

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Floyd</i>	DATE <i>6-16-08</i>
--------------------	------------------------

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER  <i>000658</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR  <i>CC: Jacobs, Post</i> <i>Cleared 6/24/08, letter attached.</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>6-25-08</i>
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

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

FAX COVER SHEET



*Log. Floyd  
Appo Sign.  
Cci Jacobs*

S. C. SENATE

FAX # (803) 212-6011

**RECEIVED**

JUN 16 2008

DATE: June 16, 2008

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

TO: Brian Kost

FROM: Debbie Barthe for Senator Hawkins

FAX NUMBER: 255-8235

PAGES: 8 (Including this page)

MESSAGE:

FYI - this is the family we spoke about this morning. I have not been able to speak with her directly, but it looks like there may be a problem with the son's last name. Let me know if you can help.

IF YOU DO NOT RECEIVE ALL OF THE SHEETS INDICATED,

PLEASE CALL (803) 212-6008.

**RECEIVED****Senator Lindsey O. Graham**

JUN 16 2008

United States Senate

290 Russell Senate Office Building  
Washington, D.C. 20510  
(202)224-5972  
(202)224-3808 Fax101 E. Washington St.  
Suite #220  
Greenville, SC 29601  
(864)250-1417  
(864)250-4322 FaxDepartment of Health & Human Services  
OFFICE OF THE DIRECTOR

By providing the following information below and signing this form, I hereby authorize the appropriate agency to furnish the office of Senator Lindsey Graham information pertaining to my claim or request. This authorization is in accordance with the *Privacy Protection Act of 1974*.

Name: Ronda Holewinski-Crowe Phone: (864) 879-8520Address: 15 Pittman RdCity: Lynman State: SC Zip: 29365Social Security Number: 370-92-7005

In the space below, briefly describe the problems that you are experiencing and explain exactly what you would like Senator Graham to do on your behalf. Without this information, it will be impossible for Senator Graham to adequately assist you. (If you need more space, please use the back of this form.)

Needs assistance obtaining Medicaid.  
Has sent copies of birth certificate, SS card, and  
immunization records to DHHS.  
Reason for denial: did not provide proof of citizenship.

Also needs assistance with SC Employment Security Comm.  
Eligible for benefits as of 4/13/08.  
Has not received any funds to date.

Signed: Ronda Holewinski-Crowe Date: 6/4/08

Note: Those requesting assistance from Senator Graham should note that if they are represented by an attorney, the attorney should be advised that you have contacted our office. If represented by an attorney, please give the attorney's name:

Please return to:

Senator Lindsey Graham  
101 E. Washington St.  
Suite #220  
Greenville, SC 29601

South Carolina Department of Health and Human Services  
Notice of Action

From: SPARTANBURG COUNTY DMHS

P.O. Box 4847

Pinewood Shopping Ctr., 1000 N Pine St.

Spartanburg SC 29305-0000

Date: 06/22/2008

Worker Name:

JACQUELINE MCLURKIN

Telephone: 864 596-2714

BG#:

10078857

HH#:

100868652

42 JMCU

**RECEIVED**

To:

RONDA ANN HOLEWINSK-GROWE

16 PITTMAN RD

LYMAN SC 29365

JUN 16 2008

Beneficiary Name:

JACOB DONALD WAGNER

Beneficiary ID:

4780164321

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

*Called Jacqueline Mclurkin*

*@ 2:20pm 6/23/08*

*DOT intimated when*

*Requested to send stuff*

*back to go to Senator*

*Your application has been denied for: OCW/CHILDRENY/PHC*

*Send Lindsay Graham  
101 E Washington St.  
Ste 220  
Greenville SC 29601*

Reason for denial:

*You did not provide proof of citizenship.*

Denied for the month(s) of: 03/2008

*John Hood 1400D  
ext 107.*

Manual/policy reference supporting this action: 102.04.01

**Fair Hearing**

If you feel your case has been closed in error, you may ask for a fair hearing before the South Carolina Department of Health and Human Services.

