

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

EA

TO	DATE
Roberts/Day/FOIA	10-21-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000092	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR CC: Brooks	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input checked="" type="checkbox"/> FOIA DATE DUE 11-4-14
	<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.			



RECEIVED

OCT 21 2014

Department of Health & Human Services
OFFICE OF THE DIRECTOR

RECEIVED

OCT 20 2014

CDHHS BUREAU OF REIM.
METHODOLOGY & POLICY

October 15, 2014

Brandy Putnam
SC Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202

RE: Alpha Health & Rehab of Greer, LLC
401 Chandler Road
Greer, South Carolina 29651
Our File No.: 12-673-MC

W. Harold Christian, Jr.

Richard V. Davis

Matthew W. Christian

Joshua D. Christian

Dear Ms. Putnam:

I am writing pursuant to the Freedom of Information Act to request all documents regarding ownership, control, licensing, and related entities, including but not limited to, CMS Form 1513.

If this cost is going to exceed \$100.00, please notify me of same prior to providing me with the information. I would greatly appreciate it if you would provide this information to me within the next 20 days. I look forward to hearing from you.

With kindest regards, I am

Very truly yours,

CHRISTIAN & DAVIS, LLC

Matthew W. Christian
Attorney at Law

MC/jah

P.O. Box 332 Greenville, SC 29602

1007 E. Washington St. Greenville, SC 29601

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TO:

FROM:

SUBJECT: Cost of Processing FOIA Request #

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

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

Please remit the above amount to the following address:

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

Please contact _____ should you have any questions.

Signature

Date: