent child (see page 17)

Exemptions
6a [X] Yourself. If someone can claim you as a dependent, do not check box 6a — Boxes checked on 6a and 6b: 1
b [ ] Spouse
c Dependents:

(1) First name / Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) Check if qualifying child for child tax credit (see pg 19)
			[ ]
			[ ]
			[ ]
			[ ]

If more than four dependents, see page 18.

No. of children on 6c who: • lived with you • did not live with you due to divorce or separation (see page 19)
Dependents on 6c not entered above
Add numbers on lines above ▶ 1

d Total number of exemptions claimed 1

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

If you did not get a W-2, see page 19.

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

7	Wages, salaries, tips, etc. Attach Form(s) W-2	7	50,340
8a	Taxable interest. Attach Schedule B if required	8a	
b	Tax-exempt interest. Do not include on line 8a (8b)		
9a	Ordinary dividends. Attach Schedule B if required	9a	
b	Qualified dividends (see page 20) (9b)		
10	Taxable refunds, credits, or offsets of state and local income taxes (see page 20)	10	
11	Alimony received	11	
12	Business income or (loss). Attach Schedule C or C-EZ	12	
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	IRA distributions (15a) b Taxable amount (see page 22)	15b	2,000
16a	Pensions and annuities (16a) b Taxable amount (see page 22)	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 page 24)	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	52,340

Adjusted Gross Income

23	Educator expenses (see page 26)	23	
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24	
25	IRA deduction (see page 26)	25	
26	Student loan interest deduction (see page 28)	26	
27	Tuition and fees deduction (see page 29)	27	
28	Health savings account deduction. Attach Form 8889	28	
29	Moving expenses. Attach Form 3903	29	
30	One-half of self-employment tax. Attach Schedule SE	30	
31	Self-employed health insurance deduction (see page 30)	31	
32	Self-employed SEP, SIMPLE, and qualified plans	32	
33	Penalty on early withdrawal of savings	33	
34a	Alimony paid b Recipient's SSN ▶	34a	
35	Add lines 23 through 34a	35	
36	Subtract line 35 from line 22. This is your adjusted gross income ▶	36	52,340

Department of the Treasury - Internal Revenue Service

Form 1040X (Rev. November 2004)

Amended U.S. Individual Income Tax Return

▶ See separate instructions.

OMB No. 1545-0091

This return is for calendar year ▶2004 , or fiscal year ended ▶

Please print or type	Your first name and initial: HOLLI J	Last name: TINDAL	Your social security number: 247-65-1942
	If a joint return, spouse's first name and initial	Last name	Spouse's social security number
	Home address (no. and street) or P.O. box if mail is not delivered to your home: PO BOX 354	Apt. no.	Phone number
	City, town or post office, state, and ZIP code. If you have a foreign address, see page 2 of the instructions.: PELION SC 29123		For Paperwork Reduction Act Notice, see page 6.

A If the name or address shown above is different from that shown on the original return, check here ▶ ☐

B Has the original return been changed or audited by the IRS or have you been notified that it will be? ☐ Yes ☒ No

C Filing status. Be sure to complete this line. Note. You cannot change from joint to separate returns after the due date.

	Single	Married filing jointly	Married filing separately	Head of household	Qualifying widow(er)
On original return ▶	☒	☐	☐	☐	☐
On this return ▶	☒	☐	☐	☐	☐

* If the qualifying person is a child but not your dependent, see page 2.

Use Part II on page 2 to explain any changes			A. Original amount or as previously adjusted (see page 2)	B. Net change - amount of increase or (decrease) - explain in Part II	C. Correct amount
Income and Deductions (see pages 2-6)					
	1 Adjusted gross income (see page 3)	1	52,340		52,340
	2 Itemized deductions or standard deduction (see page 3)	2	4,850	2,544	7,394
	3 Subtract line 2 from line 1	3	47,490	(2,544)	44,946
	4 Exemptions. If changing, fill in Parts I and II on page 2	4	3,100		3,100
	5 Taxable income. Subtract line 4 from line 3	5	44,390	(2,544)	41,846
Tax Liability	6 Tax (see page 4). Method used in col. C: TABLES	6	7,831	(637)	7,194
	7 Credits (see page 4)	7			
	8 Subtract line 7 from line 6. Enter the result but not less than zero	8	7,831	(637)	7,194
	9 Other taxes (see page 4)	9			
	10 Total tax. Add lines 8 and 9	10	7,831	(637)	7,194
Payments	11 Federal income tax withheld and excess social security and tier 1 RRTA tax withheld. If changing, see page 4	11	8,953		8,953
	12 Estimated tax payments, including amount applied from prior year's return	12			
	13 Earned income credit (EIC)	13			
	14 Additional child tax credit from Form 8812	14			
	15 Credits from Form 2439, Form 4136, or Form 8885	15			
	16 Amount paid with request for extension of time to file (see page 5)	16			
	17 Amount of tax paid with original return plus additional tax paid after it was filed	17			
	18 Total payments. Add lines 11 through 17 in column C	18			8,953
Refund or Amount You Owe					
	19 Overpayment, if any, as shown on original return or as previously adjusted by the IRS	19			1,122
	20 Subtract line 19 from line 18 (see page 5)	20			7,831
	21 Amount you owe. If line 10, column C, is more than line 20, enter the difference and see page 5	21			
	22 If line 10, column C, is less than line 20, enter the difference	22			637
	23 Amount of line 22 you want refunded to you	23			637
	24 Amount of line 22 you want applied to your estimated tax 24				

Sign Here

Joint return? See page 2. Keep a copy for your records.

Under penalties of perjury, I declare that I have filed an original return and that I have examined this amended return, including accompanying schedules and statements, and to the best of my knowledge and belief, this amended return is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which the preparer has any knowledge.

▶ Your signature Date ▶ Spouse's signature. If a joint return, both must sign. Date

Paid Preparer's Use Only

Preparer's signature ▶	Date: 05-17-2006	Check if self-employed ☒	Preparer's SSN or PTIN: 247-70-8119
Firm's name (or yours if self-employed), address, and ZIP code ▶ CROUTS TAX SERVICE, 214 EARLE ST, WAGENER SC 29164		EIN: 57-0682094	Phone no. 803-564-3336

Do not write in this space - OFFICE USE

SC 1040
(Rev. 11/8/04)

SOUTH CAROLINA INDIVIDUAL INCOME TAX RETURN 2004

For the year January 1 - December 31, 2004, or fiscal tax year beginning ____ and ending ____

PLACE LABEL HERE

Print Your first name and initial (Sr, Jr, 2nd, 3rd, 4th) Last name — Check if Deceased ☐ — Your Social Security number
HOLLI J TINDAL — 245-65-1942

Spouse's first name and initial, if married filing jointly — Spouse's last name — Check if Deceased ☐ — Spouse's Social Security number

Present home address (number and street, or P. O. Box) — Apt. No. — Area Code Daytime telephone — Do not write in this space - OFFICE USE
PO BOX 354

City, state and ZIP code — County code
PELION, SC 29123 — 32

If you do not wish to receive a booklet next year, but need a name and address label for your 2005 return, check here. ▶ ☐
Check this box if you are filing SC Schedule NR (Part year/Nonresident) ▶ ☐
Check this box if you have filed a federal or state extension ▶ ☐
Check this box if filing a composite return for partnership or "S" corporation.