- To ask for a fair hearing, send a request in writing, along with a copy of this letter, within 30 days to your worker.
- You can hire an attorney to help you or you can have someone come to the hearing and speak for you.
- If you request a hearing within 10 days of the date on this letter, you can ask in your request that your coverage continue until a final decision is made by the hearing officer. However, if the hearing officer rules that the decision to close your case was correct, you will be required to pay back any benefits you received while your case was being reviewed.

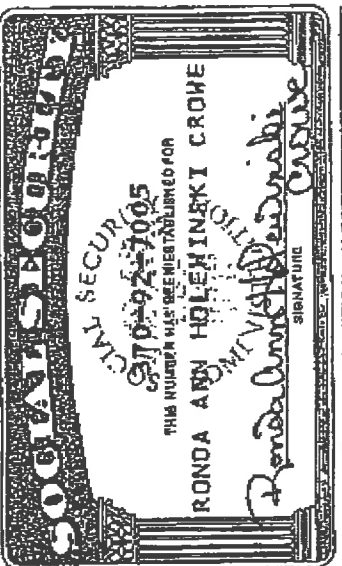
# OHIO DEPARTMENT OF HEALTH

## DIVISION OF VITAL STATISTICS

### CERTIFICATE OF LIVE BIRTH

Register's file 38824Reg. Div. No. 25  
Primary Reg. Div. No. 2500Birth No. 134

CHILD—NAME		First	Middle	Last	DATE OF BIRTH (Month, Day, Year)		Hour
1. <b>SEX</b>		<b>RONDA</b>	<b>ANN</b>	<b>HOLEWINSKI</b>	2. <b>March 16, 1969</b>		<b>2:57 A.</b>
3. <b>Female</b>		4. <b>Single</b>		5. <b>Franklin</b>		6. <b>Franklin</b>	
7. <b>City, Village, or Location of Birth</b>							
8. <b>Lockbourne Air Force Base</b>		9. <b>Base</b>		10. <b>Lockbourne AFB Hospital</b>		11. <b>State of Birth (If not in U.S.A., name country)</b>	
12. <b>MOTHER—MAIDEN NAME</b>		13. <b>Thomas</b>		14. <b>Thomas</b>		15. <b>Michigan</b>	
16. <b>RESIDENCE—STATE</b>		17. <b>Franklin</b>		18. <b>City, Village, or Location</b>		19. <b>Inside City Limits (Specify year of last)</b>	
20. <b>FATHER—NAME</b>		21. <b>Robert</b>		22. <b>Groveport</b>		23. <b>Yes</b>	
24. <b>INFORMANT'S NAME OR SIGNATURE</b>		25. <b>Donald Holewinski</b>		26. <b>Relationship to Child</b>		27. <b>Mother</b>	
28. <b>Signature of Informant</b>							
29. <b>Signature of Registrar</b>							
30. <b>DATE RECEIVED BY LOCAL REGISTRAR</b>							
31. <b>MAR 28 1969</b>							



