DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	10/1/09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 001147	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Cleared 10/9/09, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 10/9/09 [ ] FOIA DATE DUE _____ [ ] Necessary Action

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

FAX COVER SHEET

S. C. SENATE
SENATE CLERK
FAX # (803) 212-6299

DATE:	October 1, 2009
TO:	Bryan Kost
FROM:	Sen. Shoopman
FAX NUMBER:	1-803-255-~~8350~~ 8235
PAGES	1 of 9 (Including this page)

MESSAGE: Bryan,

Will you please take a look at this for Sen. Shoopman?

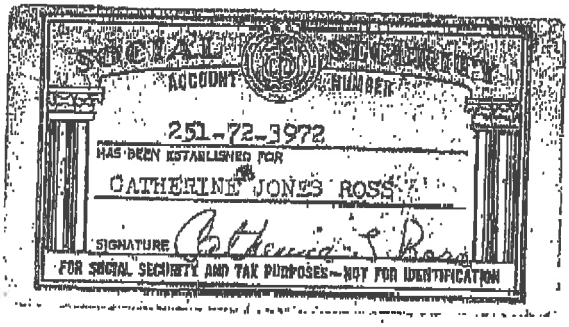
Rhonda Ross is the contact person if there is a need for any additional information. (864)-879-4048.

Thanks,

Debra

IF YOU DO NOT RECEIVE ALL OF THE SHEETS INDICATED,
PLEASE CONTACT THE SENATE CLERK'S OFFICE AT (803) 212-6200

Attn: Debra Cooper
803-212-6299 fax


SOCIAL SECURITY
ACCOUNT NUMBER
251-72-3972
HAS BEEN ESTABLISHED FOR
CATHERINE JONES ROSS
SIGNATURE Catherine J. Ross
FOR SOCIAL SECURITY AND TAX PURPOSES—NOT FOR IDENTIFICATION

Age: 64
Catherine Ross
114 Buncombe Street
Greer, S.C. 29650

Rhonda Ross - contact (Daughter)
864-879-4048

My Mother has had 4 strokes since April of this year. She suffered a stroke on July 4th, 09 causing her to loose balance & short term memory loss. She has been to Rehab (Saint Francis Hospital) where Dr. Hansen Phycologist made these findings (864-255-1076) Sept 8, 09 while bending over her back went out. Dr. Molly Adams (Palmeto Medical 864-968-5123) Disc in back were deteroiating & compressing. We have no insurance on my mother. Any help you could give us would be greatly appreciated.

Thank You
Rhonda Ross

South Carolina Department of Health and Human Services (SCDHHS)
Bureau of Eligibility Policy and Oversight, Department of Disability Determination (DDD)
Post Office Box 8206, Columbia, SC 29202-8206
Phone (803) 898-2635 Fax (803) 255-8350

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

[redacted]

**** PLEASE READ BOTH PAGES OF THIS FORM BEFORE SIGNING BELOW. ****

I voluntarily authorize and request disclosure (including written, verbal, and electronic interchange) of:

WHAT All my medical records, education records and other information related to my ability to perform tasks. This includes specific permission to release the following:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, but not limited to;
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Human Immunodeficiency Virus (HIV) infection, including Acquired ImmunoDeficiency Syndrome (AIDS) or tests for HIV or sexually-transmitted diseases
   - Gene-related impairments, including genetic test results
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and affects my ability to work
3. Copies of education tests or evaluation, including individualized educational programs, triennial assessments, psychological and speech evaluations, teacher observations and evaluations, and any other records that can help evaluate function
4. Information created within 12 months after the date this authorization is signed, as well as past information

FROM WHOM

- All medical sources
  (hospitals, clinics, labs, physicians, psychologists, etc., including mental health, correctional, and addiction treatment and Veterans Administration health care facilities)
- All educational sources
  (schools, teacher records, administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners
- Employers
- Others who may know about my condition
  (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SCDHHS/SCVRD (as needed) for additional information to identify the subject (e.g., other names used), the specific source of the material to be used.

TO WHOM The State agency authorized to process my case (usually called "SCVRD"), including contract copy services, doctors, or other professionals consulted during the disability determination process.

PURPOSE I agree to the disclosure of my health information to determine if I meet the disability criteria in order to establish my eligibility for Medicaid benefits.

