DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	1-7-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 100367	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Cleared 1/16/09, letter attached. ✓	[X] Prepare reply for appropriate signature DATE DUE 1-16-09
	[ ] 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

Committees:
Ethics, Chairman
Ways and Means
Ways and Means Budget and Finance
Ways and Means Property Tax
Ways and Means Public Education and
Special Schools Subcommittee, Chairman
School Bus Specification Committee

December 31, 2008

519-B Blatt Building
Columbia, SC 29211

Tel. (803) 734-3114

Emma Forkner, Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

RE: Alice Terrell, SSN 251-45-0731

Dear Ms. Forkner:

I am writing to you on behalf of the constituent noted above. Ms. Terrell has received SSI benefits in the past, but has recently received a denial for these benefits.

Enclosed is a copy of the information Ms. Terrell provided. I am requesting that you please review her case.

Thank you for your assistance in this matter. If you have any questions, do not hesitate to call.

Respectfully,

J. Roland Smith

J. Roland Smith
House District 84

Enclosures
cc: Alice Terrell, 366 Piney Heights, Warrenville, SC 29851

Social Security Administration
Supplemental Security Income
Notice of Disapproved Claims

Date: 08/10/2006
Claim Number: 251-45-0731

ALICE F TERRELL
PO BOX 877
LANGLEY SC 29834

We are writing about your claim for Supplemental Security Income (SSI) payments. Based on a review of your health problems you do not qualify for payments on this claim. This is because you are not disabled or blind under our rules.

We have enclosed information about the disability and blindness rules and more details about the decision on your claim.

About the Decision
Doctors and other trained staff looked at your case and made this decision. They work for your State but used our rules.

Please remember that there are many types of disability programs, both government and private, which use different rules. A person may be receiving benefits under another program and still not be entitled under our rules. This may be true in your case.

If You Disagree with the Decision
If you disagree with this decision, you have the right to appeal. We will review your case and consider any new facts you have. A person who did not make the first decision will decide your case.

- You have 60 days to ask for an appeal.
- The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- You must have a good reason for waiting more than 60 days to ask for an appeal.
- You have to ask for an appeal in writing. We will ask you to sign a form SSA-561-U2, called "Request for Reconsideration." You may request this form online at http://socialsecurity.gov/online/SSA-561.pdf. Contact one of our offices if you want help.

Enclosure:
SSA Pub. No. 05-11008
Personalized Attachment
cc:

WGU/170
Claim No.: F15709
SSA-444-U3 (4/04)

596

See Next Page

- In addition, you have to complete a "Reconsideration Disability Report" to tell us about your medical condition since you filed your claim. You may contact one of our offices or call 1-800-772-1213 to request the form. Or, you may complete this report online at http://www.socialsecurity.gov/disability/recon.

Please read the enclosed pamphlet, "Your Right to Question the Decision Made On Your SSI Claim." It contains more information about the appeal.

How the Appeal Works
You have the right to review the facts in your case. You can give us more facts to add to your file. Then we will decide your case again. You will not meet the person who will decide your case.

New Application
You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If you disagree with this decision and you file a new application instead of appealing, you might lose some benefits, or not qualify for any benefits. So, if you disagree with this decision, you should ask for an appeal within 60 days.

If You Want Help with Your Appeal
You can have a friend, lawyer, or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal. Your local Social Security Office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it.

If You Have Any Questions
If you have any questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security Office at the number shown on page 1. We can answer most questions over the phone. You can also write or visit any Social Security Office. The office that serves your area is located at:

151 CORPORATE PKWY SE
AIKEN SC 29803-7652
Telephone: (803) 648-2356

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly.

Paul D. Barnes
Regional Commissioner

WGU/170
Claim No: F15709
SSA-444-U3 (4/04)

RULES FOR SSI DISABILITY AND BLINDNESS

You must meet certain rules to qualify for SSI payments based on disability:

For Payment As A Disabled Adult
If you are age 18 or older your health problem must:

- Keep you from doing any kind of substantial work (described below), and
- Last, or be expected to last, for at least 12 months in a row, or result in death.

For Payment As A Disabled Child:
If you are under age 18 your health problems must:

- Be as severe as those that would keep an adult from doing any kind of substantial work. This means that your health problems must limit you from doing things that other children the same age normally can do, to the extent required by our rules, and
- Last, or be expected to last, for at least 12 months in a row, or result in death.

You must meet certain rules to qualify for SSI payments based on blindness:

- Your eyesight must be no better than 20/200 in the better eye with the use of a correcting lens, or
- Your visual fields must be restricted to 20 degrees or less.