CHECK YOUR FEDERAL FILING STATUS (1) ☒ Single (2) ☐ Married filing jointly (3) ☐ Married filing separately. Enter spouse's SSN here: ____ (4) ☐ Head of household (5) ☐ Widow(er) with dependent child

Federal Exemptions: Enter the number of exemptions from line 6 (d) of your 2004 federal return. ▶ 1
How many of the exemptions listed above were under the age of 6 years on December 31, 2004? ▶ 0
Enter the number of taxpayers age 65 or older, as of December 31, 2004. ▶ 0

STAPLE PAYMENT HERE

				Dollars	Cents
1	**Enter Federal taxable income from your federal Form 1040, line 42; 1040A, line 27; or 1040EZ, line 6; or line K-1 of federal Telefile. If zero or less, enter zero here.**		1	44,390	00
	STOP! **Resident filers complete lines 29 through 50. Nonresident filers complete Schedule NR and enter total from line 47 on line 5 below.**		2		00
2	TOTAL ADDITIONS. Enter amount from line 34.		3	44,390	00
3	Add lines 1 and 2. Enter total here.		4	<	00
4	TOTAL SUBTRACTIONS. Enter amount from line 50.		5	44,390	00
5	South Carolina INCOME SUBJECT TO TAX. Residents subtract line 4 from line 3 and enter the difference. Nonresidents enter amount from Schedule NR, line 47. If less than zero, enter zero.				
6	TAX: Enter tax from SOUTH CAROLINA tax tables.	6 2,743 00			
7	TAX on Lump Sum Distribution (Attach SC4972)	7 00	8	2,743	00
8	TOTAL South Carolina tax. Add lines 6 and 7. Enter the total.				
9	Child and Dependent Care (See instructions)	9 00			
10	Two Wage Earner Credit (See instructions)	10 00			
11	Other Non-refundable Credits (Attach SC1040TC)	11 00	12		00
12	TOTAL Non-refundable Credits. Add lines 9 through 11 and enter the total.		13	2,743	00
13	SUBTRACT line 12 from line 8. Enter the difference BUT NOT LESS THAN ZERO.				
14	SC INCOME TAX WITHHELD (Attach W-2 or SC41)	3,091 00			
15	2004 Estimated Tax Payments	00			
16	Amount Paid with extension	00			
17	NR sale of real estate	00			
18	Other SC Withholding (Attach Form 1099)	00			
19	Tuition Tax Credit (Attach I-319)	00			
			20	3,091	00
20	ADD lines 14 through 19 and enter the total.		21	348	00
21	If line 20 is LARGER than line 13, subtract line 13 from line 20 and enter the OVERPAYMENT.		22		00
22	If line 13 is LARGER than line 20, subtract line 20 from line 13 and enter the AMOUNT DUE.				
23	USE TAX (Due on Out-of-state Purchases. See Instructions)	23 0 00			
24	Amount of line 21 to be credited to your 2005 ESTIMATED TAX.	24 00			
25	Total Contributions for Check-offs (Attach I-330)	25 00	26		00
26	ADD lines 23 through 25 and enter the total.				
27	NET REFUND: If line 26 is larger than line 21, go to line 28. Otherwise, subtract line 26 from line 21 and enter the AMOUNT TO BE REFUNDED TO YOU.	**REFUND** ▶	27	348	00
28	NET DUE: ADD lines 22 and 26 and, if applicable, penalty amount. If line 26 is larger than line 21, subtract line 21 from line 26. Enter the AMOUNT YOU OWE. If subject to penalty for Underpayment of Estimated Tax, attach SC2210. (See instructions)	Penalty: $ ____ **BALANCE DUE** ▶	28		00

STAPLE W-2/1099 HERE

Staple a check or money order for the full amount payable to "SC Department of Revenue." Write your Social Security number and "2004 SC1040" on the payment.

ATTACH A COMPLETE COPY OF YOUR FEDERAL RETURN ONLY IF you have income and/or (loss) on federal Schedules C, D, E, F or filed

Northwestern Mutual®

Life Insurance Annual Policy Statement

10118S335900003352000312
HOLLI J TINDAL
PO BOX 354
PELION SC 29123

Insured Name:
Holli J Tindal
Direct Beneficiaries:
Susan Lee Tindal
Phil De Wight Tindal
Phil Dewight Tindal II

All information is as of January 15, 2005, and assumes all premiums are paid to that date.

Plan, Coverage and Benefits

Policy Number:	15263446	**Policy Date:**	January 15, 2000
Plan:	Adjustable CompLife®	**Additional Benefits:**	
Basic Insurance Amount:	$52,744.00		Waiver Premium Benefit
Coverage Increases From Dividends:	$540.00		
Total Death Benefit:	$53,284.00		
Net Death Benefit:	$53,223.71		

Cash Value and Dividends

Assumes Premiums Paid to January 15, 2005:

Total Cash Value:	$2,274.55	**Past Year's Cash Value Increase:**	$612.77
Net Cash Value:	$2,214.26	**2005 Dividend:**	$68.78

Dividend Used to:
Increase cash value and coverage.

Dividend scale changes, loans and surrenders will affect policy values. Please contact your Financial Representative or the Home Office for free policy illustrations showing the impact of such changes on cash values available for future income or other needs.

Financial Representative

For more information, contact:

Tracy L Smith
1901 Bull St
Columbia, SC 29201
(803) 254-0133

For address changes please contact your Financial Representative, Online Policyowner Service Department at 1(800) 388-0123 (7:00 AM to 7:00 PM CT M-F).

REFER TO THE BACK OF THIS STATEMENT FOR AN EXPLANATION OF TERMS

Network Office

James R Worrell
6235 Morrison Blvd
Charlotte NC 28211
(704)365-2014

Have questions about your policy? Get answers at http://www.northwesternmutual.com

Date Prepared: 12/24/04

Client Summary Statement
for Holli J Tindal as of 02/24/2005

The Northwestern Mutual Financial Network® is a marketing name for the sales and distribution arm of The Northwestern Mutual Life Insurance Company, its affiliates and subsidiaries. The products and services referenced are offered and sold only by appropriately appointed and licensed entities and Financial Representatives. Each Financial Representative represents one or more, but not necessarily all, of the entities shown. The Northwestern Mutual Life Insurance Company, Milwaukee, WI, (life insurance, disability insurance and annuities) is neither a registered investment adviser nor a registered broker-dealer. Securities are offered through Northwestern Mutual Investment Services, LLC (NMIS), 1-866-664-7737, member NASD and SIPC.

The information contained in these reports is for informational purposes only and may not reflect all policies, contracts, holdings or transactions, their values, costs, charges, or proceeds in your account. The information in this report does not in any way alter or supersede the terms of any policy, contract, confirmation or statement received from The Northwestern Mutual Life Insurance Company, NMIS, their subsidiaries and affiliates, or other organizations, and it has not been audited or verified. These reports should not be used as source documents for tax or other purposes. Form 1099 should be used when preparing tax returns. Please consult with your own tax advisor for specific tax advice.

Total Cash Value reflects the total gross cash value before the deduction of any loan balance. Variable life policies may also include surrender charges and an adjustment for unpaid premiums to arrive at Total Cash Value. The Net Cash Value (Surrender Value) is the Total Cash Value less any loan balance (Total Loans). For variable life policies, the Net Cash Value (Surrender Value) is the Total Cash Value less any loan balance, surrender charge and adjustment for unpaid premiums. Cash values displayed may not reflect actual premium payment status. Actual values will be determined at the time of surrender. For any variable contract, for the current date of the Statement, values are as of the close of the prior NYSE business day. For any variable contract, if the "as of date" of the Statement is prior to the current date, values are as of that day.

Tracy L Smith
1901 Bull St
Columbia SC 29201
(803)254-0133

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

FAX COVER SHEET

"CONFIDENTIAL INFORMATION ENCLOSED"

DATE: 11/3/06

TO: Jennifer Dabbs
Telephone #: 898-3965
Fax #: 255-8360

FROM: Emily Nicholson

Total Number of Pages Transmitted: 44 (Including Cover Sheet)

COMMENTS:

Hall Findal. If you have any more questions you may call Mr. Hampton at 714-7561.

Thank you in advance for your cooperation and assistance!!

DHHS- Medicaid Eligibility Region IV Office
PO Box 155 State Park SC 29147-0155
(803) 741-1165 • Fax (803) 741-9475

Rev: 01/04

January 2005 Budget Workbook

December 2004 Retro requested

Holli Tindal

BG#: 09222127

ABD/SLMB Budgetsheet

Section I - Burial Assets Exclusion Computation	
1. Determine Net Burial Assets Exclusion Limit:	
A. Maximum Burial Assets Exclusion Limit	1,500.00
B. Offset	
C. Net Burial Assets Exclusion Limit (A - B)	1,500.00
2. A. Combined Value of Burial Assets	
B. Net Burial Assets Exclusion Limit	1,500.00
C. Excluded Burial Assets	0.00
Enter 2C amount in Section II Line 14 below.	

