DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	3-3-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-386	[X] Prepare reply for the Director's signature DATE DUE 3-10-11
2. DATE SIGNED BY DIRECTOR Cleared 3/16/11, 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.			

House of Representatives

State of South Carolina

J. Roland Smith
District No. 84 - Aiken County
183 Edgar Street
Warrenville, SC 29851

519-B Blatt Building
P.O. Box 11867
Columbia, SC 29211

Tel. 803-734-3114

Committees:
Ethics, Chairman
Ways and Means

February 25, 2011

Mr. Anthony E. Keck, Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

RE: Jerry Jennings; Beneficiary ID# 1780463479

Dear Mr. Keck:

I am writing on behalf of Mr. Jerry Jennings. Mr. Jennings has contacted me regarding his Medicaid benefits ending March 1, 2011.

I am requesting that you please review his case to see if benefits can be reinstated to him. I have enclosed the information he has provided to me.

Thank you for your assistance in this matter.

Respectfully,

J. Roland Smith

J. Roland Smith
House District 84

Enclosures
cc: Jerry Jennings 456 Lawana Dr. Apt. 101, Gloverville SC 29828

Certificate of Creditable Coverage

AIKEN COUNTY DHHS
P. O. Box 2748
Aiken SC 29802-2748

JERRY JENNINGS
456 LOWANA DRIVE
APT 101
GLOVERVILLE SC 29828

Date: 02/15/2011
Worker Name:
VERTA JOHNSON
BG#: 61084085
HH #: 101055305
Name of Group Health Plan: Medicaid

IMPORTANT

This certificate provides information about prior coverage for the individual(s) listed. If you enroll in another health plan, you may need to give them a copy of this certificate. **Keep this certificate in a safe place.**

Beneficiary Name:	Beneficiary ID#	COVERAGE PERIODS:
JERRY JENNINGS	1780463479	NOV09 - FEB11

If there are other members not listed on this notice, please call your worker.

SOUTH CAROLINA HEALTH INSURANCE SERVICES

Inpatient Hospital
Well Child Care
Family Planning
Laboratory and X-Ray
Home Health
Targeted Case Management
Home and Community Based Waivers
Evaluation/Counseling/Education for Special Needs
Non-emergency Transportation to Medical Appointments
Outpatient Hospital
Vision Care
Durable Medical Equipment
Ambulance Transportation
Rehabilitative Therapies
Long-term Care/Nursing Home Facilities
Residential Treatment Facility
Physician Visits
Dental
Prescription Drugs
Hospice
Mental Health
Alcohol and Other Substance Abuse

*FOR FURTHER INFORMATION REGARDING THIS NOTICE OR SERVICE DESCRIPTIONS AND LIMITATIONS CALL 1-888-549-0820. 8:00 a.m. - 6.00 p.m. **(This is a free call)** Or write to: **S.C. Department of Health and Human Services**, P.O. Box 100147, Columbia, S.C. 29202-9181

Notice That Medicaid Coverage Will End

Wife - Ms. Erma Jean Moore Jennings
(478) 224-0009
478 224 0009

AIKEN COUNTY DHHS
P. O. Box 2748
Aiken SC 29802-2748

Date: 02/15/2011

Worker:
VERTA JOHNSON
Worker Phone: 803 642-7505
BG #: 61084085
HH #: 101055305

JERRY JENNINGS
456 LOWANA DRIVE
APT 101
GLOVERVILLE SC 29828

Medicaid coverage for the people listed below will end on **03/01/2011.**

Beneficiary Name:	Beneficiary ID#:
JERRY JENNINGS	1780463479

Reason(s): Medicaid coverage will end because:

Your income is more than policy allows.

Manual/policy reference supporting this action: **303.01.03**
A copy of this reference is available upon request.

You may qualify for Medicaid under other programs if there has been changes in your family, health or income since your last application or review. If there have been changes that we do not know about, you should re-apply.