Your can qualify for SSI benefits due to blindness even if you can do substantial work.

Information About Substantial Work

Generally, substantial work is physical or mental work you are paid to do. Work can be substantial even if it is part-time. To decide if your work is substantial, we consider the nature of the job duties, the skills and experience you need to do the job, and how much you actually earn.

Usually, we find that your work is substantial if your gross earnings average over $800.00 per month after we deduct allowable amounts. Your work may be different than before your health problems began. It may not be as hard to do and your pay may be less. However, we may still find that your work is substantial under our rules.

If you are self-employed, we consider the kind and value of your work, including your part in the management of the business, as well as your income, to decide if your work is substantial.

WGU/170
Claim No.: F15709
SSA-L444-U3 (4/04)

INFORMATION ABOUT OTHER BENEFITS

Medicaid
An agency of your state will advise you about the Medicaid program. If you have any questions about your eligibility for Medicaid or need immediate medical assistance, you should get in touch with:

Department of Social Services

WGU/170
Claim No.: F15709
SSA-444-U3 (4/04)
MLO

170/F15709 **EXPLANATION OF DETERMINATION**

ame of Claimant	NH's Name(if CDB or DWB Claim)	SSN	Type of Claim
LICE F TERRELL		251-45-0731	DI

he following evidence, listed with receipt date, was used to decide this claim.

)R DORIS E TUMMILLO MD, 05/23/06
)R JAMES M SCHEAR PHD, 06/07/06
'REEDMAN SCHOOL, 04/21/06
AIKEN COUNTY SCHOOL DISTRICT, 08/03/06

)R C P DUNBAR MD FAMILY PRACTICE Consultative Exam 06/26/06

The medical evidence does not show that your loss of vision is severe enough to meet the blindness requirements for Supplemental Security Income payments. We have determined that your condition(s) is not severe enough to keep you from working. We considered the medical and other information, your age, education, training, and work experience in determining how your condition(s) affects your ability to work.

You state you are disabled and unable to work due to slow learner, difficulty with numbers, poor eyesight, and high blood pressure . You are not performing any substantial work now.

The evidence we received shows your condition(s) causes some work-related restrictions but does not prevent you from doing all types of work. Your current work restrictions may prevent you from performing any work you may have done in the past. However, when we considered your age, education and past work experience, we found you are capable of performing a significant number of jobs in the national economy. Therefore, this claim is denied.

If your condition gets worse and keeps you from working, write, call or visit any Social Security office about filing another application.

WGU/

DISABILITY REPORT - APPEAL - Form SSA-3441-BK

Alice's Copy

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

We will use the information that you give us on this form to update your disability report information for your appeal. We will use the form to update your disability information **since you last completed a disability report.** Please complete as much of the form as you can. If you need help, your interviewer will help you finish it. If you have an appointment for an interview by telephone, have the form ready to discuss with us when we call you. If you have an appointment for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so. If you have access to the Internet, you may access the Disability Report Form - Appeal instructions at http://www.ssa.gov/online/ssa-3441.html.

If you are filling out the form for someone else, please provide information about him or her. When a question refers to "you," "your," or the "Disabled Person," it refers to the person who is applying for or has been entitled to disability benefits.

HOW TO COMPLETE THIS FORM

- Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 3, PUT INFORMATION ON ONLY ONE DOCTOR/HMO/THERAPIST/OTHER/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THIS FORM.** However, you can get help from other people, like a friend or family member.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use Section 10 - REMARKS on Page 7, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records or copies of prescriptions at home, send them to our office with your completed form or, if you are having an interview in our office, bring them and any medicine containers with you. If you need the records back, tell us and we will photocopy them and return them to you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of your medical sources, you may be able to get that information from the telephone book, medical bills, prescriptions, or prescription containers.

The Privacy Act

The Social Security Administration is authorized to collect the information on this form under sections 205(a) and (b), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on your claim or case. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on your claim or case. Although the information you furnish is almost never used for any purpose other than making a determination about your disability or continuing disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The Paperwork Reduction Act

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

AFTER COMPLETING THIS FORM, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

DISABILITY REPORT - APPEAL

For SSA Use Only -
Do not write in this box.

Related SSN – –

Number Holder

Date of Last Disability Report

Individual is filing: ☐ **Reconsideration** ☐ **Reconsideration for Disability Cessation** ☐ **Request for ALJ Hearing**

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. NAME *(First, Middle Initial, Last)*
Alice F. Terrell

B. SOCIAL SECURITY NUMBER
251-45-0731

C. DAYTIME TELEPHONE NUMBER *(If you do not have a number where we can reach you, give us a daytime number where we can leave a message.)*

(803) 593-9630
Area Code *Number*

☑ Your Number ☐ Message Number ☐ None

D. Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries, or conditions and can help you with your claim or case.