Section II - Countable Resources Computation	$ Value
1. Automobile, Truck, Etc.	0.00
2. Life Insurance (Face Value > $5000)	0.00
3. Cash on Hand	
4. Checking Account	3.91
5. Savings Account	80.03
6. U.S. Savings Bond	
7. Stocks and Bonds	
8. Trust Fund	
9. Pre-Need Burial Account (Revocable)	0.00
10. Non-Excluded Cemetary Lot(s)	
11. Real Property	0.00
12. Other	1,059.15
13. Countable Resource Subtotal	1,143.09
14. Less Burial Exclusion	0.00
Total Countable Resource Value	1,143.09
Resource Limit	4,000.00

Resource Eligible

Section III - Income Sources	
RSDI/RR Retirement	0.00
VA Benefits	0.00
Pension/Retirement	0.00
Earned Income	-4,361.00
Interest/Dividends/Rent	0.00
Cash Contributions	0.00
Other	0.00

If determining eligibility for a child(ren) living with his/her parent(s), complete the monthly deeming and allocation section

Section IV - Determination of Income Eligiblity	$ Amount	SLMB/QMB Budgeting
1. Gross Unearned Income	0.00	0.00
2. General Disregard	50.00	20.00
3. Subtotal	0.00	0.00
4. Gross Earned	4,361.00	4,361.00
5. Disregards		
a. General SSI Disregard (Allow amount not used in 2)	50.00	20.00
b. Subtotal	4,311.00	4,341.00
c. Earned Income Disregard ($65)	65.00	65.00
d. Subtotal	4,246.00	4,276.00
e. Disregard 1/2 the Amount in Line 5D	2,123.00	2,138.00
f. Subtotal	2,123.00	2,138.00
6. Total	2,123.00	2,138.00
7. Allocation	0.00	0.00
8. Countable Income	2,123.00	2,138.00
9. Appropriate Poverty Level	776.00	

SLMB Countable	S1 Limit	S2 Limit
2,138.00	931.00	1,048.00

SLMB Ineligible

Not QMB

Allocation for Children		
	Income	Allocation
	0.00	0.00
	0.00	0.00
	0.00	0.00
	0.00	0.00
	0.00	0.00
	0.00	0.00
	Total	0.00

Retroactive: _____

Categorical Eligibility: Disabled
Action: Re-budget
Decision: Denial
Month of Eligibility: _____

Eligibility Worker's Signature: Emily Nicholas

Decision Date: 10/13/2006
Processing Time: _____ Day(s)

January 2005 Budget Workbook

Primary Individual: Holli Tindal **HH#:** 10133594 **BG#:** ~~48724864~~ 09222127 **Application Date:**

Budget Group Information

Instructions

	Budget Group Members	Relationship	Income: Wages	Self Employment	SSA	VA	Pension	UCI Benefits	Child Support	Cntribtion	Interest Dividends	Other Unearned	Disregards: Childcare Paid
	1 Holli Tindal	Primary	4,361.00										
	2												
Children	3												
Children	4												
Children	5												
Children	6												
Children	7												
Children	8												
		Totals	4,361.00	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	Holli Tindal			3.91	80.03				1,059.15
2									
	Totals	0.00	0.00	3.91	80.03	0.00	0.00	0.00	1,059.15

Income Calculator

0

	Check 1	Check 2	Check 3	Check 4	Total	Average per Period	FI Monthly Average	SSI Monthly Average
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

0

	Check 1	Check 2	Check 3	Check 4	Total	Average per Period	FI Monthly Average	SSI Monthly Average
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

Gross earned income for the entire year of 2004: 52, 340
52,340 / 12 = 4,361 per month
4361/4 ~ 1090 per week
This information was obtained from the clients income taxes.
Bank information: Checking (Bank of America) : - 224.78 - 4361 = 0
Universal Credit Union checking: 3.91
IRA: 1059.15
Savings: 80.03 Total resources: 1143.09

Life insurance policy : cash value is not known

Universal 1 Credit Union, Inc.

STATEMENT

01653	XXX-XX-1942
ACCOUNT NUMBER	SOCIAL SECURITY NO.
02-01-05 02-28-05	1 of 2
FROM THROUGH	PAGE

One River Park Drive Dayton Ohio 45409 937-225-6800 800-762-9555 www.universal1cu.org

C160B1P17749**********AUTO**3-DIGIT 290
17749 1 AT 0.292

HOLLI J TINDAL
PO BOX 354
PELION SC 29123-0354

TRAN MO DAY	EFFECT MO DAY YR	TRANSACTION DESCRIPTION	AMOUNT	NEW BALANCE
		SUFFIX:00 SAVINGS PLUS		76.05
		ANNUAL PERCENTAGE YIELD 0.0000%		
		JOINT OWNERS: P O D		
		REPORTING SSN: ON-FILE Y-T-D DIVIDENDS:	.18	
		SUFFIX:18 FREE CHECKING		
		BEGINNING BALANCE 515.71		
		DEPOSITS 1870.00		
		DRAFTS 749.89		
		MISC DEBITS 122.80		
		MAINT/SERVICE CHGS .00		
		ENDING BALANCE 1513.02		
		TOTAL NUMBER DRAFTS CLEARED	12	
		YOUR AVG DAILY BALANCE WAS	601.28	
		YOUR LOW MONTH BALANCE WAS	43.02	
		DEPOSITS		
020905		TELLER DEPOSIT	400.00	
022505		DIRECT DEPOSIT	1122.00	
		US TREASURY 220 - TAX REFUND		
022505		DIRECT DEPOSIT	348.00	
		SC REFUND - TAX EFT		
		TOTAL:	1870.00	

DRAFTS

NO.	EFF DATE	AMOUNT	NO.	EFF DATE	AMOUNT	NO.	EFF DATE	AMOUNT
681	02-03	78.56	*687	02-14	50.00	691	02-22	40.00
682	02-02	41.02	688	02-16	10.00	*693	02-24	151.73
*684	02-10	20.00	689	02-16	220.93	694	02-24	20.00
685	02-16	26.66	690	02-22	45.00	695	02-24	40.00
							TOTAL:	749.89

MISCELLANEOUS DEBITS

020105	ACH WITHDRAWAL		-23.90
	TWX*AOL SERVICE - SETTLEMEN		
021405	ACH WITHDRAWAL		-70.00
	DIRECTV - DIRECTV		
021505	ACH WITHDRAWAL		-28.90
	TWX*AOL SERVICE - 0205		
		TOTAL:	122.80
	ANNUAL PERCENTAGE YIELD 0.0000%		
	JOINT OWNERS: POD		
	REPORTING SSN: ON-FILE Y-T-D DIVIDENDS:	.00	
	SUFFIX:70 IRA 12 MONTH TRAD		1060.41

NAME	ACCOUNT	SOCIAL SECURITY NO.	FROM	TO	PAGE
HOLLI J TINDAL	3901653	xxx-xx-1942	02-01-05	02-28-05	2 of 2

0228022705DIVIDEND AT MATURITY 1.26 1061.6

ANNUAL PERCENTAGE YIELD 2.4290%
ANNUAL PERCENTAGE YIELD EARNED 1.4080%
BENEFICIARIES: TINDAL/PHIL D TINDAL/SUSAN L
REPORTING SSN: ON-FILE Y-T-D DIVIDENDS: 2.52 FORFEITURES: .00

CERT NO: 0 ISSUE DATE:022705 MATURITY DATE:022706 DIV RATE: 2.4000

PLAN SUMMARY FOR ACCOUNT: 3901653
PLAN SSN: ON-FILE PLAN NUM: 1
70

SUMMARY OF YEAR-TO-DATE DIVIDENDS	2005	2004
REPORTABLE DIVIDENDS CREDITED	.18	.16
NON-REPORTABLE IRA DIVIDENDS CREDITED	2.52	20.30
TOTAL DIVIDENDS CREDITED	2.70	20.46

FOR 2005

REPORTING SSN	* IRA YTD DIVIDENDS	* OTHER YTD DIVIDENDS	* TOTAL YTD DIVIDENDS	* TOTAL YTD FED WHH	* TOTAL YTD STATE WHH	* TOTAL YTD FORFEITURES *
ON-FILE	2.52	.18	2.70	.00	.00	.00

Universal 1 Credit Union, Inc.