EXPIRES WHEN **This authorization is binding for 12 months from the date signed below.**

I UNDERSTAND THAT

- I may write to the South Carolina Department of Health and Human Services to revoke this authorization at any time.
- There are some circumstances where this information may be re-disclosed to other parties directly involved with the Medicaid eligibility determination.
- I may receive a copy of this form upon request.
- I may ask the source to allow me to inspect or get a copy of the material to be disclosed.

Signature of Applicant/Beneficiary (or Person Authorized to Act on His/Her Behalf) X Catherine J. Ross		Relationship to Applicant/Beneficiary		Date 8-12-09
Street Address	City	State	Zip	Telephone No. ( )
Signature of Witness	Date	Signature of Witness		Date

DHHS Form 921 (September 2008)

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

Applicant/Beneficiary: Catherine Ross Date: 07/06/09

Authorized Representative: Rhonda Ross

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

- ☐ Complete the Attached Review Form
- ☐ Power of Attorney, Guardianship, or Conservator Papers
- ☑ Verification of ☑ Citizenship ☐ Identity Original Documents Required.
- ☐ The income limit for institutional care is $_____ for _____. The applicant's income is over this amount. To possibly qualify for Medicaid assistance for long-term care services, an income trust must be established. You will find the forms needed to complete this process attached.
- ☐ Proof of gross income received by _____ _____. This may be a copy of an itemized check-stub, award letter, PRINTOUT, or statement on letterhead from the company or agency.
- ☒ For all accounts, copies of entire bank statements, not account summaries, for February 2006, February 2007, February 2008, February 2009 and the following month(s): July 2009
- ☐ Designate or establish a bank account for income to flow through. Return verification of this account.
- ☐ Proof of assets sold, transferred, or given away on or after February 8, 2006 to the present.
- ☐ Verification you have applied for _____ benefits on the applicant's behalf.
- ☐ Burial Assets: Copies of the applicant/spouse's ☐ Pre-need burial contract(s) ☐ burial plot deed(s) or other verification of ownership such as a statement on letterhead. If the contract or plot is not paid for, we also need verification of the payoff amount.
- ☒ Copies of all life insurance policies owned by the applicant/spouse. If the policy is not on hand, a letter from the agent showing the policy number, name of owner, face value, and current cash value of the policy can be provided. If this is not possible, give the name and address of the insurance company, and the policy number for each policy. The owner of the policy needs to sign and date DHHS Form 1280 ME, Verification of Insurance Value, to let us verify current cash values directly from the insurance company.
- ☐ Copy of annuity for _____
- ☑ Please sign and return the form(s) indicated:
  - ☐ DHHS 943, Release of Information
  - ☐ DHHS 1766-A, Burial Exclusion
  - ☐ DHHS 1280 ME, Verification of Insurance Value
  - ☐ DHHS 1282, Authorized Representatives Acknowledgement of Responsibilities
  - ☐ DHHS1212 ME, Verification of Veterans Information
  - ☑ DHHS 1253 ME, Request for Financial Investigation
  - ☐ DHHS 1296 ER, Estate Recovery Notification
- ☐ All medical insurance policies or cards and proof of premiums
- ☒ Other: copy of Walter Ross's Social Security card and Medicare card
- ☒ Other: Disability Forms

Please provide this information by 07/16/09. If you have any questions or you need additional time to secure requested information, please call your worker listed below. Thank you for your cooperation.

Worker: Barbara Blackburn, DHHS Telephone: 864-848-5395

Address: 202 Victoria St Fax: 864-848-6379

Greer, SC 29651

South Carolina Department of Health and Human Services

DISABILITY REPORT -- Adult

☑ Initial ☐ Retro Only

Instructions: This form is used to request a disability determination as an eligibility requirement for Medicaid. ***It is the responsibility of the Medicaid Eligibility Worker to ensure that each blank is completed.*** A copy of the completed form must be maintained in the case record.

Applicant Catherine J Ross (Please Print) Social Security No. 251723972

Applicant's Address 114 Buncombe St

City Greer State SC Zip Code 29650 County 23

Date of Birth 07/18/1945 Telephone 864-879-4048 Category of Application 15

If Deceased, Date of Death ____ Month ____ Day ____ Year ☐ Male ☑ Female

Application Date 07/06/09 Retro Month(s) Requested none

Contact Person Rhonda Ross Telephone 864-879-4048

Relationship to Applicant daughter

Contact Person's Address same

Medicaid Eligibility Worker Barbara Blackburn Telephone 864-848-5395

Worker's Address DHHS, 202 Victoria St, Greer, SC 29651 (Give Complete Mailing Address)

Worker's Supervisor Donna Ellis Telephone 864-454-8187

I. **DISABILITY**

a) What is your disability? Strokes

b) Are you working now? ☐ Yes ☑ No *(If yes, DHHS Form 3218E is required.)*

If no, when did your disability stop you from working? ____ Month ____ Day ____ Year

[If date is within Retro period (3 months prior to application date), DHHS Form 3218E is required.]

