DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	11-3-08

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER J00245	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ CC: Ms. Forkner Cleared 11/12/08, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 11-13-08 [ ] 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.			

Attn: Jan Mallett

Log # 245

403 Toby Creek Road
Barnwell, SC 29812
November 25, 2008

VIA FACSIMILE 803-939-0078

The Honorable Joe Wilson
Second Congressional District of South Carolina
United States Congress
1700 Sunset Boulevard
West Columbia, SC 29169

Re: Gertrude Benenhaley
SSN 247-47-6875

Dear Congressman Wilson:

On October 27, 2008, I wrote to you with concerns regarding my aunt, Gertrude Benenhalely. I am humbled by the courteous, prompt and efficient manner in which your office listened to my concerns and provided assistance on behalf of this 90 year old beloved senior citizen.

Your office contacted the Department of Health and Human Services and they responded promptly with results that gave a positive resolution to Medicaid eligibility for my aunt. Ms. Forkner and her staff are also to be commended for their assistance to the needs of financial assistance.

It is indeed with a debt of gratitude that I express my appreciation for all that you and the Department of Health and Human Services have done. Miss Benenhaley has always exhibited a life of compassion as she cared for many children at Connie Maxwell Childrens Home, and now those young ladies return their devotion to her with phone calls and visits. They have told me that she had a tremendous impact on their lives as she instilled values and set examples for their future lives. These young women were so delighted when I told them that financial assistance has been provided for the ongoing care needs of Miss Benenhaley. I have made them aware of your intervention of her behalf.

Thank you again for your continued service to the citizens of this State. May God richly bless you, your family and your staff with the abundance of His bounty throughout the coming year!

Very truly yours,

Beverly H. Dixon

Beverly H. Dixon
898-5040

cc: Emma Forkner, Director
DHHS
Via Fax 255-8235

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

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Jacobs	11-3-08

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1.			
2.			
3.			
4.			

JOE WILSON
2ND DISTRICT, SOUTH CAROLINA

ASSISTANT REPUBLICAN WHIP

COMMITTEES:
ARMED SERVICES
EDUCATION AND LABOR
FOREIGN AFFAIRS
HOUSE POLICY

Congress of the United States
House of Representatives

COUNTIES:
AIKEN*
ALLENDALE
BARNWELL
BEAUFORT
CALHOUN*
HAMPTON
JASPER
LEXINGTON
ORANGEBURG*
RICHLAND*
(*PARTS OF)

DINO TEPPARA
CHIEF OF STAFF
AND COUNSEL

October 31, 2008

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

RE: Ms. Beverly H. Dixon for her mother, Gertrude Benenhaley [247-47-6875]

Dear Ms. Forkner,

I am writing to you on behalf of Beverly Dixon who has contacted me regarding Medicaid Benefits for her mother. Enclosed is a copy of all correspondence for your perusal. Any assistance that you could offer would be most appreciated.

It is an honor to represent the people of the Second Congressional District, and I value your input.

Please respond to the Midlands District Office at 1700 Sunset Blvd., West Columbia, South Carolina 29169; Fax number 803-939-0078. Thank you for your time and concern in this and all other matters.

Yours very truly,

Joe Wilson

JOE WILSON
Member of Congress

JW/jmc
Enclosure

MIDLANDS OFFICE:
1700 SUNSET BLVD. (US 378), SUITE 1
WEST COLUMBIA, SC 29169
(803) 939-0041
FAX: (803) 939-0078

212 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-4002
(202) 225-2452
FAX: (202) 225-2455
www.joewilson.house.gov

LOWCOUNTRY OFFICE:
903 PORT REPUBLIC STREET
P.O. BOX 1538
BEAUFORT, SC 29901
(843) 521-2530
FAX: (843) 521-2535

TOLL FREE 1-888-381-1442

Total Pages: 17
ATTN: Joann Caufield

403 Toby Creek Road
Barnwell, SC 29812
October 27, 2008

VIA FACSIMILE 803-939-0078

The Honorable Joe Wilson
Second Congressional District of South Carolina
United States Congress
1700 Sunset Boulevard
West Columbia, SC 29169

Re: Gertrude Benenhaley
SSN 247-47-6875

Dear Congressman Wilson:

I would personally like to acknowledge my appreciation for your position and all that you do for the citizens of this great State. As a Barnwell County resident and employee of the State, I am grateful for your commitment to service and will always maintain my support of and for you.

