

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Singleton</i>	DATE <i>4-11-08</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER  <i>000530</i>	<input checked="" type="checkbox"/> Prepare reply for the Director's signature DATE DUE <i>4-18-08</i>
2. DATE SIGNED BY DIRECTOR  <i>Cleaved 4/18/08, letter attached.</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____ <input type="checkbox"/> FOIA DATE DUE _____ <input type="checkbox"/> Necessary Action

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



House of Representatives  
Washington, DC 20515

BOB INGLIS  
4TH DISTRICT, SOUTH CAROLINA

April 7, 2008

SCIENCE AND TECHNOLOGY  
FOREIGN AFFAIRS

**ROBERT F. BIRD**

APR 11 2008  
Department of Health & Human Services  
OFFICE OF THE DIRECTOR

Emma Forkner  
State Director  
SC Dept of Health and Human Services  
PO Box 8206, 1801 Main Street  
Columbia, SC 29202-8206

Dear Ms. Forkner:

I am writing on behalf of my constituent, Della L. Whitt, about her allegation of Medicaid fraud. Enclosed is a copy of her letter for your review.

I would greatly appreciate your addressing the questions and concerns mentioned in Della's correspondence with respect to your agency's governing rules and regulations. I have assured Della that I would write to emphasize my interest in her case and to help obtain a reply from your office.

Thank you, in advance, for your help and please feel free to call Dwayne Hatchett of my Spartanburg office if you have any questions or need further information. Dwayne can be reached at 864-582-6422.

I look forward to hearing from you soon.

Sincerely,

Bob Inglis  
Member of Congress

BI/dh

Enclosure

cc: Della L. Whitt

WASHINGTON, DC  
WASHNCR HOUSE GEORGE BUILDING  
WASHINGTON, DC 20515  
PHONE: (202) 225-6032  
FAX: (202) 225-1177

SPARTANBURG, SC  
464 EAST MAIN STREET, SUITE 8  
SPARTANBURG, SC 29302  
PHONE: (864) 582-5422  
FAX: (864) 575-6276

GREENVILLE, SC  
105 NORTH SPRING STREET, SUITE 111  
GREENVILLE, SC 29601  
PHONE: (864) 232-1741  
FAX: (864) 232-2160

PHONE: (864) 477-6100  
WWW.HOUSE.EDU/INGLIS

MEMO

1

Mr. Bert Ogden

I want to thank you for  
calling me back like you said  
you would. I am going to  
send you some paper to let  
you know what I am talking  
about. My mother!

She's money from 7 with  
Dixie's Band were her's  
before my brother and sister  
took her into taking it  
and putting in their names.  
My mother were personal  
with my sister because  
the 2/28/02. The

money were took out of  
her home 07/15/2002.  
When they put her in  
the nursing home they  
got to get that and I want  
the money there because  
as

Mama had all this money  
in the C.I.D's  
She had about 12,000.00  
At the Church in the  
1950's, when first they  
Took out of the Bank  
before the put her on  
Medicaid.

She worked in the  
mill at Geneva where  
she had 401k.

She had one son her  
son a Power of att.

Roger & his wife took  
over everything the  
day my Brother died  
and took money and  
all up to his house.

The money was in  
Rennie Sn. and  
Roger Wade Sn. and after  
Rennie died they put Michael  
Sipary

Rosen Dale Sperry S.N.  
The Store in Danville S.C. Spencer Rd  
Meland Wren Sperry  
Union S.C. Berry Farm Rd  
Shily 7 yrs now  
Deep Water Rd Union  
Peggy Henderson.  
108<sup>th</sup> St. Danville S.C.  
Will Adams. He lives  
off Lantant Hwy. Pee Ridge Rd.

The reason they are mad  
at me is cause I  
agreed not my mother  
joining my Brother for  
some Reulian a car  
subject with his legs  
burned off and when  
he did the fence went  
to his son Ronnie Jr.

MEMO

4

of

When they put names  
of Ellen Susan Murray  
Rosen Dale - Mollard Sping  
and Shirley got together  
and checked her  
checking account which  
were about

2,000.00

My sister Peggy told me this

Mama had about 10 or 12  
other insurance policies &  
don't know who they went to

what I would like  
to see that all are  
made to pay this money  
back to Medicaid

If they cannot find  
any thing at Government  
Bank they please put  
it under State Bank  
in Union

MEMO  
Went to Mumma's Home Aug 26  
Book

Rosen Dale Support  
Spencer Rd Genevaville

Millard Sperry  
Berry Farm Rd Union

Shiley moss  
Deep water Rd Union

Peggy Henderson  
Genevieve St 108 Hannie St

Gill Adams

This is like all got the money

I HEREBY CERTIFY THAT THIS IS A TRUE COPY OF THE RECORD ON FILE IN THE UNION COUNTY HEALTH DEPARTMENT

UCI 29 2007

02-29-07  
County Registrar

State of South Carolina  
Department of Health and Environmental Control  
CERTIFICATE OF DEATH