Explain why you stopped working:

c) Have you applied for SSI Disability benefits? ☐ Yes ☑ No

If yes, date of application: ____

Was application made in SC? ☐ Yes ☐ No If no, what state? ____

d) Have you applied for Social Security disability benefits? ☐ Yes ☐ No

If yes, date of application: _____

If denied by SSA, have you asked them to reconsider your claim? ☐ Yes ☐ No

Did SSA refuse to reconsider your claim? ☐ Yes ☑ No

Did you request an appeal or hearing? ☐ Yes ☑ No

II. MEDICAL INFORMATION

NOTE: If you need additional space for medical sources, list their names, addresses and reasons for visits in the "remarks" section on page six or attach a separate piece of paper.

a) List name, address and telephone number of the doctor who has your most recent medical records. *(We need a complete address to request medical records.)*

Name Virginia Knight FNP Telephone 864-968-5123

Street Address 210 Freeman Farm Road

City Duncan State SC Zip Code 29334

Date first seen: 3/5/02 Date last seen: 6/17/09 Next appointment: _____

Reason for visits Primary Care Doctor

b) Have you seen any other doctors since your disability or injury began? ☑ Yes ☐ No
If yes, complete the following. *(We need a complete address to request medical records.)*

Name Nate Normand Telephone 864-848-8200

Street Address _____

City Greer State SC Zip Code 29650

Date first seen: 6/8/09 Date last seen: 6/10/09 Next appointment: N/a

Reason for visits Emergency Room, Shortness of Breath, Weakness, Stroke, Face pulled on inside, Mouth pulled and drawn on one side.

c) Have you been hospitalized or received emergency treatment for your illness or injury?
☑ Yes ☐ No If yes, complete the following. *(We need a complete address.)*

Name of Hospital Greer Memorial Hospital Patient Number ?

Street Address

City Greer State SC Zip Code 29650

Were you an in-patient (stayed at least overnight)? ☑ Yes ☐ No

Admission Dates: 6/8/09

Reason for Hospitalization or Emergency Room Treatment Stroke, Shortness of Breath, High Blood Pressure

d) Have you received treatment from a hospital outpatient clinic or other type of clinic?
☐ Yes ☑ No If yes, complete the following. *(We need a complete address.)*

Name of Clinic Patient Number

Street Address

City State Zip Code

Date(s) of Treatment:

Reason for Treatment

e) Have you had any special diagnostic outpatient studies (x rays, blood tests, EKG's, etc.) performed at a hospital or private laboratory/clinic? ☐ Yes ☑ No
If yes, complete the following. *(We need a complete address.)*

Type of Study/Test

Name of Hospital, Clinic or Laboratory

Street Address

City State Zip Code

When were these studies done?

f) Have you been evaluated (examination or testing), or treated by any of the following agencies?

1.	S.C. Department of Mental Health Clinic	☐ Yes	☐ No
2.	Alcohol and Drug Facility	☐ Yes	☐ No
3.	South Carolina Health Department Clinic	☐ Yes	☐ No
4.	S.C. Department of Disabilities & Special Needs OR Mental Retardation Facility	☐ Yes	☐ No
5.	Veterans Administration	☐ Yes	☐ No
6.	Vocational Rehabilitation	☑ Yes	☐ No

7. Other ☐ Yes ☐ No If yes, identify: _____

For each of the agencies listed above for which you have been seen, complete the following:

Name of Facility Saint Francis Hospital

Street Address 1 Saint Francis Drive

City Greenville State SC Zip Code 29601

Date first seen: 7/8/09 Date last seen: 7/16/09 Next appointment: _____

Type of Treatment or Evaluation Received Physical, Occupational, Speach Therapy

Case Manager Dr. Hansen Telephone 864-255-1076

Name of Facility _____

Street Address _____

City _____ State _____ Zip Code _____

Date first seen: _____ Date last seen: _____ Next appointment: _____

Type of Treatment or Evaluation Received _____

Case Manager _____ Telephone _____

g) Has your doctor told you to restrict your activities in any way? ☑ Yes ☐ No
If yes, give the name of the doctor and state what he told you.