The purpose of my letter is to request your assistance in obtaining Medicaid benefits on behalf of my 90 year old aunt, Gertrude Benenhaley. I am Power of Attorney for my aunt, and I am enclosing a copy of this document for your files. Ms. Benenhaley is currently a resident at an assisted living facility (McElveen Manor) in Sumter. She is a retired employee of Connie Maxwell Children's Home in Greenwood. Other than Social Security, her only source of additional income is her retirement from Connie Maxwell. She has no other assets. On July 10, 2008, I completed a Medicaid Application, and was informed that this application was denied due to my aunt's income being approximately $60 in excess of Medicaid guidelines. Since that time, GuideStone Financial has sent a Proof of Termination effective August 31, 2008, for a grant in the amount of $200. I have spoken with the Department of Health and Human Services in Sumter and explained the current circumstances, and they have requested that I complete another application due to change in financial circumstances. I have complied with their request, and I am providing you with the entire package of information that has been sent to DHHS.

Congressman Wilson, if there is anything that you can do to assist in the expediting of this request, I would be most grateful. If you need any additional information, please call me at 803-898-5040.

Very truly yours,

Beverly H. Dixon

Enclosures

820/244

STATE OF SOUTH CAROLINA)
) DURABLE POWER OF ATTORNEY
COUNTY OF SUMTER)

KNOW ALL MEN BY THESE PRESENTS that, as Principal, I, Gertrude Benenhaley, do hereby make, constitute and appoint Beverly H. Dixon as my true and lawful attorney for me and in my name and stead,

1. To enter upon and take possession of any lands, building, tenements, or other structures, or any part, or parts, thereof, that may belong to me, or to the possession whereof I may be entitled;

2. To ask, collect and receive any rents, profits, issues, or income of any and all of such lands, buildings, tenements, or other structures, or any part of parts thereof;

3. To make, execute and deliver any deed, mortgage, or lease, whether with or without covenants and warranties, in respect of any such land, building, tenements, or other structures, or any part or parts thereof, and to manage any such lands, and to manage, repair, alter, rebuild or reconstruct any buildings, houses, or other structures, or any part or parts thereof, that may now or hereafter be erected upon such lands;

4. To demand, sue for, collect, recover and receive all goods, claims, debts, moneys, interest and demands whatsoever, now due, or that may hereafter be due, or belong to me (including the right to institute any action, suit, or legal proceeding, for the recovery of any land, buildings, tenements, or other structures, or any part or parts thereof, to the possession whereof I may be entitled), and to make, execute and deliver receipts, releases, or other discharges therefore, under seal or otherwise;

5. To make, execute, endorse, accept and deliver any and all bills of exchange, checks, drafts, notes and trade acceptances;

6. To pay all sums of money, at any time or times, that may hereafter be owing by me upon any bill of exchange, check, draft, note or trade acceptance, made, executed, endorsed, accepted and delivered by me, or for me, and in my name, by my said attorney;

GB

7. To sell any and all shares of stocks, bonds, or other securities now or hereafter belonging to me, that may be issued by any association, trust or corporation, whether private or public, to make, execute and deliver any assignment or assignments, of any such shares of stock, bonds or other securities, and to vote said shares of stock;

8. To defend, settle, adjust, compound, submit to arbitration and compromise all actions, suits, accounts, reckonings, claims and demands, whatsoever, that now or hereafter shall be pending between me and any person, firm or corporation, in such manner and in all respects as my said attorney shall think fit;