STATE BIRTH NUMBER: \_\_\_\_\_  
 DECEASED'S LEGAL NAME (include maiden name, if first, middle, last): **Mary Pearl Lindsey**  
 2 SEX: **Female**  
 3 SOCIAL SECURITY NUMBER: **072-009535**  
 4 STATE FINE NUMBER: **072-009535**

4a AGE - Last Birthday: **91** 4b UNDER 1 YEAR: \_\_\_\_\_ 4c UNDER 1 DAY: \_\_\_\_\_  
 (Years) (Months) (Days) (MM/DD/YYYY)  
 5. DATE OF BIRTH: **04/22/1915** 6 BIRTHPLACE (City and State or Foreign Country): **Gaylesville, S.C.**

7a RESIDENCE STATE: **S.C.** 7b COUNTY: **Union** 7c CITY OR TOWN: **Union** 7d INSIDE CITY LIMITS?  Yes  No  
 7e STREET AND NUMBER: **1817 Jonesville Hwy.** 7f ZIP CODE: **29379**

8. EVER IN US ARMED FORCES?  Yes  No  
 9. MARITAL STATUS AT TIME OF DEATH:  Married  Widowed  Divorced  Never Married  Unknown  
 10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage): **322 Spencer Rd. Jonesville, S.C. 29353**

11. FATHER'S NAME (First, Middle, Last): **William Baldwin** 12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): **Ida Madde Sanders**  
 13a. DECEASED'S NAME: **Roger Lindsey** 13b. RELATIONSHIP TO DECEASED: **Son** 13c. MAILING ADDRESS (Street and Number, City, State, Zip Code): **322 Spencer Rd. Jonesville, S.C. 29353**

14. PLACE OF DEATH (Check only one - see instructions):  
 DEATH OCCURRED IN A HOSPITAL:  Inpatient  Emergency Room/Outpatient  Died on arrival  Facility name: **Elthen Sadler Nursing Home**  
 PLACE OF DEATH: **Home** 15. CITY OR TOWN, STATE AND ZIP CODE: **Union, S.C. 29379**  
 Other (Specify): \_\_\_\_\_ 16. METHOD OF DISPOSITION:  Burial  Cremation  
 Donation  Entombment  Removal from state  
 Other (Specify): \_\_\_\_\_ 17. CITY OF BIRTH: **Union**

18. PLACE OF DISPOSITION (Name of cemetery, crematory, other place): **Gilead Baptist Church Cemetery**  
 19. NAME AND ADDRESS OF FUNERAL HOME: **Holcombe Funeral Home, Inc. 310 W. South St. Union, S.C. 29379**  
 20. COLOCATION CITY, TOWN AND STATE: \_\_\_\_\_ 21. NAME AND ADDRESS OF FUNERAL HOME: \_\_\_\_\_  
 22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT: **R. B. Lindsey** 23a. LICENSE NUMBER (or license): **2657**  
 23b. EMPLOYER LICENSE NUMBER: \_\_\_\_\_ 23c. LICENSE NUMBER (or facility): **356**

24. DATE PRONOUNCED DEAD (MM/DD/YYYY): **03-02-2007** 25. TIME PRONOUNCED DEAD: **9:06 PM**  
 26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable): \_\_\_\_\_ 27. LICENSE NUMBER: \_\_\_\_\_ 28. DATE SIGNED (MM/DD/YYYY): \_\_\_\_\_

29. DATE OF DEATH (Specify Month): **March 2, 2007** 30. ACTING PHYSICIAN'S NAME AND ADDRESS: **Chronic Abdominal Pain**  
 31. WAS CONSUMER OR MEDICARE EX-GRATIA CONTACTED?  Yes  No  
 32. PART 1. Enter the date of acute-onset, chronic, or complications that directly caused the death; DO NOT enter time of events such as accidental falls, respiratory arrest, or ventricular fibrillation without showing the etiology; DO NOT ABREVIATE. Enter only one cause on a line. Add additional lines if necessary.  
 IMMEDIATE CAUSE (if final disease or condition resulting in death): **Chronic Abdominal Pain** Due to (or as a consequence of):  
 Sequence of events: a. **Diarrhea** Due to (or as a consequence of):  
 b. **2 hr acute Pac.** Due to (or as a consequence of):  
 c. **HTN** Due to (or as a consequence of):

