DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Lupra	3/10/14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000308	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR CC: Lynch, Threatt Cleared 3/25/14, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 3-19-14 [ ] 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.			

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1.			
2.			
3.			
4.			

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

Committees:
Ways & Means, 3rd V.C.
Transportation and Regulatory
Subcommittee, Chairman
Revenue Policy
Invitations & Memorial Resolutions

House of Representatives
State of South Carolina

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

Tel. (803) 734-3115

March 6, 2014

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

RE: Gilbert B. Ryals, Sr.; SSN.....2225; DOB Mar. 3, 1932

Dear Mr. Keck:

I am writing this letter on behalf of constituents of mine, Ms. Amanda Cason and her father, Mr. Gilbert B. Ryals, Sr. Ms. Cason contacted me requesting assistance with Mr. Ryals application for Medicaid Nursing Home benefits.

It is my understanding that this is a very time sensitive situation and I am asking you to please consider the enclosed application as expeditiously as possible.

Thanking you in advance for your assistance in this matter.

Respectfully,

J. Roland Smith

J. Roland Smith
House District 84

Enclosures

cc: Amanda Cason, POB 76, Langley, SC 29834

RECEIVED
MAR 10 2014
Department of Health & Human Services
OFFICE OF THE DIRECTOR

AIKEN PSYCHIATRIC & PSYCHOTHERAPY ASSOC.
DAVID A. STEINER, M.D.
33 VARDEN DRIVE
AIKEN, SC 29803-5614
(803) 642-3604 TEL
(803) 642-5536 FAX
DEA#: BS1524893(SC), FS 2444588(GA)
LIC #: 16256(SC), 41969(GA)

NAME Gilbert Ryals DOB
ADDRESS DATE 3/4/14

TAMPER-RESISTANT FEATURES INCLUDE: SAFETY-BLUE ERASE-RESISTANT BACKGROUND, "ILLEGAL" PANTOGRAPH AND REFILL INDICATOR

℞ Gilbert Ryals is a patient of the undersigned and he requires hospitalization in a nursing home due to his severe dementia and need for daily supervision.

Label
Refill: NR 1 2 3 4 5

DISPENSE AS WRITTEN SUBSTITUTION PERMITTED

AAPS0414839

Adriana

MEDICAID CHECKLIST FOR NURSING HOME ASSISTANCE, GENERAL HOSPITAL, HOME AND COMMUNITY BASED WAIVER SERVICE

Applicant/Beneficiary: Gilbert B. Ryals, Sr Date: 2/28/2014

Authorized Representative: Amanda Cason

Application Date: 2/7/2014

We are currently working on your application/review for Medicaid long-term care services. To complete the eligibility process, some additional information will be needed concerning you, and if married, your spouse. **Please see the items ☑ checked below:**

- ☐ Complete the Attached Review Form
- ☐ Power of Attorney, Guardianship, or Conservator Papers
- ☐ Verification of ☐ Citizenship ☐ Identity Original Documents Required.
- ☐ The income limit for institutional care is $_____ for _____. The applicant's income is over this amount. To possibly qualify for Medicaid assistance for long-term care services, an income trust must be established. You will find the forms needed to complete this process attached.
- ☐ Proof of gross income received by _____. This may be a copy of an itemized check-stub, award letter, PRINTOUT, or statement on letterhead from the company or agency.
- ☒ For all accounts, copies of **entire** bank statements, not account summaries, for February 2014, January 2014, February 2013, February 2012, February 2011, February 2010, February 2009, and the following month(s): Please submit complete bank statements for months/years listed above. If any accounts have opened or closed within this time, please submit verification from banks.
- ☐ Designate or establish a bank account for income to flow through. Return verification of this account.
- ☒ Proof of assets sold, transferred, or given away on or after February 2009 to the present. _____
- ☐ Verification you have applied for _____ benefits on the applicant's behalf.
- ☐ Burial Assets: Copies of the applicant/spouse's ☐ Pre-need burial contract(s) ☐ burial plot deed(s) or other verification of ownership such as a statement on letterhead. If the contract or plot is not paid for, we also need verification of the payoff amount.
- ☒ Copies of all life insurance policies owned by the applicant/spouse. If the policy is not on hand, a letter from the agent showing the policy number, name of owner, face value, and current cash value of the policy can be provided. If this is not possible, give the name and address of the insurance company, and the policy number for each policy. The owner of the policy needs to sign and date DHHS Form 1280 ME, Verification of Insurance Value, to let us verify current cash values directly from the insurance company.
- ☐ Copy of annuity for _____
- ☒ Please sign and return the form(s) indicated:
  - ☒ DHHS 943, Release of Information
  - ☐ DHHS 1766-A, Burial Exclusion
  - ☐ DHHS 1280 ME, Verification of Insurance Value
  - ☒ DHHS 1282, Authorized Representatives Acknowledgement of Responsibilities
  - ☐ DHHS 1212 ME, Verification of Veterans Information
  - ☐ DHHS 1253 ME, Request for Financial Investigation
  - ☐ DHHS 1296 ER, Estate Recovery Notification
- ☐ All medical insurance policies or cards and proof of premiums
- ☒ Other: Please Complete 3400-B - attached
- ☒ Other: ****PLEASE RETURN THIS CHECKLIST WITH YOUR INFORMATION****