9. To hire accountants, attorneys at law, clerks, workmen and others, and to remove them and appoint others in their place, and to pay and allow the persons to be so employed such salaries, wages, or other remunerations as my said attorney shall think fit;

10. To enter into, make, sign, execute and deliver, acknowledge and perform any contract, agreement, writing, or thing that may in the opinion of my said attorney be necessary or proper to be entered into, made, or signed, sealed, executed, delivered, acknowledged or performed;

11. To make gifts to my spouse or issue for estate planning purposes, including gifts to my attorney, even though I may not have established a pattern of giving during my lifetime, except that no gifts to my issue may exceed the available annual exclusion from gift taxes in any year.

12. Without, in anywise, limiting the foregoing, generally to do, execute and perform any other act, deed, matter or thing, whatsoever, that ought to be done, executed and performed, or that in the opinion of my said attorney ought to be done, executed or performed in and about the premises, or every nature and kind, whatsoever, as fully and effectually as I could do it personally present;

13. This power of attorney shall not be affected by physical disability or mental incompetence of the principal which renders any the principal incapable of managing his/her own Estate; that is to say, that it is my intention that the authority which I have herein conferred upon my said attorney shall be exercisable to him/her notwithstanding any physical disability or mental incompetence which might hereinafter occur; and

14. I, Gertrude Benenhaley, the said Principal, do hereby ratify and confirm all whatsoever my said attorney shall do, or cause to be done, in or about the premises by virtue of this power of attorney.

IN WITNESS WHEREOF, as Principal, I have executed this Durable Power of Attorney this 19 day of October, 2001, and I have directed that photographic copies of this power be made which shall have the same force and effect as an original.

Gertrude Benenhaley
GERTRUDE BENENHALEY

STATE OF SOUTH CAROLINA)
) ATTESTATION
COUNTY OF SUMTER)

This Durable Power of Attorney was signed, sealed, published and declared by Gertrude Benenhaley as his/her appointment of an attorney-in-fact in the presence of us who, at his/her request and in his/her presence and in the presence of each other, have hereunto subscribed our names as witnesses hereto.

Witness

Katherine A. Burgess
Witness

STATE OF SOUTH CAROLINA)
) PROBATE
COUNTY OF SUMTER)

PERSONALLY appeared deponent and made oath that deponent saw the within named Principal, sign, seal and as the Principal's act and deed deliver the within Durable Power of Attorney and that deponent, with the other witnesse whose name is subscribed above, witnessed the execution thereof.

SWORN to before me this
19th day of October, 2001.
Katherine A. Burgess (L.S.)
Notary Public for South Carolina

My Commission Expires: 7-26-11

TOTAL PAGES: 12

403 Toby Creek Road
Barnwell, SC 29812
October 24, 2008

Via FACSIMILE 803-773-8883

Department of Social Services
Sumter, SC 29150

Re: Gertrude Benenhaley
SSN 247-46-6875

ATTN: LANA - MEDICAID DIVISION

I recently spoke with you regarding my aunt, and in compliance with your instructions, I have completed a Medicaid Application. I previously submitted an application to your office on July 10, 2008. I was informed that this application had been denied. Since that time, termination of income in the amount of $200 per month became effective on August 31, 2008. A copy of that letter from GuideStone is enclosed.

Your assistance in the expediting of this application will be greatly appreciated, as my aunt's resources are very limited and her monthly care at McElveen Manor is $1,400. This does not include her medications and other necessities.

Please let me know if there is any further information that you may need in the processing of this application. I may be reached during the day at 803-898-5040.

Your assistance in this matter is greatly appreciated.

Very truly yours,

Beverly H. Dixon

Beverly H. Dixon

Enclosures

South Carolina Department of Health and Human Services
Application for the South Carolina Medicaid Program

This application is developed specifically for Aged, Blind, or Disabled Adults.