She Cannot be left alone. Needs help with daily activities (walking, bathing, ect.) Dr. Sam Parimi MD. 864-627-4032

III. EDUCATION/TRAINING INFORMATION

a) What is the highest grade of school you completed and when? 12 Grade 1963 Year

b) Did you attend college, trade/technical school, or special training? ☐ Yes ☑ No

If yes, complete the following:

Type of college, trade/technical school, or special training _____

Indicate the years attended: _____ to _____ Did you graduate? ☐ Yes ☐ No

c) Did you attend special education classes? ☐ Yes ☑ No If yes, complete the following:

Name of School _____

Street or Post Office Address _____

7. Other ☐ Yes ☐ No If yes, identify: _____

For each of the agencies listed above for which you have been seen, complete the following:

Name of Facility Saint Francis Hospital

Street Address 1 Saint Francis Drive

City Greenville State SC Zip Code 29601

Date first seen: 7/8/09 Date last seen: 7/16/09 Next appointment: _____

Type of Treatment or Evaluation Received Physical, Occupational, Speach Therapy

Case Manager Dr. Hansen Telephone 864-255-1076

Name of Facility _____

Street Address _____

City _____ State _____ Zip Code _____

Date first seen: _____ Date last seen: _____ Next appointment: _____

Type of Treatment or Evaluation Received _____

Case Manager _____ Telephone _____

g) Has your doctor told you to restrict your activities in any way? ☑ Yes ☐ No
If yes, give the name of the doctor and state what he told you.

She Cannot be left alone. Needs help with daily activities (walking, bathing, ect.) Dr. Sam Parimi MD. 864-627-4032

III. EDUCATION/TRAINING INFORMATION

a) What is the highest grade of school you completed and when? 12 Grade 1963 Year

b) Did you attend college, trade/technical school, or special training? ☐ Yes ☑ No

If yes, complete the following:

Type of college, trade/technical school, or special training. _____

Indicate the years attended: _____ to _____ Did you graduate? ☐ Yes ☐ No

c) Did you attend special education classes? ☐ Yes ☑ No If yes, complete the following:

Name of School _____

Street or Post Office Address _____

Log#0147

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

October 9, 2009

The Honorable Phillip W. Shoopman
Member, South Carolina Senate
Post Office Box 142
Columbia, South Carolina 29202

Dear Senator Shoopman:

Thank you for contacting our agency on behalf of Mrs. Catherine J. Ross regarding Medicaid eligibility and her healthcare needs.

A member of my staff has been in direct contact with Ms. Rhonda Ross, her daughter and medical affairs representative, regarding Medicaid eligibility and the rules and regulations governing the program. Ms. Ross was given contact information for a staff person in our Constituent Services Division if she needs further assistance regarding Medicaid. We also provided Ms. Ross with other helpful resources that can assist residents in our state with their healthcare services, prescriptions and daily living needs.

Thank you for your continued interest and support of the South Carolina Medicaid program. If I may be of further assistance on this or any other matter, please let me know.

Sincerely,

Emma Forkner
Director

EF/jcle

South Carolina Department of Health & Human Services

Emma Forkner • Director
Mark Sanford • Governor

October 9, 2009

Ms. Rhonda Ross
114 Buncombe Street
Greer, South Carolina 29650

Dear Ms. Ross:

Senator Phillip W. Shoopman contacted our agency on behalf of your mother, Catherine J. Ross, regarding Medicaid eligibility and her healthcare needs.

Our records indicate Mrs. Ross applied for Medicaid benefits on July 6, 2009. Barbara Blackburn, your mother's eligibility worker in Greenville County's Greer Office, has determined she meets "financial" eligibility for Medicaid's *Home and Community Based Services (HCBS)*. Now, it must be determined if she meets "categorical" eligibility. Staff in our Division of Community Long Term Care will arrange an appointment to visit your mother in her home to see if she meets the medical level-of-care requirement. Also, we have asked disability medical consultants to expedite their review of your mother's medical records to see if she meets the definition of being disabled. If you have any questions about the eligibility process for HCBS, please contact Ms. Blackburn at (864) 848-5395.

In the meantime, enclosed is information on other programs and organizations that can assist residents in South Carolina with their healthcare needs, prescriptions and daily living expenses. We hope this information is helpful.

If you have questions about the Medicaid program, please contact Denise Epps in Constituent Services at (803) 898-2505, and she will be happy to assist you.

Sincerely,

Alicia Jacobs

Alicia Jacobs
Deputy Director

AJ/cle
Enclosures

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