STATEMENT

3901653	xxx-xx-1942
ACCOUNT NUMBER	SOCIAL SECURITY NO.
01-01-05 01-31-05	1 of 2
FROM THROUGH	PAGE

One River Park Drive Dayton Ohio 45409 937-225-6800 800-762-9555 www.universal1cu.org

RECEIVED
MAR 2 4 2005
DHHS
COLUMBIA REGIONAL OFFICE

C155B1P16763**********AUTO**3-DIGIT 290
16763 1 AT 0.292
HOLLI J TINDAL
PO BOX 354
PELION SC 29123-0354

TRAN MO DAY	EFFECT MO DAY YR	TRANSACTION DESCRIPTION	AMOUNT	NEW BALANCE
		SUFFIX:00 SAVINGS PLUS		80.03
010605		TELLER DEPOSIT	595.94	675.97
011005		TFR TO SHARES 3901653-18	-79.80	596.17
011205		TFR TO SHARES 3901653-18	-75.30	520.87
012805		TFR TO SHARES 3901653-18	-473.00	47.87
013105		DIVIDEND	.18	48.05

ANNUAL PERCENTAGE YIELD 0.0000%
ANNUAL PERCENTAGE YIELD EARNED 0.5136%
JOINT OWNERS: P O D
REPORTING SSN: ON-FILE Y-T-D DIVIDENDS: .18

SUFFIX:18 FREE CHECKING

BEGINNING BALANCE	3.91		
DEPOSITS	710.81		
DRAFTS	115.30	TOTAL NUMBER DRAFTS CLEARED	3
MISC DEBITS	83.71		
MAINT/SERVICE CHGS	.00	YOUR AVG DAILY BALANCE WAS	75.77
ENDING BALANCE	515.71	YOUR LOW MONTH BALANCE WAS	.00

DEPOSITS

011005	TFR FROM SHARES 3901653- 0	79.80
011205	TFR FROM SHARES 3901653- 0	75.30
012405	TELLER DEPOSIT	82.71
012805	TFR FROM SHARES 3901653- 0	473.00
	TOTAL:	710.81

DRAFTS

NO.	EFF DATE	AMOUNT	NO.	EFF DATE	AMOUNT	NO.	EFF DATE	AMOUNT
556	01-12	41.39	557	01-12	33.91	*560	01-26	40.00
							TOTAL:	115.30

MISCELLANEOUS DEBITS

011005	ACH WITHDRAWAL DIRECTV - DIRECTV	-83.71	
		TOTAL:	83.71

ANNUAL PERCENTAGE YIELD 0.0000%
JOINT OWNERS: POD
REPORTING SSN: ON-FILE Y-T-D DIVIDENDS: .00

NAME	ACCOUNT	SOCIAL SECURITY NO.	FROM	TO	PAGE
HOLLI J TINDAL	3901653	xxx-xx-1942	01-01-05	01-31-05	2 of 2

SUFFIX:70 IRA 12 MONTH TRAD

012705DIVIDEND 1059.15
ANNUAL PERCENTAGE YIELD 1.4098% 1.26 1060.41
ANNUAL PERCENTAGE YIELD EARNED 1.4097%
BENEFICIARIES: TINDAL/PHIL D TINDAL/SUSAN L
REPORTING SSN: ON-FILE Y-T-D DIVIDENDS: 1.26 FORFEITURES: .00

CERT NO: 0 ISSUE DATE:022704 MATURITY DATE:022705 DIV RATE: 1.4000

PLAN SUMMARY FOR ACCOUNT: 3901653
PLAN SSN: ON-FILE PLAN NUM: 1
70

SUMMARY OF YEAR-TO-DATE DIVIDENDS	2005	2004
REPORTABLE DIVIDENDS CREDITED	.18	.16
NON-REPORTABLE IRA DIVIDENDS CREDITED	1.26	20.30
TOTAL DIVIDENDS CREDITED	1.44	20.46

FOR 2005

REPORTING SSN	IRA YTD DIVIDENDS	OTHER YTD DIVIDENDS	TOTAL YTD DIVIDENDS	TOTAL YTD FED WHH	TOTAL YTD STATE WHH	TOTAL YTD FORFEITURES
ON-FILE	1.26	.18	1.44	.00	.00	.00

Universal 1 Credit Union, Inc.

STATEMENT

2901653	XXX-XX-1942
ACCOUNT NUMBER	SOCIAL SECURITY NO.
12-01-04 12-31-04	1 of 2
FROM THROUGH	PAGE

One River Park Drive Dayton Ohio 45409 937-225-6800 800-762-9555 www.universal1cu.org

C331B1P43870**********AUTO**3-DIGIT 290
43870 1 AT 0.292
HOLLI J TINDAL
PO BOX 354
PELION SC 29123-0354

TRAN MO	TRAN DAY	EFFECT MO	EFFECT DAY	EFFECT YR	TRANSACTION DESCRIPTION	AMOUNT	NEW BALANCE
					SUFFIX:00 SAVINGS PLUS		5.00
12	07	04			TELLER DEPOSIT	75.00	80.00
12	31	04			DIVIDEND	.03	80.03
					ANNUAL PERCENTAGE YIELD 0.5011%		
					ANNUAL PERCENTAGE YIELD EARNED 0.5408%		
					JOINT OWNERS: P O D		
					REPORTING SSN: ON-FILE Y-T-D DIVIDENDS: .16		
					SUFFIX:18 CHECKING		

BEGINNING BALANCE	-151.71		
DEPOSITS	280.00		
DRAFTS	117.38	TOTAL NUMBER DRAFTS CLEARED	1
MISC DEBITS	7.00		
MAINT/SERVICE CHGS	.00	YOUR AVG DAILY BALANCE WAS	13.29
ENDING BALANCE	3.91	YOUR LOW MONTH BALANCE WAS	-151.71

DEPOSITS

12	07	04			TELLER DEPOSIT		280.00	
						TOTAL:	280.00	

DRAFTS

NO.	EFF DATE	AMOUNT	NO.	EFF DATE	AMOUNT	NO.	EFF DATE	AMOUNT
554	12-16	117.38					TOTAL:	117.38

MISCELLANEOUS DEBITS

12	31	04			MIN BAL CHK FEE		-7.00	
						TOTAL:	7.00	
					ANNUAL PERCENTAGE YIELD 0.0000%			
					JOINT OWNERS: POD			
					REPORTING SSN: ON-FILE Y-T-D DIVIDENDS: .00			
					SUFFIX:70 IRA 12 MONTH TRAD			1057.93
					**********			
					** **			
					** IMPORTANT TAX RETURN INFORMATION INCLUDED **			
					** **			
					**********			
12	27	04			DIVIDEND		1.22	1059.15
					IRA FAIR MARKET VALUE AS OF DECEMBER 31, 2004: 1059.15			

NAME	ACCOUNT	SOCIAL SECURITY NO.	FROM	TO	PAGE
HOLLI J TINDAL	3901653	xxx-xx-1942	12-01-04	12-31-04	2 of 2

ANNUAL PERCENTAGE YIELD 1.4098%
ANNUAL PERCENTAGE YIELD EARNED 1.4121%
BENEFICIARIES: TINDAL/PHIL D TINDAL/SUSAN L
REPORTING SSN: ON-FILE Y-T-D DIVIDENDS: 20.30 FORFEITURES: .00

CERT NO: 0 ISSUE DATE:022704 MATURITY DATE:022705 DIV RATE: 1.4000

PLAN SUMMARY FOR ACCOUNT: 3901653
PLAN SSN: ON-FILE PLAN NUM: 1
70
TOTAL DISTRIBUTION THIS YEAR: 2000.00

FOR 2004 REPORTING SSN	IRA YTD DIVIDENDS	OTHER YTD DIVIDENDS	TOTAL YTD DIVIDENDS	TOTAL YTD FED WHH	TOTAL YTD STATE WHH	TOTAL YTD FORFEITURES
ON-FILE	20.30	.16	20.46	.00	.00	.00

STATEMENT

Universal 1 Credit Union, Inc.

One River Park Drive Dayton Ohio 45409 937-225-6800 800-762-9555 www.universal1cu.org

01653	XXX-XX-1942
ACCOUNT NUMBER	SOCIAL SECURITY NO.
11-01-04 11-30-04	1 of 2
FROM THROUGH	PAGE

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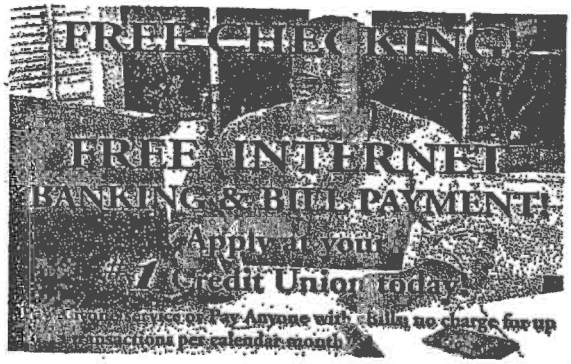
C150B1P16590**********AUTO**3-DIGIT 290
16590 1 AT 0.292
HOLLI J TINDAL
PO BOX 354
PELION SC 29123-0354



TRAN MO DAY	EFFECT MO DAY YR	TRANSACTION DESCRIPTION		AMOUNT	NEW BALANCE
		SUFFIX:00 SAVINGS PLUS			36.24
111704		TRNSFR TO DRAFT ACCT	41659	-29.30	6.94
		TFR TO SHARES 3901653-18			
		Palmetto 1220 B AVENUE	WEST COLUMBIASCUS		
112404		TFR TO SHARES 3901653-18		-1.94	5.00
		ANNUAL PERCENTAGE YIELD 0.0000%			
		JOINT OWNERS: P O D			
		REPORTING SSN: ON-FILE	Y-T-D DIVIDENDS: .13		
		SUFFIX:18 CHECKING			
		BEGINNING BALANCE 139.70			
		DEPOSITS 31.24			
		DRAFTS 225.65	TOTAL NUMBER DRAFTS CLEARED 3		
		MISC DEBITS 97.00			
		MAINT/SERVICE CHGS .00	YOUR AVG DAILY BALANCE WAS -21.78		
		ENDING BALANCE -151.71	YOUR LOW MONTH BALANCE WAS -151.71		
		DEPOSITS			
111704		TRNSFR TO DRAFT ACCT	41659	29.30	
		TFR FROM SHARES 3901653- 0			
		Palmetto 1220 B AVENUE	WEST COLUMBIASCUS		
112404		TFR FROM SHARES 3901653- 0		1.94	
			TOTAL:	31.24	

DRAFTS

NO.	EFF DATE	AMOUNT	NO.	EFF DATE	AMOUNT	NO.	EFF DATE	AMOUNT
551	11-01	129.00	552	11-26	72.65	553	11-24	24.00
							TOTAL:	225.65

MISCELLANEOUS DEBITS

111704		ATM WITHDRAWAL	41659	-40.00	
		Palmetto 1220 B AVENUE	WEST COLUMBIASCUS		
112404		PAID NSF FEE# 553		-25.00	
112604		PAID NSF FEE# 552		-25.00	
113004		MIN BAL CHK FEE		-7.00	
			TOTAL:	97.00	
		ANNUAL PERCENTAGE YIELD 0.0000%			
		JOINT OWNERS: POD			
		REPORTING SSN: ON-FILE	Y-T-D DIVIDENDS: .00		
		SUFFIX:70 IRA 12 MONTH TRAD			1056.67
112704		DIVIDEND		1.26	1057.93

NAME	ACCOUNT	SOCIAL SECURITY NO.	FROM	TO	PAGE
HOLLI J TINDAL	3901653	xxx-xx-1942	11-01-04	11-30-04	2 of 2

ANNUAL PERCENTAGE YIELD 1.4098%
ANNUAL PERCENTAGE YIELD EARNED 1.4130%
BENEFICIARIES: TINDAL/PHIL D TINDAL/SUSAN L
REPORTING SSN: ON-FILE Y-T-D DIVIDENDS: 19.08 FORFEITURES: .00

CERT NO: 0 ISSUE DATE:022704 MATURITY DATE:022705 DIV RATE: 1.4000

PLAN SUMMARY FOR ACCOUNT: 3901653
PLAN SSN: ON-FILE PLAN NUM: 1
70
TOTAL DISTRIBUTION THIS YEAR: 2000.00

FOR 2004 REPORTING SSN	IRA YTD DIVIDENDS	OTHER YTD DIVIDENDS	TOTAL YTD DIVIDENDS	TOTAL YTD FED WHH	TOTAL YTD STATE WHH	TOTAL YTD FORFEITURES
ON-FILE	19.08	.13	19.21	.00	.00	.00

Bank of America

Bank of America, N.A.
P.O. Box 25118
Tampa, FL 33622-5118

Statement Period
01-12-05 through 02-08-05
Number of checks enclosed: 0
B 07 0 A P 07 00

Account Number: 0007 6919 283

00006155 1 AT 0.292 12 09005 001 SCH999 I1
HOLLI J TINDAL
PO BOX 354
PELION SC 29123-0354

Our free Online Banking service allows you to check balances, track account activity, pay bills and more. With Online Banking you can also view up to 18 months of this statement online and even turn off delivery of your paper statement. Enroll at www.bankofamerica.com.

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www.bankofamerica.com

For additional information or service, you may call:
1.800.432.1000 Customer Service
1.800.288.4408 TTD/TTY (For the Deaf)
1.866.888.5086 En Español

Or you may write to:
Bank of America, N.A.
P.O. Box 25118
Tampa, FL 33622-5118

MyAccess checking

HOLLI J TINDAL

Your Account at a Glance

Account Number		0007 6919 2835
Beginning Balance on 01-12-05	$	530.23
Service Charges and Other Fees	-	5.95
Ending Balance on 02-08-05	$	536.18

A monthly maintenance fee was applied to your MyAccess checking account because we did not receive a direct deposit to your account during this statement cycle. Please call our 24-hour Customer Service if you would like information about how to avoid this fee.

H

HOLLI J TINDAL

Statement Period
01-12-05 through 02-08-05
Number of checks enclosed: 0
B 07 0 A P 07

Account Number: 0007 6919 2835

ffective April 2, 2005, if you use your Check Card or ATM Card to purchase goods or services (or to obtain cash om an ATM) in currency other than U.S. dollars, the currency conversion exchange rate used by Visa will be:

rate selected by Visa from a range of rates available in wholesale currency markets for the applicable central ocessing date, which rate may differ from the rate Visa receives, or the government-mandated rate in effect for the ntral processing date. Visa will no longer add a 1% adjustment factor and show it as part of the U.S. dollar nount.

ıe Check Card Foreign Currency Conversion Adjustment fee determined by us and shown as a separate charge for ch converted Check Card purchase (but not ATM cash withdrawals) will be 3% of the U.S. dollar amount. Please ll the number on this statement with questions regarding this change or to find out about other options for ternational transactions.

MyAccess checking Additions and Subtractions

ate osted	Amount($)	Resulting Balance($)	Transaction
-08	5.95-	536.18-	Monthly Maintenance Fee

Daily Balance Summary

ıte	Balance	Date	Balance
ginning	530.23-	02-08	536.18-

nd money instantly to other Bank of America customers - free. With Online Banking you can make secure, rson-to-person transfers from your checking, savings or credit card account to millions of other Bank of America stomers with checking or savings accounts - and the money will be available immediately. Enroll or sign in today at vw.bankofamerica.com.

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Bank of America

Bank of America, N.A.
P.O. Box 25118
Tampa, FL 33622-5118

H

Statement Period
12-15-04 through 01-11-05
Number of checks enclosed: 0
B 07 0 A P 07 0025945

Account Number: 0007 6919 2835

00005694 1 AT 0.292 13 12005 001 SCM999 I1 4
HOLLI J TINDAL
PO BOX 354
PELION SC 29123-0354

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1.800.288.1408 TDD/TTY: Users Only
1.800.688.6386 En Español

Or you may write to:
Bank of America, N.A.
P.O. Box 25118
Tampa, FL 33622-5118

MyAccess checking

HOLLI J TINDAL

Your Account at a Glance

Account Number		0007 6919 2835
Beginning Balance on 12-15-04	$	224.78
Deposits and Other Additions	+	2,771.06
Checks Posted	-	919.32
ATM and Debit Card Subtractions	-	1,865.24
Service Charges and Other Fees	-	236.95
Other Subtractions	-	55.00
Ending Balance on 01-11-05	$	530.23

A monthly maintenance fee was applied to your MyAccess checking account because we did not receive a direct deposit to your account during this statement cycle. Please call our 24-hour Customer Service if you would like information about how to avoid this fee.

Recycled Paper

H

HOLLI J TINDAL

Statement Period
12-15-04 through 01-11-05
Number of checks enclosed: 0
B 07 0 A P 07

Account Number: 0007 6919 2835

ssolve to save more in 2005. Automatic transfers from checking to savings are an easy way to save. Start saving now id you can watch your money grow all year long.

id you know that your online checking account statements are secure and protected in Online Banking? You can ren stop delivery of your paper statement altogether. Enroll or sign in to Online Banking today at ww.bankofamerica.com. Select the Account Activity tab and click on the "Stop/Resume mailing paper statements" nk.