NAME Danelle S. Brooks RELATIONSHIP sister

ADDRESS 30 Hazel Grove Road
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

Beech Island SC 29842 DAYTIME PHONE (803) 827-0031
City *State* *ZIP* *Area Code* *Number*

SECTION 2 - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

A. Has there been any change (for better or worse) in your illnesses, injuries, or conditions **since you last completed a disability report?** ☑ Yes ☑ No

If "**Yes**," please describe in detail:

I have been going through alot of stuff with my eyes

Approximate date the changes occurred:

Month	Day	Year
9	14	07

B. Do you have any new physical or mental limitations as a result of your illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☑ No

If "**Yes**," please describe in detail:

Approximate date the changes occurred:

Month	Day	Year

C. Do you have any new illnesses, injuries or conditions **since you last completed a disability report?** ☑ Yes ☐ No

If "**Yes**," please describe in detail:

Blurry Vision and bloodpressure

Approximate date the changes occurred:

Month	Day	Year

If you need more space, use Section 10 - REMARKS.

SECTION 3 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. **Since you last completed a disability report,** have you seen or will you see a **doctor/hospital/clinic** or anyone else for the illnesses, injuries, or conditions that limit your ability to work? ☑ YES ☐ NO

B. **Since you last completed a disability report,** have you seen or will you see a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☑ NO

C. List **other names** you have used on your medical records.

If you answered "NO" to both A and B, go to Section 4 - MEDICATIONS.

Tell us who may have medical records or other information about your illnesses, injuries, or conditions **since you last completed a disability report.**

D. List each DOCTOR/HMO/THERAPIST/OTHER. Include your **next appointment.**

1.

NAME Doctor Youmans	DATE
STREET ADDRESS 5110 Woodside Executive Court	FIRST VISIT 10/1/07
CITY Aiken / STATE SC / ZIP 29803	LAST VISIT
PHONE (803) 643-0588 (Area Code / Phone Number) / PATIENT ID # (If known)	NEXT APPOINTMENT 11/1/07
REASONS FOR VISITS Bloodpressure, Headache eyes	
WHAT TREATMENT DID YOU RECEIVE? New Medicine giving	

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP -	LAST VISIT
PHONE ( ) - (Area Code) (Phone Number)	PATIENT ID # (if known)		NEXT APPOINTMENT
REASONS FOR VISITS			
WHAT TREATMENT DID YOU RECEIVE?			

If you need more space, use Section 10 - REMARKS.

E. List each HOSPITAL/CLINIC. Include your **next appointment.**

HOSPITAL/CLINIC		TYPE OF VISIT	DATES	
NAME		☐ INPATIENT STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS				
CITY	STATE ZIP -	☐ OUTPATIENT VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE ( ) - (Area Code) (Phone Number)		☐ EMERGENCY ROOM VISITS	DATES OF VISITS	

Next appointment _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you **receive?** _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Section 10 - REMARKS.

F. Since you last completed a disability report, does **anyone else have medical records or information** about your illnesses, injuries, or conditions (for example, Workers' Compensation, insurance companies, prisons, attorneys, or welfare agency), or are you scheduled to see anyone else? ☐ YES ☑ NO

If "**YES**," complete information below:

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST VISIT
PHONE ( ) - (Area Code) (Phone Number)			NEXT APPOINTMENT
CLAIM NUMBER (if any)			
REASONS FOR VISITS			

If you need more space, use Section 10 - REMARKS.

SECTION 4 - MEDICATIONS

Are you currently taking any **medications** for your illnesses, **injuries** or conditions? ☑ YES ☐ NO

If "**YES**," please tell us the following: (*Look at your medicine containers, if necessary.*)

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE
~~Hydrochlorothiazide~~	~~Suykerbuyk~~	~~High blood pressure~~	
potassium CL	~~Suykerbuyk~~		
Bisoprolol HCTZ	Dr Youmans	Blood pressure	

If you need more space, use Section 10 - REMARKS.

SECTION 5 - TESTS

Since you last completed a disability report, have you had any **medical tests** for illnesses, injuries, or conditions **or do you** have any such tests scheduled? ☐ YES ☑ NO

If "YES," please tell us **the following:** *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN WAS/WILL TEST BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY – Name of body part			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY – Name of body part			
MRI/CT SCAN – Name of body part			

If you need more space, use Section 10 - REMARKS.