**SOUTH OHIO**  
HOLEWINSKI-CROWE, RONDA A  
7000 MAIDSTONE DR APT 16  
BOLLING SPRINGS SC 293196325

**CLASS: DM Hgt: 5-11 Wgt: 160**  
**Sex: F DOB: 03-16-1969**  
**Issued: 05-19-2003 42011 M 4**

**DL #: 70509**  
**Expires: 16-2008**

**Registration Note:** *See back*


# RECEIVED

JUN 16 2008

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

06/16/2008 11:51AM

## State Of Georgia Certificate Of Birth

Local File Number		005052		1. State File Number		110 - 01-020694	
2. Child's Name: First		3. Middle		4. Last		5. Jr., II	
Jacob		Robert		Donald		Grove	
9. This Birth (Single, Twin, Triplet, etc.)				10. If Not Single Specify Birth Order			
Single				11. County Of Birth			
12. Hospital/Facility Name				13. City, Town Or Location Of Birth			
Northside Hospital				Atlanta			
14. Mother's Name: First		15. Middle		16. Last		17. Maiden (Last Name)	
Ronda		Ann		Crowe		Holewinski	
20. Residence - State		21. County		22. City, Town Or Location		23. Street And Number Or Residence	
Georgia		Cherokee		Acworth		5637 Forest Place	
24. Mother's Mailing Address - If Same As Above Enter Zip Code				25. Residence Inside City Limits?			
30102				No			
26. Father's Name: First		27. Middle		28. Last		29. Date Of Birth	
Robert		Irvin		Crowe		Jan. 19, 1973	
30. State Of Birth, If Not U.S.A. Name Country		31. The Above Named Child Was Born Alive At The Place And Time On					
Georgia		The Date Stated Above					
Katie Jett		Mar. 06, 2001					
32. Date		33. Attendant At Birth (Other Than Certifier)					
35. Certifier - Name And Title		36. Physician's Medical Lic. No.					
Katie Jett, Supervisor		Mar. 06, 2001					
37. Certifier - Mailing Address (Street Or R.F.D. No., City Or Town, State, Zip)		38. Date Received By Local Registrar					
1000 Johnson Ferry Rd., Atlanta, Georgia 30342		March 07, 2001					
38. Registrar (Signature)		39. Date Received By Local Registrar					
		March 07, 2001					

Form 3919

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Department of Health & Human Services  
OFFICE OF THE DIRECTOR

06/16/2008 11:51AM

JUN-16-2008 MON 11:48 AM SC SENATE

FAX NO. 8032126298

P. 06

## SOUTH CAROLINA CERTIFICATE OF IMMUNIZATION

(TO BE COMPLETED BY A LICENSED PRACTITIONER OF MEDICINE, SURGERY, OR OSTEOPATHY, OR BY HIS OR HER AUTHORIZED REPRESENTATIVE)