Please provide this information by 3/21/14. **If you have any questions or you need additional time to secure requested information,** please call your worker listed below. Thank you for your cooperation.

Worker: SCDHHS - CENTRAL MAIL Telephone: 803-643-1938

Address: P.O. BOX 100101 Fax: 803-643-1911

COLUMBIA, SC 29202-3101

Healthy Connections

South Carolina Department of Health and Human Services

Additional Information for Institutional and In-Home Care

Nursing Home **In-Home Care**

This form is used to gather other information needed to make a decision about eligibility for Nursing Home, Institutional or In-Home care. All of the rights and responsibilities agreed to when the original application was signed are still in effect. If there are any questions about those rights and responsibilities or questions about this form, please contact Healthy Connections at 1-888-549-0820.

1. Who is the person needing assistance?

a. Name (First, Middle, Last) enjaimar Gilbert ~~Robert~~ Ryals Sr. | b. Social Security Number | c. Date of birth (mm/dd/yyyy) 3/3/1932

2. Where is the person right now? ☐ Home ☐ Hospital ☑ Nursing Home ☐ Other

If not at home, tell us where the person is.

Name of facility: Trinity

Date entered facility: _____

3. Please check if anyone has Conservatorship, Guardianship, or Power of Attorney for the applicant.

If yes, please give us a copy of the legal papers and the name and phone number of the person.

☐ Conservatorship Name: N/A

☐ Guardianship Name: _____

☐ Power of Attorney Name: _____

4. If married and entering a nursing home, does the applicant want to give (allocate) part or all of income to spouse remaining at home? ☐ Yes ☑ No

5. If there are dependent children or dependent adults, does the applicant want to give (allocate) income to the dependent children or dependent adults? ☐ Yes ☑ No

6. Has the applicant or spouse ever worked somewhere that has a retirement benefit for which he or she may be eligible to receive money? ☐ Yes ☑ No

If YES, who was working, where and for how long? _____

7. Do you or anyone in your home receive, or have applied for, any other income? ☐ Yes ☐ No

Before we can make a decision on your application, you may have to give us proof of income for the past 4 weeks.

If **YES**, check all boxes that apply and complete the table below. If you have already told us about a type of income on your application, you do not have to tell us about it again.

☑ Supplemental Security Income (SSI) ☐ Child support ☐ Disability benefits

☐ Veterans Administration (VA) benefits ☐ Military allotments ☐ Money from friends or relatives

☐ Federal retirement (Civil Service, FERS) ☐ Land contract, mortgage or other notes payable to a household member (Please provide a copy of the contract, mortgage, note or other agreement)

Person receiving/expecting money	Income source/type	How often received	Amount received	Comments
Gilbert Ryals Sr.	SSI.	3rd of month	1100.00	

8. Please check the box beside any of the things shown that you or someone in your home owns or are buying. Tell us about it in the table. When you return this form, you must send proof of these assets or resources.

- ☐ Bank Checking Account
- ☐ Bank Savings Account
- ☐ Certificate of Deposit
- ☐ Trust Fund or Trust Account
- ☐ Safe Deposit Box (include contents)
- ☐ Car, Truck, Van
- ☐ Annuity (provide a copy)
- ☐ Cash on Hand
- ☐ Stocks, Bonds, Mutual Funds
- ☐ Motorcycle, Boat, Camper
- ☐ Farm Machinery or Business Equipment
- ☐ Pre-Need Burial Contract
- ☐ Cemetery Burial Space
- ☐ Money Set Aside for Burial
- ☐ DirectExpress Debit Card for SSA, SSI or other benefits
- ☐ 401k, IRA, or Retirement Account
- ☐ Life Insurance
- ☐ Other: N/A
  please be specific

Owned by	Tell Us About The Asset Include the name of bank or funeral home, and any account numbers or other information used to identify the asset.	Current Value or Balance
a.		
b.		
c.		
d.		
e.		
f.		