Note: You only need to tell us the Social Security Number and answer the questions about being a US Citizen for the people for whom you want full Medicaid benefits. However, if you give us your Social Security Number, even if you are not applying for benefits, it may help us process your application faster. We only use Social Security Numbers to help us verify income.

- A citizen applying for Medicaid must provide original documents to prove US citizenship and identity
- A non-citizen applying for Medicaid must provide Bureau of Citizenship and Immigration Services (BCIS) documents to support his/her legal entry into the US.
- A non-citizen applying for Emergency Services Only is not required to provide these documents or a Social Security Number.

1. Tell us about yourself. **Date received by DHHS:**

Name (First, Middle Initial, Last):	**Social Security Number**: (not required for emergency services)	**Date of Birth:**
GERTRUDE W. BENENHALEY	247-46-6875	08-22-1918

Address where you get mail (include apartment number):	**City:**	**State:**	**Zip Code:**	**County:**
403 TOBY CREEK ROAD	BARNWELL	SC	29812	BARNWELL

Home Address (if not the same as your mailing address):	**City:**	**State:**	**Zip Code:**	**Telephone Number:**
				( )

Your Full Name at Birth: This helps us verify citizenship	**Your Mother's Full Name at her Birth:**	**County/State where you were born:**
GERTRUDE WILHEMENIA BENENHALEY	MARY RAY	SUMTER SC

Do you want Medicaid for yourself?	**Sex:**	**Marital Status:**	**Are you currently attending school?**	**Check all that apply:**	**What language do you use most?**
☑ Yes ☐ No	☑ Female ☐ Male	☑ Single ☐ Widowed ☐ Married ☐ Separated ☐ Divorced	☐ Yes ☑ No If yes, what grade? ___	☑ US Citizen ☑ Disabled ☐ Pregnant ☐ Emergency Services Only	☑ English ☐ Sign Language ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ Other _____ ☐ Russian

Medicare Number, if applicable:	**Race:**
247-46-6875-A	☑ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Cuban ☐ Refugee Entrant ☐ Puerto Rican ☐ Hispanic ☐ Asian American/Oriental ☐ Other

If an Authorized Representative is completing this application, please complete the following:

Name: BEVERLY H. DIXON

Address: 403 TOBY CREEK ROAD
BARNWELL, SC 29812

Phone Number: 803-898-5040 (W)
803-259-1419 (H)

Relationship: NEICE/POA

APPLICANT-RESIDENT OF McELVEEN MANOR
SUMTER, SC

2. Tell us about the people who live with you A Social Security Number is not required if applying for Emergency Services Only.

Name: (First, Middle Initial, Last)		**Social Security Number:**		**Full Name at Birth:**	**Mother's Full Name at her Birth:**
Is this person applying for Medicaid? ☐ Yes ☐ No	**Check all that apply:** ☐ US Citizen ☐ Disabled ☐ Pregnant ☐ Emergency Services Only	**Sex:** ☐ Female ☐ Male **Date of Birth:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	**How is this person related to the person on page 1?** ☐ Child ☐ Spouse ☐ Other: ________	**Currently attending school?** ☐ Yes ☐ No If yes, what grade? ________ / **County/State where you were born:**
Medicare Number, if applicable:		**Race:** ☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other			

Name: (First, Middle Initial, Last)		**Social Security Number:**		**Full Name at Birth:**	**Mother's Full Name at her Birth:**
Is this person applying for Medicaid? ☐ Yes ☐ No	**Check all that apply:** ☐ US Citizen ☐ Disabled ☐ Pregnant ☐ Emergency Services Only	**Sex:** ☐ Female ☐ Male **Date of Birth:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	**How is this person related to the person on page 1?** ☐ Child ☐ Spouse ☐ Other: ________	**Currently attending school?** ☐ Yes ☐ No If yes, what grade? ________ / **County/State where you were born:**
Medicare Number, if applicable:		**Race:** ☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other			