To re-apply you can do one of the following:

- Contact your worker.
- Call 1-888-549-0820 or visit www.scdhhs.gov for an application.

If the reason shown above states that your Medicaid coverage will stop because of "Failure to Return Review Form" AND you have not received a review form or have already returned your review form please contact your worker right away.

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 fair 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.

Untitled

Date: 02/22/2011

Subjest: Household income

To Whom It May Concern,
I Jerry Jennings have not seen nor supperted or sent money to Mrs. Jean Jennings since May of 2010. In May of 2010 she left and went to Perry, Georgia to her mothers who was in bad health. As of yet she has not returned. I was able to speak with her on 02/21/11 and she informed me that she would not return.
Thank you,

Jerry Jennings

0000028462 JENNINGS,JERRY W Share 0071: CHECKING [1600762668] Transaction Summary

02/22/2011

Post Date	ID	Eff Date	Transaction	Trans Amt	Balance Chg	Int/Pnlty	Fees	New Balance	Description	Prev Available
			%% ACH Trace 031736011219569							
			ID: 3031036030 CO: SOC SEC							
12/02/2010	S 0071	[12/03/2010]	ACH Deposit	1,096.00	1,096.00	0.00	0.00	1,366.84	SOC SEC	270.84
			%% ACH Trace 091000015590750							
			CO: CUNA MUTUAL							
			TYPE: AD&D PREM ID: 1390230590							
12/03/2010	S 0071	12/03/2010	ACH Withdra...	3.00	-3.00	0.00	0.00	1,363.84	CUNA MUTUAL	1,366.84
			%% ACH Trace 021000022393150							
			CO: NATIONWIDE							
			TYPE: INS PREM ID: 5314177100							
12/03/2010	S 0071	12/03/2010	ACH Withdra...	40.06	-40.06	0.00	0.00	1,323.78	NATIONWIDE	1,363.84
12/07/2010	S 0071	12/07/2010	Draft Withdra...	92.08	-92.08	0.00	0.00	1,231.70	Draft Number: 001335	1,323.78
12/07/2010	S 0071	12/07/2010	Draft Withdra...	298.00	-298.00	0.00	0.00	933.70	Draft Number: 001333	1,231.70
12/08/2010	S 0071	12/08/2010	Draft Withdra...	109.00	-109.00	0.00	0.00	824.70	Draft Number: 001338	933.70
12/09/2010	S 0071	12/09/2010	Draft Withdra...	200.00	-200.00	0.00	0.00	624.70	Draft Number: 001339	824.70
12/09/2010	S 0071	12/09/2010	Draft Withdra...	32.00	-32.00	0.00	0.00	592.70	Draft Number: 001337	624.70
12/13/2010	S 0071	12/13/2010	Draft Withdra...	30.90	-30.90	0.00	0.00	561.80	Draft Number: 001334	592.70
12/16/2010	S 0071	12/16/2010	Draft Withdra...	28.13	-28.13	0.00	0.00	533.67	Draft Number: 001336	561.80
			BI-LO 604 4435 JEFFERSON DAV CLEARWATER SC							
12/24/2010	S 0071	12/24/2010	POS Withdra...	9.44	-9.44	0.00	0.00	524.23	#000000667697	533.67
			LANGLEY SC							
12/29/2010	S 0071	12/29/2010	INQ FOUR SEASONS-1 2868 HIGHWAY 421							
			Date 12/30/10 0 0000059309 0 5411							
			WM SUPERCENTER AIKEN SC							
12/31/2010	S 0071	12/31/2010	Debit Card W...	110.52	-110.52	0.00	0.00	413.71		524.23
			%% ACH Trace 031736011171475							
			ID: 3031036030 CO: SOC SEC							
12/31/2010	S 0071	[01/03/2011]	ACH Deposit	1,096.00	1,096.00	0.00	0.00	1,509.71	SOC SEC	413.71
			LANGLEY SC							
12/31/2010	S 0071	12/31/2010	INQ FOUR SEASONS-1 2868 HIGHWAY 421							
			%% APY Earned 0.04% 12/01/10 to 12/31/10							
12/31/2010	S 0071	12/31/2010	Dividend Dep...	0.02	0.02	0.00	0.00	1,509.73	0.030%	1,509.71
01/04/2011	S 0071	01/04/2011	Draft Withdra...	200.00	-200.00	0.00	0.00	1,309.73	Draft Number: 001343	1,509.73
01/04/2011	S 0071	01/04/2011	Draft Withdra...	298.00	-298.00	0.00	0.00	1,011.73	Draft Number: 001340	1,309.73
			%% ACH Trace 021000020537204							
			CO: NATIONWIDE							
			TYPE: INS PREM ID: 5314177100							
01/04/2011	S 0071	01/04/2011	ACH Withdra...	39.35	-39.35	0.00	0.00	972.38	NATIONWIDE	1,011.73
01/05/2011	S 0071	01/05/2011	Draft Withdra...	50.00	-50.00	0.00	0.00	922.38	Draft Number: 001341	972.38
01/07/2011	S 0071	01/07/2011	Draft Withdra...	68.36	-68.36	0.00	0.00	854.02	Draft Number: 001344	922.38
~~01/12/2011~~	~~S 0071~~	~~01/12/2011~~	~~Draft Withdra...~~	~~200.00~~	~~-200.00~~	~~0.00~~	~~0.00~~	~~854.02~~	~~Draft Number: 001347~~	~~854.02~~
01/12/2011	S 0071	01/12/2011	Cash Withdr...	200.00	-200.00	0.00	0.00	654.02		854.02
01/13/2011	S 0071	01/13/2011	Draft Withdra...	109.00	-109.00	0.00	0.00	545.02	Draft Number: 001345	654.02
01/19/2011	S 0071	01/19/2011	Draft Withdra...	28.13	-28.13	0.00	0.00	516.89	Draft Number: 001342	545.02