MyAccess checking Additions and Subtractions

ate osted	Amount($)	Resulting Balance($)	Transaction
2-15	135.84+	88.94	Return Of Posted Check / Item (Received On 12-14) Electronic Transaction
2-15	135.84+	46.90	Return Of Posted Check / Item (Received On 12-14) Electronic Transaction
2-15	602.49+	649.39	Deposit
2-15	44.45-	604.94	CheckCard 1213 Cvs Pharmacy #5471 Q03 Lexington SC 24445004349012780837282
2-15	33.00-	571.94	Overdraft Fee For Activity Of 12-14 Electronic Transa
2-15	33.00-	538.94	Overdraft Fee For Activity Of 12-14 Electronic Transa
2-17	60.00-	478.94	Check 1498
2-17	158.89-	320.05	CheckCard 1216 Cingular*0156757700135 800-331-0500 TN 24493984351007166935576
2-20	595.94+	915.99	Counter Credit
2-23	1,000.00+	1,915.99	Counter Credit
2-23	55.00-	1,860.99	ATM/Check Card Temporary Cr Reversal On 10/04/04 Card # 4356400009662838 Claim #466-06Oct04
2-23	558.37-	1,302.62	Check 1497
2-23	384.34-	918.28	CheckCard 1222 Target 00019232 Columbia SC 24164074357091008319522
2-23	135.84-	782.44	CheckCard 1222 Dtv*directv Service 800-347-3288 CA 24692164357000306561255
2-24	71.29-	711.15	CheckCard 1223 Target 00019232 Columbia SC 24164074358091007296969
2-24	17.31-	693.84	CheckCard 1222 Shell Oil 57528069602 West Columbiasc 24692164358000407179543
2-27	170.61-	523.23	CheckCard 1223 Belk #178 Dutch Square Columbia SC 24445004359023864996735
2-27	162.94-	360.29	CheckCard 1224 Wal-Mart Stores, IN Orangeberg SC 24455014359140002869222
2-27	116.99-	243.30	CheckCard 1224 Belk #513 Orangeburg Orangeburg SC 24445004361025064437002
2-27	99.75-	143.55	CheckCard 1223 Belk #178 Dutch Square Columbia SC 24445004359023864996651
2-27	74.18-	69.37	CheckCard 1224 Jcpenney Store 2152 Orangeburg SC 24299164359901705658037
2-27	68.90-	0.47	CheckCard 1224 Belk #513 Orangeburg Orangeburg SC 24445004361025064436921
2-27	63.57-	63.10-	CheckCard 1224 Belk #513 Orangeburg Orangeburg SC 24445004361025064437184
2-28	296.18-	359.28-	CheckCard 1227 Winn-Dixie #1235 S9I South Congaresc 24445004363026722114023

Bank of America

HOLLI J TINDAL

Statement Period
12-15-04 through 01-11-05
Number of checks enclosed: 0
B 07 0 A P 07 002594

Account Number: 0007 6919 2835

MyAccess checking Additions and Subtractions

Date Posted	Amount($)	Resulting Balance($)	Transaction
12-28	33.00-	392.28-	Overdraft Fee For Activity Of 12-27
12-29	148.00-	540.28-	Electronic Transa Check 1499
12-29	33.00-	573.28-	Overdraft Fee For Activity Of 12-28
12-30	148.00+	425.28-	Electronic Transa Return Of Posted Check / Item (Received On 12-29)
12-30	33.00-	458.28-	Check #0000001499 Overdraft Fee For Activity Of 12-29
12-31	4.95-	463.23-	Check #0000001499 Check 1500
01-03	4.95+	458.28-	Return Of Posted Check / Item (Received On 12-31)
01-03	33.00-	491.28-	Check #0000001500 Overdraft Fee For Activity Of 12-31
01-05	148.00-	639.28-	Check #0000001500 Check 1499
01-06	148.00+	491.28-	Return Of Posted Check / Item (Received On 01-05)
01-06	33.00-	524.28-	Check #0000001499 Overdraft Fee For Activity Of 01-05
01-11	5.95-	530.23-	Check #0000001499 Monthly Maintenance Fee

Checks Posted in Numerical Order

Check Number	Date Posted	Amount($)	Check Number	Date Posted	Amount($)	Check Number	Date Posted	Amount($)
1497	12-23	558.37	1499	12-29	148.00	1500	12-31	4.95
1498	12-17	60.00	1499*	01-05	148.00			

Total Checks Posted **$919.32**

* The asterisk shows a break in the check number order. Your check may have been in a previous statement or may still be outstanding.

Daily Balance Summary

Date	Balance	Date	Balance	Date	Balance
Beginning	224.78-	12-24	693.84	12-31	463.23-
12-15	538.94	12-27	63.10-	01-03	491.28-
12-17	320.05	12-28	392.28-	01-05	639.28-
12-20	915.99	12-29	573.28-	01-06	524.28-
12-23	782.44	12-30	458.28-	01-11	530.23-

Bank of America

Bank of America, N.A.
P.O. Box 25118
Tampa, FL 33622-5118

Page 1 of 4
Statement Period
11-10-04 through 12-14-04
Number of checks enclosed: 0
B 07 0 A P 07 0000179

Account Number: 0007 6919 2835

15005 001 SCM999 I12 0

HOLLI J TINDAL
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PELION SC 29123-0354

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Or you may write to:
Bank of America, N.A.
P.O. Box 25118
Tampa, FL 33622-5118

MyAccess checking

HOLLI J TINDAL

Your Account at a Glance

Account Number		0007 6919 2835
Beginning Balance on 11-10-04	$	194.60
Deposits and Other Additions	+	3,030.11
Checks Posted	-	1,108.22
ATM and Debit Card Subtractions	-	1,959.64
Service Charges and Other Fees	-	39.95
Other Subtractions	-	341.68
Ending Balance on 12-14-04	$	224.78-

A monthly maintenance fee was applied to your MyAccess checking account because we did not receive a direct deposit to your account during this statement cycle. Please call our 24-hour Customer Service if you would like information about how to avoid this fee.

BANK OF AMERICA

HOLLI J TINDAL

Statement Period
11-10-04 through 12-14-04
Number of checks enclosed: 0
B 07 0 A P 07 00(

Account Number: 0007 6919 283

MyAccess checking Additions and Subtractions

Date Posted	Amount($)	Resulting Balance($)	Transaction
12-02	27.10-	396.15	CheckCard 1201 D.F. Shumpert Groce Pelion SC 24455014336040005251782
12-02	4.95-	391.20	Check 1489
12-03	105.00-	286.20	Check 1488
12-03	17.96-	268.24	CheckCard 1201 Shell Oil 57528069602 West Columbiasc 24692164337000715164522
12-06	245.94+	514.18	Deposit
12-06	160.00-	354.18	Check 1490
12-06	50.42-	303.76	CheckCard 1204 Tyler Brothers Wagener SC 24246514339206299200328
12-06	49.00-	254.76	CheckCard 1203 Kmart 00041418 W Columbia SC 24399004339904141338877
12-06	23.90-	230.86	CheckCard 1203 Twx*aol Service 1204 800-827-6364 VA 24692164338000766789986
12-07	72.03-	158.83	CheckCard 1205 Ocharleys 01003151 Lexington SC 24164074341119370216734
12-07	70.00-	88.83	Cingular ;Des=check Pymt;ID=1491 Eff Date: 041207;Indn:01567577
12-08	1,001.88+	1,090.71	Deposit
12-08	80.00-	1,010.71	BkofAmerica ATM 12/08 #000006985 Withdrwl Airport Bc W. Columbia SC
12-09	53.20-	957.51	Check 1493
12-09	19.80-	937.71	Check 1495
12-09	17.53-	920.18	CheckCard 1207 Shell Oil 57528069602 West Columbiasc 24692164343000188699287
12-10	30.00-	890.18	Stop Payment Fee
12-10	106.72-	783.46	CheckCard 1209 D.F. Shumpert Groce Pelion SC 24455014344040005637477
12-10	75.00-	708.46	Check 1496
12-13	162.00-	546.46	Branch Banking 12/12 #000020812 Withdrwl Lexington - Pelio Lexington SC
12-13	160.00-	386.46	BkofAmerica ATM 12/11 #000004233 Withdrwl Hwy 378 - Lexing Lexington SC
12-13	106.55-	279.91	CheckCard 1211 Mikes Liquor And Party Pelion SC 24254774347443503000033
12-13	101.80-	178.11	CheckCard 1211 Elante Day Spa Lexington SC 24073144347900013109898
12-13	26.00-	152.11	Check 1492
12-13	18.68-	133.43	CheckCard 1211 Exxonmobil75 04227914 Lexingto SC 24164054347378000051608
12-13	2.00-	131.43	Branch Banking 12/12 #000020812 Withdrwl Lexington - Pelio Lexington SC Fee
12-14	135.84-	4.41-	**Directv ;Des=directv ;ID= Eff Date: 041214;Indn: *holli Tindal
12-14	135.84-	140.25-	**Directv ;Des=checkpaymt;ID=1494 Eff Date: 041214;Indn:014666692
12-14	50.00-	190.25-	§BkofAmerica ATM 12/13 #000009868 Withdrwl Springs Crossing Lexington SC
12-14	28.58-	218.83-	§CheckCard 1213 Ruby Tuesday #3613 Columbia SC 24792624349221131400385
12-14	5.95-	224.78-	Monthly Maintenance Fee

HOLLI J TINDAL

Statement Period
11-10-04 through 12-14-04
Number of checks enclosed: 0
B 07 0 A P 07

Account Number: 0007 6919 2835

§There were not enough funds available in your account to cover all the electronic transactions received on 12-14. The transaction(s) indicated here have been paid. Any service charge(s) will be reflected on your next statement.
**We have stopped payment on this electronic transaction as you requested. This indicates that the transaction was presented for payment. We have since returned th electronic transaction and credited your account for the amount of the transaction. This credit will appear on your next statement.