SECTION 6 - UPDATED WORK INFORMATION

Have you **worked since you last completed a disability report?** ☐ YES ☑ NO

If **"YES,"** you **will be asked to give details** on a separate form.

SECTION 7 - INFORMATION ABOUT YOUR ACTIVITIES

A. How do your **illnesses, injuries**, or conditions affect your ability to care for your personal needs?

Well It is very hard to do different things For myself because of the changes that I Have in my eyes and I am tired all the time

B. What changes have occurred in your daily activities **since you last completed a disability report?**

If none, show **"NONE."** Alot of things has changed not being able to watch TV or clean up my house

If you need more space, use Section 10 - REMARKS.

SECTION 8 - EDUCATION/TRAINING INFORMATION

Have you completed any type of **special job training, trade or vocational school since you last completed a disability report?** ☐ YES ☑ NO

If **"YES,"** describe what type: _____

Approximate date completed: _____

SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Since you last completed a disability report, have you participated in the Ticket Program or another program of vocational rehabilitation services, employment services or other support services, to help you go to work? ☐ YES ☑ NO

If **"YES,"** complete the following information:

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____
(Number, Street, Apt. No.(if any), P.O. Box, or Rural Route)

_____ - _____
City *State* *ZIP*

DAYTIME PHONE NUMBER ( ) - _____
Area Code *Number*

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____
(IQ, vision, physicals, hearing, workshops, etc.)

SECTION 10 - REMARKS

Use this section for any additional information you did not show in earlier parts of this form. When you are finished with this section (or if you don't have anything to add), be sure to go to the next page and complete the blocks there.

Just wanted to say I have been not able To See good or my bloodpressure has been Going up and Down And I still have Problems with my back. right now I am going to this Doctor because OF my Bloodpressure And I will have To go to him Again. headaches alot due to Bloodpressure, I don't like to go around Alot of people so I don't stay at home Mostly. I still have trouble with my hand And my back Disc problem

I have never worked I was on SSI Before because I was Disabled so I didn't Work in the past. when I got married I Lost my SSI that is the only reason Check the records from 1988 to 2001 you will see.

Alice

I had to get help
with the papers

SECTION 10 - REMARKS

I used to get SSI A long time ago Because I Was slow I Never did have A Job And even if I Got one I don't Think I Could Keep it because of my Medical problems holds me back from It. I diill be getting alot of test Run because of my eyes

Thanks
Alice

Name of person completing this form *(Please print)*
Alice F. Terrell

Date Form Completed *(Month, day, year)*
10/2/07

Address *(Number and street)*
PO Box 817

e-mail address *(optional)*

City
Langley

State
SC

ZIP
29834

WHOSE *Records to be Disclosed*	Form Approved OMB No. 0960-0623
NAME *(First, Middle, Last)*	
SSN _ _	Birthday *(mm/dd/yy)*
SSA USE ONLY NUMBER HOLDER (If other than above)	
NAME	
SSN _ _	

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records;* also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s)** *including*, **and 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**
   - **Records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS); and tests for HIV.**
   - **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 educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
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, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"). **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability, and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask. I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY	**IF not signed by subject of disclosure, specify basis for authority to sign**
INDIVIDUAL authorizing disclosure	☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**
SIGN ▶ Alice Terrell	(Parent/guardian/personal representative sign here if two signatures required by State law) ▶
Date Signed 10/2/07	Street Address
Phone Number (with area code)	City / State / ZIP

WITNESS *I know the person signing this form or am satisfied of this person's identity.*

SIGN ▶	IF needed, second witness sign here (e.g., if signed with "X" above) **SIGN ▶**
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section

GPO U.S. GOVERNMENT PRINTING OFFICE: 2006—320-641/20032 Form HA-501-US (5-2003) ef (8-2005)

SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS

Form Approved
OMB No. 0960-0269

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **signed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)*

See Privacy Act Notice

1. CLAIMANT	2. WAGE EARNER, IF DIFFERENT	3. SOC. SEC. CLAIM NUMBER	4. SPOUSE's CLAIM NUMBER
Alice F Terrell		251-45-0731	- -

5. **I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE.** I disagree with the determination made on my claim because:
I do have alot of problems and I can't see to good

An Administrative Law Judge of the Office of Hearings and Appeals will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

6. I have additional evidence to submit. ☐ Yes ☐ No

Name and address of source of additional evidence.