Name: (First, Middle Initial, Last)		**Social Security Number:**		**Full Name at Birth:**	**Mother's Full Name at her Birth:**
Is this person applying for Medicaid? ☐ Yes ☐ No	**Check all that apply:** ☐ US Citizen ☐ Disabled ☐ Pregnant ☐ Emergency Services Only	**Sex:** ☐ Female ☐ Male **Date of Birth:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	**How is this person related to the person on page 1?** ☐ Child ☐ Spouse ☐ Other: ________	**Currently attending school?** ☐ Yes ☐ No If yes, what grade? ________ / **County/State where you were born:**
Medicare Number, if applicable:		**Race:** ☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental ☐ Refugee Entrant ☐ Other			

3. Retroactive

Did you or anyone who lives with you receive medical services in the past 3 months?

Who? ______________________ Which month(s)? ______________________

In order for us to determine eligibility for these month(s), you are required to provide proof of income and resources for each month listed.

4. Tell us how much income your family has.
Enter GROSS pay before taxes and deductions, not take home pay. Enter zero ("0") if you are not working. **You must send us proof of income for the past 4 weeks.**

Your Income from Employment	Other Parent's/Spouse's Income from Employment (or living in the home)
Name of person employed N/A	Name of person employed
Employer's Name	Employer's Name
Employer's Address	Employer's Address
Employer's Phone Number (including area code)	Employer's Phone Number (including area code)
Gross amount earned per pay period before taxes? $	Gross amount earned per pay period before taxes? $
How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly	How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly
Still employed? ☐ Yes ☐ No If no, where did you work last?	*Still employed? ☐ Yes ☐ No If no, where did you work last?*
When did you stop working there?	When did you stop working there?

Is anyone self-employed? ☐ Yes ☐ No If yes, please name Self-Employment Business and/or Partnership

You must send copies of all the most recently filed Federal income tax forms with all schedules.

Other Income	Amount	Which family member gets this income?	How often is this income received?
Child Support	$ —		
Alimony	$ —		
Social Security Income	$ 516.00	APPLICANT	MONTHLY
Unemployment Benefits	$ —		
Veterans Benefits	$ —		
Workers Compensation/Long Term or Short Term Disability	$ —		
Money from Friends/Relatives	$ —		
Retirement/Pensions/Annuities	$ 38.46 351.61 > 390.07	APPLICANT	MONTHLY
Other Income (*Please Explain*)	$ —		

5. If your family does not have any source of income, explain in the space below how your household bills are being paid.

_____

_____

6. Does anyone in your family own the following? You must send proof of Assets/Resources with this application.

Asset/Resource	Yes	No	Company name, address, and phone #; Account/Policy number; and/or Description	Who does it belong to?	What is the value?	How much is owed?
Cash on Hand	✓		WACHOVIA BANK, NA	APPLICANT	$ 616.45	
Checking Account(s)					$	
Savings Account(s)			NONE		$	
Certificate(s) of Deposit			NONE		$	
Annuities/Trusts/Stocks/ Bonds	✓		GUIDESTONE FINANCIAL		$	
Home Property (location/description)			NONE		$	$
Other Property (location/description)			NONE		$	$
Life/Burial insurance					$	$
Burial Contracts					$	$
Burial Plots					$	$
Vehicles (make, model, year)					$	$
Retirement Account					$	$
Other (please be specific)					$	$

7. Do you pay someone to take care of your child(ren) under 12 and/or a dependent adult while you work or attend school?

☐ Yes ☐ No _____ Number of children under age 12 and/or dependent adults for whom you pay for care. **You must provide proof of this payment.**

8. Tell us about any health or medical insurance covering anyone for whom you are applying. Please send us a copy of the card(s), front and back. Include Medicaid in another state. Even if you already have health insurance, you can still qualify for Medicaid.