0000028462 JENNINGS,JERRY W Share 0071: CHECKING [1600762668] Transaction Summary

02/22/2011

Post Date	ID	Eff Date	Transaction	Trans Amt	Balance Chg	Int/Pnlty	Fees	New Balance	Description	Prev Available
01/25/2011	S 0071	01/25/2011	Draft Withdra...	58.90	-58.90	0.00	0.00	457.99	Draft Number: 001346	516.89
01/27/2011	S 0071	01/27/2011	Draft Withdra...	300.00	-300.00	0.00	0.00	157.99	Draft Number: 001348	457.99
			%% APY Earned 0.02% 01/01/11 to 01/31/11							
01/31/2011	S 0071	01/31/2011	Dividend Dep...	0.01	0.01	0.00	0.00	158.00	0.030%	157.99
			%% ACH Trace 031736011124341							
			ID: 3031036030 CO: SOC SEC							
02/02/2011	S 0071	[02/03/2011]	ACH Deposit	1,096.00	1,096.00	0.00	0.00	1,254.00	SOC SEC	158.00
			SC							
			WAL-MART #4487 3581 RICHLAND AVE AIKEN (N)							
02/03/2011	S 0071	02/03/2011	POS Withdra...	84.37	-84.37	0.00	0.00	1,169.63	#000000260505	1,254.00
			%% ACH Trace 021000025051556							
			CO: NATIONWIDE							
			TYPE: INS PREM ID: 5314177100							
02/03/2011	S 0071	02/03/2011	ACH Withdra...	39.35	-39.35	0.00	0.00	1,130.28	NATIONWIDE	1,169.63
02/04/2011	S 0071	02/04/2011	Draft Withdra...	50.00	-50.00	0.00	0.00	1,080.28	Draft Number: 001354	1,130.28
02/04/2011	S 0071	02/04/2011	Draft Withdra...	150.00	-150.00	0.00	0.00	930.28	Draft Number: 001350	1,080.28
02/10/2011	S 0071	02/10/2011	Draft Withdra...	58.90	-58.90	0.00	0.00	871.38	Draft Number: 001352	930.28
02/10/2011	S 0071	02/10/2011	Draft Withdra...	109.00	-109.00	0.00	0.00	762.38	Draft Number: 001353	871.38