(Please submit it to the hearing office within 10 days. Your servicing Social Security Office will provide the address. Attach an additional sheet if you need more space.)

7. Check one of the blocks:
- ☐ I wish to appear at a hearing
- ☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)

You have a right to be represented at the hearing. If you are not represented but would like to be, your Social Security office will give you a list of legal referral and service organizations. (If you are represented and have not done so previously, complete and submit form SSA-1696 (Appointment of Representative).)

[You should complete No. 8 and your representative (if any) should complete No. 9. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 9.]

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

8. (CLAIMANT'S SIGNATURE) (DATE)	9. (REPRESENTATIVE'S SIGNATURE/NAME) (DATE)
Alice F. Terrell 9/14/07	
ADDRESS: PO Box 877	(ADDRESS) ☐ ATTORNEY; ☐ NON ATTORNEY:
CITY: Langley STATE: SC ZIP CODE: 29834	CITY STATE ZIP CODE
TELEPHONE NUMBER: (803) 593-9630	TELEPHONE NUMBER ( ) -
FAX NUMBER ( ) -	FAX NUMBER ( ) -

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION-ACKNOWLEDGMENT OF REQUEST FOR HEARING

10. Request received for the Social Security Administration on _____ (Date) by: _____ (Print Name)

(Title) (Address) (Servicing FO Code) (PC Code)

11. Was the request for hearing received within 65 days of the reconsidered determination? ☐ YES ☐ NO
If no is checked, attach claimant's explanation for delay; and attach copy of appointment notice, letter, or other pertinent material or information in the Social Security office.

12. Claimant is represented ☐ Yes ☐ No
☐ List of legal referral and service organizations provided

13. Interpreter needed ☐ Yes ☐ No
Language (including sign language): _____

14. Check one:
- ☐ Initial Entitlement Case
- ☐ Disability Cessation Case
- ☐ Other Postentitlement Case

16. HO COPY SENT TO: _____ HO on _____
- ☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title VIII; or
- ☐ Title II CF held in FO to establish CAPS ORBIT; or
- ☐ CF requested ☐ Title II; ☐ Title XVI ☐ Title VIII
(Copy of teletype or phone report attached)

15. Check all claim types that apply:

☐ RSI only	(RSI)
☐ Title II Disability-worker or child only	(DIWC)
☐ Title II Disability-Widow(er) only	(DIWW)
☐ SSI Aged only	(SSIA)
☐ SSI Blind only	(SSIB)
☐ SSI Disability only	(SSID)
☐ SSI Aged/Title II	(SSAC)
☐ SSI Blind/Title II	(SSBC)
☐ SSI Disability/Title II	(SSDC)
☐ HI Entitlement	(HIE)

Log 0367

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

January 16, 2009

The Honorable J. Roland Smith
United States House of Representatives
519-B Blatt Building
Columbia, South Carolina 29211

Dear Representative Smith:

Thank you for contacting our agency on behalf of Ms. Alice Terrell regarding her Supplemental Security Income (SSI) benefits and healthcare needs.

We were unable to reach Ms. Terrell by phone, but responded in writing and provided her with information regarding SSI, as well as, other healthcare programs that may offer assistance with her prescriptions, inpatient hospitalization and other medical needs. She was also given a contact person to call should she have additional questions.

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
Director

EF/jcl

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

January 15, 2009

Ms. Alice Terrell
366 Piney Heights
Warrenville, South Carolina 29851

Dear Ms. Terrell:

Representative Roland Smith contacted our agency on your behalf regarding Supplemental Security Income (SSI) eligibility and your healthcare needs.

Your application for SSI through the Social Security Administration (SSA) was denied because you did not meet the disability criteria, and you are appealing the decision. Medicaid benefits are available automatically to individuals eligible for SSI. If you have any questions regarding your SSI appeal, please call the Columbia SSA Office of Adjudication and Review at (803) 799-7771.

An alternate health insurance option through AugeoBenefits offers a variety of health insurance plans from top-rated insurance carriers. You may wish to look over the enclosed brochure and contact them at 1-866-273-5613 or visit their website at www.augeobenefits.com/sc for additional information.

Enclosed is information on other programs and organizations that can assist residents in South Carolina with their healthcare needs, prescriptions and inpatient hospitalization. If you have any questions about the Medicaid program, please contact Ms. Jennifer Lynch at (803) 898-3965 or toll-free at 1-888-549-0820, Ext. 3965 and she will be happy to assist. We hope this information proves helpful.

Sincerely,

Alicia Jacobs

Alicia Jacobs
Deputy Director

AJ/cl
Enclosures

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