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
GUIDESTONE / UNUM	SHOWN UNDER GROUP COVERAGE DOES NOT PROVIDE INDIVIDUAL POLICY NO.				

IMPORTANT

Check below to tell us what you attached.

- **Sending this information in with the application will help us to process your application faster.**
- **You must read and sign this form on the last page to complete your application.**

☑ Proof Of Income

- ☐ Copies of pay stubs for the **last 4 weeks for any adult person listed**; *or* a letter from employer that shows last 4 weeks of GROSS pay.
- ☐ A copy of the letter telling the gross amount of any benefits received (Social Security, Unemployment, VA, Workers' Compensation, etc.)
- ☐ Proof of all other income for the last 4 weeks, including child support.

NOTE: You may be required to apply for additional potential benefits, such as unemployment or Social Security Benefits.

- ☐ Proof of Assets/Resources listed in application.
- ☐ Proof of income/resources for the past 3 months if you have received medical services.
- ☐ Most recent income tax forms including all schedules, if you are self employed.
- ☐ Proof of due date from doctor, nurse, or Health Department for each pregnant woman.
- ☐ Verification of the childcare/dependent adult expenses (statement from daycare, receipt, etc.)
- ☐ Bureau of Citizenship and Immigration Services (BCIS) documents for each non-citizen applying for full Medicaid. Does not apply to Emergency Services Only.
- ☐ Original Documents of citizenship and identity for each US citizen applying for Medicaid. (If you have provided this information before, you do not have to provide it again.)

ALSO ENCLOSING:
1) PROOF OF FINANCIAL TERMINATI FROM GUIDESTONE
2) INSURANCE CARDS

Other documents can be used to provide proof. If you are not sure what to send, call our toll-free line at 1-888-549-0820 for help.

The South Carolina Department of Social Services' Child Support Enforcement Division (CSED) provides services to establish paternity and child support, modify child support orders, and enforce support orders. Services are available to Medicaid beneficiaries without charge. I understand that if I check "no" and ask for child support services later, I will have to pay a $25 fee. I want to voluntarily apply for these services: ☐ Yes ☐ No

Rights and Responsibilities

1. I know that my children under age 19 who are eligible for Partners for Health Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Medicaid Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Medicaid Card(s).
   a. I know that, in accordance with the federal rules governing the Medicaid Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.
   b. I know that, in accordance with the federal rules governing the Medicaid Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about my family and me with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medicaid programs, and the TANF and Food Stamp agency (DSS, in this state). Immigration status will be verified with the Department of Homeland Security (DHS).
   c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.
   d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.
3. I know that my Social Security Number, which I am required to provide, under §1137(a)(1) of the Social Security Act [42 U.S.C. 1320b-7(a)(1)], may be used or released in connection with the exceptions in Item 2, above.
4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.
5. I know that the Medicaid program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Medicaid has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.
6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Medicaid coverage.
7. I understand that I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.
8. I know that I may request a hearing if I believe an error has been made in processing my application.

☐ **I have read the Rights and Responsibilities, or they have been read to me.** *(If possible, both the Applicant and Authorized Representative should sign.)*

Applicant's Signature: Gertrude Beasley Date:

Signature of Authorized Representative: Beverly H. Dilon, PA Date: October 24, 2008

Mission:Dignity
Assisting Retired Ministers and Spouses

August 26, 2008

6730
GERTRUDE W BENENHALEY
403 TOBY CREEK RD
BARNWELL SC 29812-3806

PROOF OF TERMINATION

We have terminated the monthly grant from the Mission:Dignity (formerly Adopt An Annuitant) program for the following:

Name: GERTRUDE W. BENENHALEY
Grant amount: $200.00
Termination date: AUGUST 31, 2008

Guidelines for Mission:Dignity do not permit payments to persons who receive Medicaid or other income-based assistance. Therefore, we have terminated the monthly payment from their Mission:Dignity grant.