33. WAS AN AUTOPSY PERFORMED?  Yes  No  
 34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?  Yes  No  
 35. DND TOBACCO USE CONTRIBUTED TO DEATH?  Yes  Probably  No  
 36. IF FEMALE:  Not pregnant within past year  Pregnant at time of death  Not pregnant, but pregnant within 42 days of death  Not pregnant, but pregnant 43 days to one year before death  Unknown if pregnant within the past year  
 37. MANNER OF DEATH:  Natural  Homicide  Accident  Pending Investigation  Suicide  Could not be determined

38. DATE OF INJURY (Specify Month): \_\_\_\_\_ 39. TIME OF INJURY: \_\_\_\_\_ 40. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, wooded area): \_\_\_\_\_ 41. INJURY AT WORK?  Yes  No  
 42. LOCATION OF INJURY: State: \_\_\_\_\_ City or Town: \_\_\_\_\_ Apartment Number: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Street & Number: **ESNH**

43. DESCRIBE HOW INJURY OCCURRED: \_\_\_\_\_  
 44. IF TRANSPORTATION INJURY, SPECIFY:  Driver/Operator  Pedestrian  Passenger  Other (Specify): \_\_\_\_\_

45. CERTIFIER (Check only one)  
 Certifying physician. To the best of my knowledge, death occurred due to the cause(s) and manner stated.  
 Paramedic and Certifying physician. To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.  
 Coroner/Medical Examiner. On the basis of observation and/or investigation, my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.  
 Signature of certifier: \_\_\_\_\_

46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32): **801 W. Main St. Union SC 29379**  
 47. TITLE OF CERTIFIER: **MD** 48. LICENSE NUMBER: **32412** 49. DATE CERTIFIED (MM/DD/YYYY): **04/03/2007**  
 50. FOR REGISTRAR ONLY - DATE FILED (MM/DD/YYYY): **04/03/2007**

49. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER: \_\_\_\_\_

NAME OF DECEASED: **Mary Pearl Lindsey**  
 For use by physician or institution

Items 24-49 To Be Completed By: MEDICAL CERTIFIER

Items 1-23c To Be Completed/Verified By: FUNERAL DIRECTOR

# First Citizens Bank

Member F.D.I.C.

## Certificate of Deposit Book Entry Receipt

**Payee(s):**

RONNIE E LIPSEY SR  
ROGER D LIPSEY SR  
328 SPENCER RD  
JONESVILLE, SC 29353

Account No. 754116998886

Date 07/15/2002 Branch 443

Interest Rate: 3.92 APY: 4.00

Amount: \$72,335.59

Type: Automatically Renewable

Term: 24 Months

Interest Payment Frequency: Annually

Maturity Date: 07/15/2004

Interest Payment Method: Compound to CD

  
Patty Morrison  
Authorized Signature

### Early Withdrawal Penalties

Any withdrawal prior to maturity will be permitted only with our consent which must be obtained at the time the request for early withdrawal is made. The advance consent and penalty provisions (outlined below) will not apply in the following situations: (1) death or mental incompetence of depositor; (2) request for withdrawal of accrued interest or interest paid to CD (if any) during the current term; (3) request to close a Convertible-CD ninety (90) days after opening/renewal to purchase another Convertible CD or 12-Month or greater CD, for the same or greater principal amount.

We reserve the right to charge a substantial bank penalty if you withdraw any portion of the principal amount of a CD prior to maturity. If the penalty amount exceeds the amount of the accrued interest, a reduction in principal may be necessary to meet the penalty requirement. The following penalty provisions will apply to the principal amount withdrawn prior to maturity:

- \* for CDs with a term of 12 months or less, the penalty is three months' simple interest.
- \* for CDs with a term greater than 12 months, the penalty is six months' simple interest.

Refer to the CERTIFICATE OF DEPOSIT DISCLOSURE for additional terms, conditions, and disclosures.

# First Citizens Bank



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

Mark Sanford  
Governor

Emma Forkner  
Director

April 18, 2008

The Honorable Bob Inglis  
House of Representatives  
330 Cannon House Office Building  
Washington, DC 20515

Dear Congressman Inglis:

Thank you for your letter on behalf of your constituent, Ms. Della L. Whitt. Please be assured that we will investigate this allegation, and will also seek recovery of any Medicaid funds if we determine they have been inappropriately paid. To this end I have forwarded Ms. Whitt's complaint to our Division of Program Integrity and our Estate Recovery Department.

I truly appreciate your support of the South Carolina Medicaid program.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Emma Forkner'.

Emma Forkner  
Director

EF/ssm

Log # 530



Office of the Director

P. O. Box 8206 Columbia South Carolina 29202-8206  
(803) 898-2504 Fax (803) 255-8235