Checks Posted in Numerical Order

Check Number	Date Posted	Amount($)	Check Number	Date Posted	Amount($)	Check Number	Date Posted	Amount($)
1484	11-22	10.00	1488	12-03	105.00	1493	12-09	53.20
1485	11-22	558.37	1489	12-02	4.95	1495*	12-09	19.80
1486	11-26	30.00	1490	12-06	160.00	1496	12-10	75.00
1487	12-01	65.90	1492*	12-13	26.00			

Total Checks Posted $1,108.22

* The asterisk shows a break in the check number order. Your check may have been in a previous statement or may still be outstanding.

Daily Balance Summary

Date	Balance	Date	Balance	Date	Balance
Beginning	194.60	11-24	329.21	12-06	230.86
11-10	322.34	11-26	217.47	12-07	88.83
11-12	304.44	11-29	105.23	12-08	1,010.71
11-15	646.90	11-30	611.17	12-09	920.18
11-16	618.64	12-01	423.25	12-10	708.46
11-19	608.64	12-02	391.20	12-13	131.43
11-22	336.21	12-03	268.24	12-14	224.78

Great news! Cutoff time on deposits at most banking centers in North & South Carolina is extended until 5pm Mon-Thu & 6pm on Fri. Also cutoff time for deposits at Bank of America ATMs is extended to 6pm Mon-Fri. Some deposits may be subject to holds; see deposit envelope for details. To find the closest banking center or ATM, visit www.bankofamerica.com.

Client Summary Statement
for Holli J Tindal as of 02/24/2005

Insured Policy Number	Plan	Policy Date	Net Death Benefit	Annualized Premium	Last Dividend	Dividend Option	Net Cash Value **	Total Loans
Holli J Tindal 15-263-446	ACL	01/15/2000	52,923	692.28	68.78	PUR ADDS	1,913.75	360.80

** Cash values displayed may not reflect actual premium payment status. Actual values will be determined at the time of surrender.

Tracy L Smith
1901 Bull St
Columbia SC 29201
(803)254-0133

02/24/2005

Client Summary Statement
for Holli J Tindal as of 02/24/2005

Insured Policy Number	Plan	Beneficiary	Owner	Payer	ISA Number
Holli J Tindal 15-263-446	ACL	Susan Lee Tindal Phil De Wight Tindal Phil Dewight Tindal II	Holli J Tindal	Holli J Tindal	89-663-84

** Cash values displayed may not reflect actual premium payment status. Actual values will be determined at the time of surrender.

Tracy L Smith
1901 Bull St
Columbia SC 29201
(803)254-0133

Holli J. Tindal
Post Office Box 354
Pelion, South Carolina 29123
(803) 894-6133

COPY

February 7, 2005

RECEIVED
FEB 14 2005
DHHS
COLUMBIA REGIONAL OFFICE

Social Security Administration
Supplemental Security Income
Strom Thurmond Federal Building
1835 Assembly Street
Columbia, South Carolina 29201

RE: Holli Josette Tindal
Claim Number: 247-65-1942 DI

Dear Sir/Madam:

Please be advised that I write this letter in an effort to appeal the enclosed copy of the decision dated January 21, 2005, and received by me on or about January 28, 2005. I wish to appeal the decision.

The one asset that I may have and which may possibly exceed the $ 2,000.00 "limit on resources" is a life insurance policy that I have had since the year of 2000. I am a 35 year old female but felt that approximately five years ago it would be beneficial to my family to insure my life for $ 50,000.00, by paying monthly premiums of $ 58.69 on this policy during the time I was still employed. I am no longer employed as my employer retired as of December 31, 2004. I have spoken to my insurance agent (Ms. Tracy Smith at Northwestern Mutual at (803) 254-0133) and she has informed me that since I am now disabled and unemployed that the monthly premiums will be deducted from the cash value of the policy. Since I am unemployed, now disabled with two broken feet, and a prognosis of six months to one year of being unable to walk, I do not believe that the current amount will be maintained considering my monthly premiums will be $ 58.69 plus interest which will be deducted from the cash value. Thus over the course of my disability will lower the cash value below $ 2,000.00. Until I become physically able and employed I will be unable to make the premium payments. I do not feel that I should have to sell this resource as it will be a benefit to my family should I become deceased.

Please feel free to contact my insurance agent and/or me for further explanation if necessary. I would appreciate any consideration that can be given to this matter as I am in dire straits with my financial capabilities at present.

Social Security Administration
Supplemental Security Income
RE: Holli Josette Tindal
Claim Number: 247-65-1942 DI
Page Two
January 7, 2005

Also since becoming unemployed I will no longer have the benefit of having health insurance coverage which cost was maintained by my employer. I will be facing many medical costs, outside of my regular living expenses and I have absolutely no idea of how I am going to pay these costs without some assistance.

Please review this matter and advise if I should need to complete a "Request for Reconsideration" form. If so, please forward me form number SSA-561, as I am unable to walk or make any appointments other than telephone-related appointments.

With kindest regards, I am,

Respectfully,

Holli J. Tindal

Holli J. Tindal

Enclosure

Social Security Administration
Supplemental Security Income
Notice of Disapproved Claim

Date: January 21, 2005
Claim Number: 247-65-1942 DI

583 0114,M08,004,039762 000039762 01 MB 0.309

HOLLI JOSETTE TINDAL
PO BOX 354
PELION SC 29123-0354

RECEIVED
FEB 14 2005
DHHS
COLUMBIA REGIONAL OFFICE

* Application Filed *
January 14, 2005

* Type of Claim *
Individual–Disabled

You cannot get Supplemental Security Income for the reason given below.

Why We Can't Pay You

We find that you have resources worth more than $2,000.00 for January 2005 on.

For you to receive SSI payments, the resources that you own cannot be worth more than $2,000.00 for January 2005 on. We call this amount the limit on resources.

Resources are the things that you own such as cash, stocks, bank accounts, certain types of life insurance, buildings, and land on which you do not live. We do not include as resources the home in which you live, one car used for necessary activities, and some other things.

See Next Page

SSA-L8030

Time to File an Appeal

To file an appeal, you must file your request for review **within 60 days** from the date you get this notice.

The Appeals Council assumes you got the notice 5 days after the date shown above unless you show you did not get it within the 5-day period. The Council will dismiss a late request unless you show you had a good reason for not filing it on time.

Time to Submit New Evidence

You should submit any new evidence you wish to the Appeals Council to consider with your request for review.

How an Appeal Works

Our regulations state the rules the Appeals Council applies to decide when and how to review a case. These rules appear in the Code of Federal Regulations, Title 20, Chapter III, Part 404 (Subpart J) and Part 416 (Subpart N).

If you file an appeal, the Council will consider all of my decision, even the parts with which you agree. The Council may review your case for any reason. It will review your case if one of the reasons for review listed in our regulation exists. Section 404.970 and Section 416.1470 of the regulation list these reasons.

Requesting review places the entire record of your case before the Council. Review can make any part of my decision more or less favorable or unfavorable to you.

On review, the Council may itself consider the issues and decide your case. The Council may also send it back to an Administrative Law Judge for a new decision.

If No Appeal and No Appeals Council Review

If you do not appeal and the Council does not review my decision on its own motion, you will not have a right to court review. My decision will be a final decision that can be changed only under special rules.

See Next Page

If You Have Any Questions

If you have any questions, you may call, write or visit any Social Security office. If you visit an office, please bring this notice and decision with you. The telephone number of the local office that serves your area is (803)929-7635. Its address is Social Security Administration, 1835 Assembly Street, 2nd Floor, Strom Thurmond Federal Building, Columbia, SC 29201.

William F. Pope
Administrative Law Judge

cc: Harry F. Smithson
Attorney at Law
P.O. Box 7965
Columbia, SC 29202

SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals

ORDER

IN THE CASE OF	CLAIM FOR
Holli Josette Tindal (Claimant)	Period of Disability, Disability Insurance Benefits, and Supplemental Security Income
(Wage Earner)	247-65-1942 (Social Security Number)

I approve the fee agreement between the claimant and her representative subject to the condition that the claim results in past-due benefits.