If you have any questions, please contact us at the address on this letter or call 1-888-98-GUIDE (1-888-984-8433) and ask a Customer Service representative for the Department of Financial Assistance.

Sincerely,

Department of Financial Assistance

Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
GERTRUDE BENENHALEY

CLAIM NUMBER
247-46-6875-A

SEX
FEMALE

IS ENTITLED TO
HOSPITAL INSURANCE
MEDICAL INSURANCE

EFFECTIVE DATE
8-1-83
8-1-83

SIGN HERE ▷ Gertrude Benenh

AARP HEALTH CARE OPTIONS

Insured Member
GERTRUDE W BENENHALEY

Membership No.
09454064511

001082
MEDICARE SUPPLEMENT COVERAGE

Wachovia Bank, N.A.
SC3272
930 Assembly Street
Columbia, SC 29201

Tel 803 253-6754
Fax 803 253-6757

Access Fifty Checking

S1 1001019839309 008 30 0 104 SAFEKEPT Replacement Statement 004

WACHOVIA

GERTRUDE BERENHALEY
BEVERLY H DIXON PS
403 TOBY CREEK ROAD
BARNWELL SC 29812

Access Fifty Checking 9/09/2008 thru 10/09/2008

Account number: 1001019839309
Account owner(s): GERTRUDE BERENHALEY
BEVERLY H DIXON

Account Summary

Opening balance 9/09	$3,227.03	
Deposits and other credits	1,086.07	+
Checks	3,606.07	-
Automated Checks	59.83	-
Other withdrawals and service fees	120.75	-
Closing balance 10/08	3616.45	

Deposits and Other Credits

Date	Amount	Description	
9/18	100.00	DEPOSIT	0000004551956820
9/30	38.46	AUTOMATED CREDIT GUIDESTONE FINAN RETIRE PMT CO. ID. 1790928948 080930 PPD	4200827091386709
9/30	351.61	AUTOMATED CREDIT GUIDESTONE FINAN RETIRE PMT CO. ID. 1750939948 080930 PPD	4200827091286604
10/03	576.00	AUTOMATED CREDIT US TREASURY 303 SOC SEC CO. ID. 3021036030 081003 PPD	4200827522974865
Total	$1,086.07		

Checks

Number	Amount	Date	Number	Amount	Date	Number	Amount	Date	
2061	20.50	9/10	2065	1,000.00	9/12	2068	1,400.00	10/08	5857648010 12511170720 5197571221
2062	111.94	9/10	2066	18.27	9/23	Total	$3,606.07		11505924460 14586711120
2064*	55.36	9/11	2067	1,000.00	9/25				18842656660 19838333310

*Indicates a break in check number sequence (checks could be listed under Automated Checks)

Automated Checks

Number	Amount	Date	Description	
2063	59.83	9/12	AUTOMATED CHECK VERIZON WEST ARC VERIZONTX CO. ID. 1005027730 080912 ARC MISC 2063	4200823691286955
Total	$59.83			

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Other Withdrawals and Service Fees

Date	Amount	Description	
10/06	130.75	AUTOMATED DEBIT AARP HEALTH CARE PREMIUM CO. ID. 1936069387 081006 PPD	220082780643491
Total	$130.75		

Daily Balance Summary

Dates	Amount	Dates	Amount	Dates	Amount
09/10	3,194.99	09/23	2,241.13	10/06	2,016.45
09/11	3,138.81	09/25	1,941.13	10/09	616.45
09/12	2,079.40	09/30	1,621.20		
09/18	2,259.40	10/03	2,147.20		

Effective immediately, the maximum ATM cash withdrawal limit per calendar day for
Check Cards ranges from $100 - $2,000 based on the type of account you maintain.
The maximum limit for ATM Cards ranges from $100 - $1,500. An ATM cash withdrawal
limit is just one way Wachovia protects your account. For more information about
Wachovia's efforts to protect you, visit wachovia.com/securityplus.

