DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	12-28-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000318	[X] Prepare reply for the Director's signature DATE DUE 1-08-08
2. DATE SIGNED BY DIRECTOR Ms. Jackson Cleared 1/11/08, letter attached.	[ ] Prepare reply for appropriate signature DATE DUE [ ] 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.			

LINDSEY O. GRAHAM
SOUTH CAROLINA

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

UNITED STATES SENATE

December 21, 2007

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

Re: Shirley McNeil
SS# 031-62-5090

Dear Ms. Forkner:

Enclosed is a copy of correspondence I have received from the above named constituent. I believe you will find it self-explanatory.

Your reviewing this material and providing any assistance or information possible under the governing statutes and regulations will be greatly appreciated. Thank you for your attention in this matter. I look forward to hearing from you soon.

Sincerely,

Lindsey O. Graham
United States Senator

LOG/lt

Please refer to case (498011) in your response.

Please reply to: Senator Lindsey Graham
530 Johnnie Dodds Boulevard, Suite 202
Mt Pleasant, South Carolina 29464

November 29, 2007

Janice Cooper
4468 Elderwood Court
Ladson, SC, 29456 (Charleston County)
843-851-2647

Re: Shirley McNeil

Dear Sir and To Whom it May Concern:

This letter comes to you as a plea for help in dealing with state government for assistance. At the end of July, my niece Shirley (who I have had legal custody of since she was 3 years old) had a psychotic episode that was diagnosed as having 'nihilistic delusions'. A person having these delusions believes they are dead or a part of their body is dead. Certainly, someone insane cannot be expected to work! She was hospitalized and misdiagnosed as depressed. Since this is a very rare condition that occurs maybe 1 in 100, 000 people, she suffered until we found the right psychiatrist. Dr. Christopher Jones from Summerville Behavioral Health has been treating her and she is slowly getting better.

One of her medicines will cost $400.00 a month; the other will be close to the same price. She will not be able to become a productive member of society without these medications and has no insurance. Also, she needs to visit other doctors due to her problem and I cannot afford to help her. I have been paying these doctors out of my pocket and I only work part-time and make approximately 20k annually. Each visit with the doctors at Summerville Behavioral Health costs a minimum of $150.00 and she needs to visit twice a month. With a mortgage, car payment, electric, water, and insurance bills to pay, there is very little left each month to stretch my pay check and I am falling behind on my household bills!

I would appreciate any help you can give me. I am sending you copies of all paperwork submitted to DSS and a copy of the denial letter. You have our permission to contact any person necessary and the doctors listed. We do not wish to cause anyone a problem; we just need a little help getting a young adult voter back on her feet! Thanks in advance for any help you can give our family.

Sincerely yours,

Janice Cooper Shirley McNeil

Janice Cooper and Shirley McNeil

Medicaid Letter of Action

From: **CHARLESTON COUNTY DHHS**
P. O. Box 13748
Charleston SC 29422-0000

To: **SHIRLEY G MCNEIL**
4468 ELDERWOOD CT
LADSON SC 29456

Date: **11/27/2007**
Worker Name:
KELLY STANKOWITZ
Telephone: **843 740-5943**
BG #: **99810585**
HH #: **100512368**
10 KELLS

Recipient Name:
SHIRLEY G MCNEIL

Recipient ID:
2601965302

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

Reason for denial:

You did not complete the required actions.

You did not provide proof of citizenship and identity.

Denied for the month(s) of: **10/2007**

Manual/policy reference supporting this action: **101.14**
102.04.03

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

November 20, 2007

Janice Cooper
4468 Elderwood Court
Ladson, SC, 29456
843-851-2647

RE: Shirley McNeil

Dear Ms. Stankowitz,

In July, August, and September 2007 Shirley McNeil started having delusions of being dead and she was unable to go to work toward the end of July. This type of psychological problem runs in the maternal side of her family and was inherited. She was admitted into Trident Hospital July 30 and she was diagnosed as 'depressed'. She had no insurance so I have had to pay for her prescriptions and all doctor visits leading up to the hospital stay and since. It has cost me out of pocket:

Dr. Campbell	Carolina Family Medicine	2 visits = $180
Dr. Christopher Jones	Summerville Behavioral Health	3 visits = $257.00
Counselor Anna Musolf	Summerville Behavioral Health	5 visits = $280.00

Also, I have been paying Shirley's monthly bills of $400.00 car payment, $100.00 car insurance payment, $75.00 phone bill to Suncom, and she has not been able to pay her $100.00 rent, either. Plus, I have provided all her food, shelter, and toiletries such as shampoo, toothpaste, and other necessities.

Shirley needs to see her gynecologist because she has not had a menstrual period since June. Also, her eye sight has changed dramatically due to medications that she will have to take for life. I cannot afford these doctor visits in addition to the Summerville Behavioral Health visits she needs in order to get better and return to being a productive member of society. She needs Medicaid to help restore her to the healthy, vibrant young woman she used to be. I cannot provide for all of her needs because I work part-time and can barely pay my own bills. This has put me behind on the household bills.