My determination is limited to whether the fee agreement meets the statutory conditions for approval and is not otherwise excepted. I neither approve nor disapprove any other aspect of the agreement.

HOW TO ASK US TO REVIEW THE FEE AGREEMENT DETERMINATION

You or your representative may ask us to review the determination on the fee agreement. If you decide to ask us for a review, write us within 15 days from the day you get this order. Tell us that you disagree and give your reasons.
Send your request to this address:

- Ollie Garmon
  Regional Chief Administrative Law Judge
  61 Forsyth Street, SW
  Suite 20T10
  Atlanta, GA 30303

Your representative also has 15 days to write us if he or she does not agree with the determination on the fee agreement.

You should include the social security number(s) shown on this order on any papers that you send us.

William F. Pope
Administrative Law Judge
APR 27 2006
Date

SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals

DECISION

IN THE CASE OF	**CLAIM FOR**
Holli Josette Tindal (Claimant)	Period of Disability, Disability Insurance Benefits, and Supplemental Security Income
(Wage Earner)	247-65-1942 (Social Security Number)

PROCEDURAL HISTORY

The claimant filed applications for a period of disability and disability insurance benefits and for supplemental security income on January 10, 2005, and March 3, 2005, respectively. She alleges disability since December 29, 2004. Her applications were denied initially and upon reconsideration, and a timely request for hearing was filed on January 23, 2006. The claimant is represented by Harry F. Smithson, an attorney.

After a careful review of the documentary evidence, I find that a fully favorable decision can be issued without oral testimony.

ISSUES

At issue in this case is whether the claimant is entitled to a period of disability and disability insurance benefits under Sections 216(i) and 223, respectively, of the Social Security Act, as amended; and whether the claimant is disabled under Section 1614(a)(3)(A) of the Act. The Social Security Act defines disability as the inability to engage in any substantial gainful activity due to physical or mental impairments which can be expected either to result in death or to last for a continuous period of not less than 12 months. The specific issues are whether the claimant was under a disability; and, if so, when such disability commenced and the duration thereof; and whether the special earnings requirements of the Act are met for the purpose of entitlement to a period of disability and disability insurance benefits.

EVALUATION OF THE EVIDENCE

After a thorough evaluation of the entire record, I find that the claimant has been disabled since December 29, 2004. She met the insured status requirements of the Social Security Act on that date and continues to meet them through December 31, 2009. The claimant was 34 years old on the date her disability began. She has a 12th grade education and worked as a paralegal. She has not engaged in any substantial gainful activity since the disability onset date.

The claimant has a severe impairment due to bilateral heel fractures.

The claim sustained bilateral heel fractures in an automobile accident on December 29, 2004. She has had multiple surgeries and was in a wheelchair until May 2005, and she continues to require the use of crutches to ambulate (Exhibit 10F, page 5). According to treatment notes, the claimant has atrophy and persistently severe limitation of subtalar motion of the left ankle, swelling in both ankles, and severe dorsiflexion in the left ankle to only three or four degrees (normal is 20 degrees). While the claimant's treating orthopedic surgeon, Dr. Coleman Fowble, reported on February 27, 2006, that he wants the claimant to work on weight-bearing "as much as her comfort level allows" (Exhibit 10F, page 5), he opined on March 23, 2006, that she should not walk for any length of time and was able to stand and walk for less than two hours in an 8-hour day (Exhibit 10F, page 2).

Listing 1.03 refers to reconstructive surgery of a major weight bearing joint (ankle-foot is included in the definition under 1.00F) without return of effective ambulation within twelve months. Ineffective ambulation is defined generally as having insufficient lower extremity function to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities.

The claimant's impairment meets the requirements of Listing 1.03, and she is disabled.

In concluding that the claimant is disabled, I have considered the opinions of the State agency medical and psychological consultants. As the medical opinions of expert physicians and psychologists, they cannot be ignored. Social Security Ruling 96-5p. However, as those of nonexamining medical sources, their opinions are weighed by stricter standards, based to a greater degree on medical evidence, qualifications, degree of specialization, and clarity of explanations for their opinions, which can be given weight only insofar as they are supported by the whole record, including new evidence received after their opinions were rendered. Social Security Ruling 96-6p.

New evidence has been submitted which was not available for review by the State agency physicians. That evidence reveals material facts regarding the claimant's medical condition. Since that evidence was not available for review by the State agency physicians in their consideration of the record, their opinions are not based on the whole record and cannot be afforded significant weight in the determination of the claimant's residual functional capacity.

FINDINGS

After consideration of the entire record, the Administrative Law Judge makes the following findings:

1. The claimant met the insured status requirements of the Act on December 29, 2004. She has not performed any substantial gainful activity since that time.

2. The claimant has an impairment or a combination of impairments considered "severe" based on the requirements in the Regulations 20 CFR §§ 404.1520(b) and 416.920(b).

3. The claimant's impairment meets the requirements of Listing 1.03, Appendix 1, Subpart P, Regulation No. 4.

4. The claimant has been under a disability as defined by the Social Security Act and Regulations since December 29, 2004.

DECISION

Based on the Title II application filed on January 10, 2005, the claimant is entitled to a period of disability commencing December 29, 2004, and to disability insurance benefits under sections 216(i) and 223 of the Social Security Act, respectively, and the claimant's disability has continued at least through the date of this decision.

It is the further decision of the Administrative Law Judge that based on the Title XVI application filed on March 3, 2005, the claimant has been disabled since December 29, 2004, under section 1614(a)(3)(A) of the Social Security Act, and the claimant's disability has continued through the date of this decision.

The Social Security Administration must also determine whether the claimant meets the income and resources and other eligibility requirements for supplemental security income payments, and if the claimant is eligible, the amount and the month(s) for which the claimant will receive payment. The claimant will receive a notice from another office of the Social Security Administration when that office makes those determinations.

I recommend that this case be diaried for review in one year.

William F. Pope
Administrative Law Judge
APR 20 2006
Date

LIST OF EXHIBITS

Claimant: Holli Josette Tindal **SSN:** 247-65-1942

Exh. No.	Part No.	Description	No. of Pages
		PAYMENT DOCUMENTS/DECISIONS	
1	A	- 2A	
		JURISDICTIONAL DOCUMENTS/NOTICES	
1	B	- 6B	
7	B	VE Resume – Carroll Crawford	1
8	B	Pre-Hearing Brief and Request for On-the-Record Decision dated 03/30/06 from Harry Smithson, claimant's attorney	4
		NON-DISABILITY DEVELOPMENT	
1	D	- 3D	
		SUPPLEMENTAL SECURITY INCOME (SSI)	
1	SSI	- 3SSI	

LIST OF EXHIBITS

Claimant: Holli Josette Tindal **SSN:** 247-65-1942

Exh. No.	Part No.	Description	No. of Pages
		DISABILITY RELATED DEVELOPMENT AND DOCUMENTATION	
1	E	Work History Report dated 03/18/05	8
2	E	Vocational Analysis	3
3	E	Vocational Analysis	3
4	E	Disability Report - Appeal dated 12/22/05	7
5	E	Daily Activities Questionnaire dated 02/23/05	4
6	E	Report of Contact dated 05/19/05	1
7	E	Claimant's Medications	

LIST OF EXHIBITS

Claimant: Holli Josette Tindal **SSN:** 247-65-1942

Exh. No.	Part No.	Description	No. of Pages
		MEDICAL RECORDS	
1	F	Medical Records dated 09/15/98 from Carolina Primary Care	
2	F	Medical Records covering the period from 03/11/99 to 11/16/04 from Columbia Womens Healthcare	
3	F	Hospital Records for admission on 12/29/04 through discharge on 01/07/05 from Lexington Medical Center	
4	F	Hospital Records for admission on 01/14/05 through discharge on 01/19/05 from Lexington Medical Center	
5	F	Medical Records covering the period from 01/24/05 to 05/27/05 from Winyah Home Health Care	
6	F	Medical Records dated 08/01/05 & 10/21/05 from Coleman D. Fowble, MD	
7	F	Medical Records covering the period from 01/10/05 to 11/14/05 from Midlands Orthopaedics	
8	F	Medical Consultants Evaluation completed by DDS Physicians	
9	F	Medical Report and Opinion Re: Ability to do Work-Related Activities dated 03/10/06 from W. Paul Carlson, Th.D.	
10	F	Medical Records dated 12/05/05 – 02/27/06 and Opinion Re: Ability to do Work-Related Activities from Coleman D. Fowble, M.D., Midlands Orthopaedics	