Effective December 1, 2008 the non-Wachovia ATM fee for withdrawals, transfers, and
balance inquiries at a non-Wachovia ATM in a foreign country will be $5.00 each.

Earn $25 or more with Wachovia! With our Customer Referral Program, when you tell
someone why you're with Wachovia and they open a Wachovia Free Checking account
we'll give you both $25. And now, making a referral is easier than ever with our new
online referral option. Visit wachovia.com/referral for more details.

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Access Fifty Checking

02 1001019819309 008 1c 0 104 SAFEKEPT Replacement Statement 004

WACHOVIA

Customer Service Information

	Phone Number	Address
Checking & Savings Accounts, Check Card & ATM Card	800-WACHOVIA 800-922-4684	WACHOVIA BANK, NATIONAL ASSOCIATION NC8502 P O BOX 563966 CHARLOTTE NC 28256-3966
TDD (For the Hearing Impaired) En español para cuentas corrientes y de ahorros	800-835-7721 800-326-8977	
Bank By Mail (Deposits Only)		WACHOVIA BANK, NATIONAL ASSOCIATION VA3289 P O BOX 26090 RICHMOND VA 23260-6090
Consumer Loan Accounts	800-347-1131	WACHOVIA BANK, NATIONAL ASSOCIATION VA0343 P O BOX 13327 ROANOKE VA 24040-0343

In Case of Errors or Questions About Your Electronic Transfers: Telephone us at 800-WACHOVIA, 800-922-4684, or write to us at WACHOVIA BANK, NATIONAL ASSOCIATION, NC8502, P O BOX 563966, CHARLOTTE NC 28256-3966, as soon as you can, if you think your statement or receipt is wrong or if you need more information about a transfer on the statement or receipt. We must hear from you no later than 60 days after we sent you the FIRST statement on which the error or problem appeared.
1. Tell us your name and account number (if any).
2. Describe the error or the transfer you are unsure about, and explain as clearly as you can why you believe there is an error or why you need more information.
3. Tell us the dollar amount of the suspected error.
We will investigate your complaint and will correct any error promptly. If we take more than 10 business days to do this, we will credit your account for the amount you think is in error. You will have use of the money during the time it takes us to complete our investigation.

Log # 0345

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

November 12, 2008

The Honorable Joe Wilson
United States House of Representatives
Midlands District Office
1700 Sunset Boulevard, Suite 1
West Columbia, South Carolina 29169

Dear Congressman Wilson:

Thank you for contacting our agency on behalf of Ms. Beverly H. Dixon concerning her questions about Medicaid eligibility for her aunt, Ms. Gertrude Benenhaley of Sumter, South Carolina.

A member of our staff has been in direct contact with Ms. Dixon regarding her aunt's healthcare needs as well as Medicaid eligibility and the rules and regulations governing the program.

We appreciate 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/jcoll

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

November 10, 2008

Ms. Gertrude W. Benenhaley
c/o Ms. Beverly H. Dixon
403 Toby Creek Road
Barnwell, South Carolina 29812

Dear Ms. Benenhaley:

Congressman Joe Wilson contacted our agency on your behalf regarding your concerns about Medicaid eligibility. We have been in direct contact with your niece and Power of Attorney, Beverly H. Dixon, regarding your healthcare needs.

We are currently processing your application to determine eligibility under the Optional State Supplementation (OSS) program. The OSS program is for individuals who are aged, blind or disabled and reside in a community residential care facility. Your eligibility worker, Ms. Lana Baird, has been in contact with your niece and will do all possible to expedite your eligibility determination.

If you have any questions about the Medicaid program or application process, please call Ms. Baird at (803) 773-5531, Ext 232. We hope this information is helpful.

Sincerely,

Alicia Jacobs

Alicia Jacobs
Acting Deputy Director

AJ/coll

cc: Beverly H. Dixon, Power of Attorney

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