Sincerely yours,

Janice Cooper

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 Shirley McNeil (Please Print) Social Security No. 231-62-5090

Applicant's Address 4468 Elderwood ct

City Ladson State SC Zip Code 29456 County charleston

Date of Birth 08-21-1982 Telephone (843) 851-2647 Category of Application

If Deceased, Date of Death ____ Month ____ Day ____ Year Male or Female (Circle One)

Application Date ____ Retro Month(s) Requested August, 2007

Contact Person Janice Cooper Telephone (843) 851-2647

Relationship to Applicant mother / Aunt / Court appointed guardian

Contact Person's Address 4468 Elderwood ct (Give Complete Mailing Address)

Medicaid Eligibility Worker NA Telephone ( )

Worker's Address ____ (Give Complete Mailing Address)

Worker's Supervisor ____ Telephone ( )

Date of Disability Onset or Last Continuing Disability Review July 15, 2007

I. **DISABILITY**

a) What is your disability? delusions - initial delusions make patient believe they or their brain is dead

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

If no, when did your disability stop you from working? 08 Month 4 Day 07 Year

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

Explain why you stopped working: I feel like I have no brain

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

If yes, date of application: ____

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_____

Street Address_____

City_____ State_____ Zip Code_____

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

Type of Treatment or Evaluation Received_____

Case Manager_____ Telephone (____) _____

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.

he told me my life won't be normal until I stop believing the delusions.

III. EDUCATION/TRAINING INFORMATION

a) What is the highest grade of school you completed and when? 12 Grade 2000 Year

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

V. REMARKS

Use this section to answer any previous questions and to add additional information that you think will be helpful in making a decision in your disability claim.

Shirley was a ward of the court due to mental problems from mother. This is hereditary. this is why custody was appointed from MASS. SOCIETY for the Prevention of Cruelty to Children awarded custody since November 4, 1985. to Janice Cooper,

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE.

Print Name of Applicant/Representative Shirley McNeil / JANICE Cooper

Applicant/Representative Signature Shirley McNeil Janice Cooper **Date** 10-1-07 / 10/1/07

Relationship SELF / Aunt / Guardian appointed by Court

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

For Office Use Only – TO BE COMPLETED BY SCDHHS

Applicant/Beneficiary Name (First)	(Middle)	(Last)

Social Security No.	Date of Birth	Household No.

**** 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 or 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)	Relationship to Applicant/Beneficiary	Date
Shirley McNeil	Self	10-1-07

Street Address	Telephone No.
4445 Elderwood Ct	(843)851-2643

City	State	Zip Code	Signature of Witness	Date
Ladson	SC	29456		10-1-07

Log #318

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

January 11, 2008

The Honorable Lindsey Graham
United States Senate
530 Johnnie Dodds Boulevard, Suite 202
Mt. Pleasant, South Carolina 29464

Dear Senator Graham:

Thank you for your correspondence regarding Medicaid eligibility and the healthcare needs of Ms. Janice Cooper's niece, Shirley G. McNeil (case # 498011). We appreciate the opportunity to be of assistance.

A member of our staff has been in direct contact with Ms. Cooper to discuss Medicaid eligibility and income policy. We also provided her with contact information on other healthcare programs that may be of help to her niece.

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

Emma Forkner
Director

EF/jcodl

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

January 11, 2008

Ms. Shirley G. McNeil
4468 Elderwood Court
Ladson, South Carolina 29456

Dear Ms. McNeil:

At the request of your aunt, Janice Cooper, Senator Lindsey Graham asked our agency to assist with your questions and concerns regarding Medicaid eligibility.

Our records indicate you applied for Medicaid under the Aged, Blind or Disabled program on October 5, 2007. Your initial application was denied when the required documentation was not provided. We reopened your case for an eligibility determination in December when the additional materials were received. We will process your application as quickly as possible and notify you once a decision has been made. If you have questions regarding your application, please call your eligibility worker, Ms. Kelly Stankowitz, in our Charleston County Office at (843) 740-5943.

We have enclosed information on programs and organizations that can assist residents in South Carolina with their healthcare services, prescriptions, inpatient hospitalization, and daily living needs. If you have additional questions about the Medicaid program, please contact Bob Liming at (803) 898-2621 or (toll free) 1-888-549-0820, Ext. 2621. I hope this information is helpful.

Sincerely,

Alicia Jacobs

Alicia Jacobs
Interim Deputy Director

AJ/codl
Enclosures

C: Ms. Janice Cooper, Medicaid Authorized Representative

Medicaid Eligibility and Beneficiary Services
P.O. Box 8206 • Columbia, South Carolina 29202-8206
Phone (803) 898-2502 • Fax (803) 255-8235