Section Ia - DAY CARE		Section Ib - SCHOOL																																																																																												
<p>____/____/____ Date For Next Immunization (Child can attend day care for no more than one month following this date.)</p> <p>OR</p> <p><input type="checkbox"/> Final certificate for DAY CARE ATTENDANCE*</p>		<p><input checked="" type="checkbox"/> Has received all immunizations required for SCHOOL ENTRY*</p> <p>(INITIALS IF CHECKED BEFORE CHILD'S FOURTH BIRTHDAY)</p>																																																																																												
		<p><b>EXEMPTIONS</b> (Check all that apply!)</p> <p><input type="checkbox"/> MEDICAL CONTRAINDICATION Complete Section IV below. Child can attend school for no more than one month following the earliest expiration date in Section IV.</p> <p><input type="checkbox"/> AGE-RELATED EXEMPTION Date of fourth birthday or next immunization after fourth birthday (child can attend school for no more than one month following this date): ____/____/____</p> <p><input type="checkbox"/> CATCHING UP Date for next immunization (child can attend school for no more than one month following this date): ____/____/____</p>																																																																																												
<p>*Required standards of immunization for permanent certification for day care attendance and for school entry are published annually by SCOMIE Division of Immunization and Prevention (Telephone 1-(800) 257-6687).</p>																																																																																														
<p>Section II - CHILD'S IDENTIFICATION 1420271833 - WAGNER, JACOB D DOB: 03/02/2001</p>																																																																																														
<p>Section III - DATES OF IMMUNIZATIONS</p> <table border="1"> <thead> <tr> <th>VACCINES</th> <th>M/D/Y</th> <th>M/D/Y</th> <th>M/D/Y</th> <th>M/D/Y</th> <th>M/D/Y</th> <th>M/D/Y</th> </tr> </thead> <tbody> <tr> <td>Hepatitis B</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>HepB-Ped</td> <td>04/30/01</td> <td>07/05/01</td> <td>04/25/02</td> <td></td> <td></td> <td></td> </tr> <tr> <td>HepB-Adult</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>OPV</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>IPV</td> <td>04/30/01</td> <td>07/05/01</td> <td>07/26/02</td> <td>09/12/06</td> <td></td> <td></td> </tr> <tr> <td>DTP or DTaP</td> <td>04/30/01</td> <td>07/05/01</td> <td>09/04/01</td> <td>07/26/02</td> <td>09/12/06</td> <td></td> </tr> <tr> <td>DT or TD</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>HIB</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hib-PRPOMP</td> <td>04/30/01</td> <td>07/05/01</td> <td>04/25/02</td> <td></td> <td></td> <td></td> </tr> <tr> <td>MMR</td> <td>07/26/02</td> <td>09/12/06</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>VAR</td> <td>04/25/02</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Other:</td> <td>PCV 4 130101</td> <td>7/5/01</td> <td>9/12/06</td> <td>1/1</td> <td>1/1</td> <td>1/1</td> </tr> </tbody> </table>				VACCINES	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y	Hepatitis B							HepB-Ped	04/30/01	07/05/01	04/25/02				HepB-Adult							OPV							IPV	04/30/01	07/05/01	07/26/02	09/12/06			DTP or DTaP	04/30/01	07/05/01	09/04/01	07/26/02	09/12/06		DT or TD							HIB							Hib-PRPOMP	04/30/01	07/05/01	04/25/02				MMR	07/26/02	09/12/06					VAR	04/25/02						Other:	PCV 4 130101	7/5/01	9/12/06	1/1	1/1	1/1
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<p>Section IV - MEDICAL CONTRAINDICATION This child is exempted from receiving each of the vaccines listed below for a MEDICAL REASON.</p> <table border="1"> <thead> <tr> <th>VACCINE(S)</th> <th>DATE EXEMPTION EXPIRES</th> <th>OR PERMANENT EXEMPTION</th> </tr> </thead> <tbody> <tr> <td></td> <td>/ /</td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td>/ /</td> <td><input type="checkbox"/></td> </tr> </tbody> </table>				VACCINE(S)	DATE EXEMPTION EXPIRES	OR PERMANENT EXEMPTION		/ /	<input type="checkbox"/>		/ /	<input type="checkbox"/>																																																																																		
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<p>Section V - CERTIFICATION OF IMMUNIZATION STATUS</p> <p>SPARTANBURG COUNTY HEALTH DEPT</p> <p>Type or Print Certifier's Name 864-596-2227</p> <p>Certifier's Telephone Number</p> <p>Certifier's Signature or Stamp 09/12/2006</p> <p>Date Certificate Issued</p>																																																																																														

DIRECT148 (10/2001)

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06/16/2008 11:51AM

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

JUN-16-2008 MON 11:49 AM SC SENATE

FAX NO. 8032126298

P. 07

\*\*\* REC 2008137 084646 H6DC18H0 CX27 CIPQYA7 PQA7 (F-CX2 ) \*\*\*

NUM1 DTE:05/16/08 SSN:674-10-3732 XC: UNIT:VIP PG:001

SOCIAL SECURITY ADMINISTRATION  
SOCIAL SECURITY NUMBER PRINTOUT

OUR RECORDS INDICATE THAT SOCIAL SECURITY NUMBER 674-10-3732 MCL  
IS ASSIGNED TO JACOB , DONALD , WAGNER , .

YOUR SOCIAL SECURITY CARD IS THE OFFICIAL VERIFICATION OF YOUR SOCIAL SECURITY  
NUMBER. THIS PRINTOUT DOES NOT VERIFY YOUR RIGHT TO WORK IN THE UNITED STATES.

PROTECT YOUR SOCIAL SECURITY NUMBER FROM FRAUD AND IDENTITY THEFT. BE CAREFUL  
WHO YOU SHARE YOUR NUMBER WITH.

SOCIAL SECURITY ADMINISTRATION  
148 MAGNOLIA STREET  
SPARTANBURG SC 29306

M. Yang SRT

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Department of Health & Human Services  
OFFICE OF THE DIRECTOR

06/16/2008 11:51AM



South Carolina Department of Health and Human Services  
MEDICAID ELIGIBILITY CHECKLIST

Applicant's Name: Rhonda Holewinski-Crowe Date: 5/23/08

Budget Group Number: \_\_\_\_\_ Social Security Number: 370-92-7005

To determine Medicaid eligibility, the Department of Health and Human Services will need the items checked for the applicant, spouse, and children under age 21:

- ☐ Power of Attorney, Guardianship, or Conservator Papers
- ☐ Verification of ☐ Citizenship ☐ Identity Original Documents Required.
- ☐ Social Security numbers for persons requesting Medicaid
- ☐ Proof of gross income received by \_\_\_\_\_
- ☐ Proof of pregnancy and due date
- ☐ All bank or other financial account statements for \_\_\_\_\_
- ☐ Copies of trust agreements
- ☐ Pre-need burial contracts
- ☐ Proof of amount owed on real and personal property
- ☐ Proof of assets sold, transferred, or given away during the past \_\_\_\_\_ months
- ☐ Year, make, and model of all motor vehicles
- ☐ All life insurance policies
- ☐ All medical insurance policies or cards and proof of premiums
- ☐ DHHS Form 3218ME or 3218D-ME
- ☐ Proof of child care expenses
- ☐ DHHS Form 2700ME
- ☒ Other. Statement of how you pay your bills. *ask you change your mind about applying for for someone family benefits for yourself, I have enclosed the necessary child support form 2700.*

Please provide this information by \_\_\_\_\_. If you have any questions, please call your worker listed below for additional information. Thank you for your cooperation.

Worker: John Hood

Telephone: 596-2674 x. 107

Address: DHHS P.O. Box 4847

Spartanburg, SC 29305

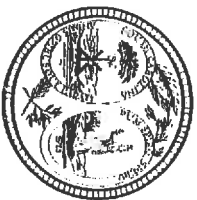
DHHS Form 1213ME (September 2006)

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JUN 16 2008

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

06/16/2008 11:51AM



Log 658



*State of South Carolina*  
*Department of Health and Human Services*

Mark Sanford  
Governor

Emma Forkner  
Director

June 24, 2008

The Honorable John D. Hawkins  
Member, South Carolina Senate  
602 Gressette Building  
Columbia, South Carolina 29202

Dear Senator Hawkins:

Thank you for contacting our agency on behalf of Ms. Ronda A. Holewinski-Crowe regarding her concerns about Medicaid eligibility.

A member of our staff has been in direct contact with Ms. Holewinski-Crowe to address her concerns regarding Medicaid eligibility and the rules and regulations governing the program. We also mailed her information on other programs and organizations that can assist residents in South Carolina with their healthcare 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,

A handwritten signature in cursive script that reads "Emma Forkner".

Emma Forkner  
Director

EF/jcol

Log 658



*State of South Carolina*  
*Department of Health and Human Services*

Mark Sanford  
Governor

Emma Forkner  
Director

June 23, 2008

Ms. Ronda A. Holewinski-Crowe  
15 Pittman Road  
Lyman, South Carolina 29365

Dear Ms. Holewinski-Crowe:

Senator Lindsay Graham contacted Senator John Hawkins on your behalf after receiving your letter concerning Medicaid eligibility requirements. We apologize for any problems you encountered during our eligibility process.

I am pleased to inform you that your son, Jacob's, application for Medicaid under the Partners for Healthy Children program has been approved with coverage effective March 1, 2008. Your application for coverage under the Aged, Blind or Disabled program is currently under review to determine if you meet the disability requirements. We will process your application as quickly as possible, and notify you once a decision has been made.

Mr. C. Ben Davis, Area Director, Spartanburg Office of the Employment Security Commission will be able to answer your questions about unemployment benefit payments. Mr. Davis is located at 364 South Church Street, Spartanburg, SC 29304, or he may be reached by telephone at 864-573-7525.

Enclosed is information on other programs and organizations that can assist residents in South Carolina with their healthcare needs. If you have additional questions about Medicaid, please contact Jennifer Lynch at (803) 898-3965, and she will be happy to assist you. I hope this information is helpful.

Sincerely,

A handwritten signature in cursive script, reading "Alicia Jacobs".

Alicia Jacobs  
Acting Deputy Director

AJ/coll  
Enclosures