J. Roland Smith
Member, House of Representatives
183 Edgar Street
Warrenville, SC 29851

Mr. Anthony E. Keck, Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

AUGUSTA 29202

South Carolina Department of
Health & Human Services

Anthony E. Keck • Director
Nikki R. Haley • Governor

Log 386

March 16, 2011

The Honorable J. Roland Smith
South Carolina House of Representatives
Post Office Box 11867
519-B Blatt Building
Columbia, South Carolina 29211

Dear Representative Smith:

Thank you for contacting this agency on behalf of Mr. Jerry Jennings regarding his Medicaid eligibility and healthcare needs.

We were unable to reach Mr. Jennings by phone, but mailed him a letter explaining his current Medicaid status. We also provided him with information on other healthcare programs and resources that may be of assistance to him. He was provided with contact information for a Constituent Services staff member should he need further assistance.

As you are aware, the Health Insurance Portability and Accountability Act (HIPAA) confidentiality requirements preclude us from discussing medical information without the client's written consent. We have enclosed an Authorization to Disclose Health Information form if you would like more information than we are currently able to provide.

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,

Anthony E. Keck
Director

AEK/jjgl

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

Blue Log No. 0386

South Carolina Department of Health & Human Services

Anthony E. Keck • Director
Nikki R. Haley • Governor

March 10, 2011

Mr. Jerry Jennings
456 Lawana Drive
Apt. 101
Gloverville, South Carolina 29828

Dear Mr. Jennings:

Representative Roland Smith asked our agency to assist with questions concerning Medicaid eligibility and your healthcare needs.

Your coverage under Medicaid's Aged, Blind or Disabled (ABD) program ended effective March 1, 2011 because your income is above the allowable limit of $908 for an individual. Your Medicaid coverage was secondary to your Medicare coverage.

You are eligible under our Specified Low Income Medicare Beneficiary (SLMB) program which will continue to pay your Medicare Part B monthly premium. Fortunately, you have full Medicare coverage for your healthcare needs.

If your situation changes, you may re-apply for Medicaid benefits at any time. You may reach our Aiken Medicaid Office at (803) 643-1938.

Enclosed is information on other programs and organizations that can assist residents in South Carolina with their healthcare needs and prescriptions. If you have questions about the Medicaid program, please contact Ms. Jenny Lynch in Constituent Services at (803) 898-3965. I hope this information is helpful.

Sincerely,

Alicia Jacobs

Alicia Jacobs
Deputy Director

AJ/jgl
Enclosures

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

Log 386

South Carolina Department of Health & Human Services

Anthony E. Keck • Director
Nikki R. Haley • Governor

March 16, 2011

The Honorable J. Roland Smith
South Carolina House of Representatives
Post Office Box 11867
519-B Blatt Building
Columbia, South Carolina 29211

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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,

Anthony E. Keck
Director

AEK/jjgl

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

SCDHHS AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

Record #: _____ Client SS #: _____

I _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Provider/Plan/Agency)

from the records of the above named client to: _____
(Recipient Name/Address/Phone/Fax)

_____

_____

for the specific purpose(s): _____

_____

Specific information to be disclosed: _____

_____

_____

I understand that this authorization will expire on the following date, event or condition: _____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that refusal to sign this authorization will not condition or limit my access to treatment, payment, enrollment or eligibility for benefits available to me.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

****

NOTE: This Authorization was revoked on	_____	_____
	(Date)	*(Signature of Staff)*

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Client) *(Date)* *(Signature of Witness)* *(Date)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Staff) *(Date)* *(Signature of Witness)* *(Date)*