9. Do you or your spouse own any property?

If you answer YES to any of the following questions, please tell us about the property.

Home (house, buildings and land where you live)	☐ Yes	☑ No
Other House or Building (not your home)	☐ Yes	☑ No
Land (not connected to the home)	☐ Yes	☑ No
Vacation Home or Time Share Property	☐ Yes	☑ No

What is the address/location of the property?
List Home Property First

_____

_____

_____

Owner's Name: _____

Is this your Home Property or Primary Residence where you currently live or where you want to return to live if you are living somewhere else?

☐ Yes ☐ No

What is the address/location of the property?

_____

_____

_____

Owner's Name: _____

10. Does anyone else have a bank account or any other asset for the applicant or spouse?

☐ Yes ☑ No

If YES, at what bank or location, and in whose names? _____

11. Has the applicant or spouse closed any bank accounts in the past five (5) years? ☐ Yes ☐ ~~No~~

If YES, at what bank, and in whose names?

A. _____ B. _____

Date Closed: _____ Date Closed: _____

Closing Balance: _____ Closing Balance: _____

12. Has the applicant or spouse sold or given as a gift, any cash, property, vehicle, boat or other resource to any person any time in the past five (5) years? ☐ Yes ☐ ~~No~~

Item Sold or Given Away	Person to whom it was Sold or Given	Date Given or Sold	Amt. Received

13. Where has the applicant lived in the past five (5) years?

City	County	State (Use 2-letter abbreviation)	From	To
Langley SC.	Aiken	SC	2011	2014

14. If ever married, give the following information about the applicant's spouse(s). (List the most recent first.)

Name of most recent spouse: N/A

☐ Living

☐ In a medical facility ☐ Separated: when or how long? _____

☐ Married, living together ☐ Divorced (list Date, State and County where divorce was filed):

☐ Married, living apart (not separated) _____

Current Address: _____ Phone number: _____

☐ Deceased

Date of death: _____ State and County where estate was probated: _____

Name of next most recent spouse: Peggy W Reyals - Divorced 1980's

☑ ~~Divorced~~ Date and place divorce was filed: _____

☐ ~~Deceased~~ Date of death: _____

State and County where estate was probated: _____

Name of next most recent spouse: _____

☐ Divorced Date and place divorce was filed: _____

☐ Deceased Date of death: _____

State and County where estate was probated: _____

15. Give the following information about the applicant's mother and father, if known.

Mother: Bertha Ryals

☐ Living Address: _____ Phone number: _____

☑ Deceased Date of Death: _____ County & State where estate was probated: _____

Father: Shade Ryals

☐ Living Address: _____ Phone number: _____

☑ Deceased Date of Death: _____ County & State where estate was probated: _____

Signature of person completing this form:	Relationship
Amanda Cason	daughter

Please print this form, then sign it on the line above before submitting.

ESTATE RECOVERY

(BE SURE TO GET A COPY OF THE ESTATE RECOVERY BROCHURE)

As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:

- A person of any age who was a patient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
- A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.

FOR SCDHHS USE ONLY	
Verifications in File: ☐ DHHS 1255 ME ☐ DHHS 1253 ME	Level of Care Verified: ☐ Intermediate ☐ Skilled ☐ SNF (Medicare)
Checked for Transfers: ☐ Yes ☐ No	Were any Transfers Discovered: ☐ Yes ☐ No
Calculated Sanction Period: _____	

South Carolina Department of Health and Human Services

INFORMATION RELEASE FORM

I hereby authorize the South Carolina Department of Health and Human Services to verify my income including but not limited to Social Security, Supplemental Security Income, Veterans Benefits, private pensions, earned income, etc.; my resources including but not limited to checking and savings accounts, certificates of deposit, individual retirement accounts, credit union accounts, etc.; insurance, medical history, and expenses; and any other facts relevant to my eligibility for participation in programs administered by the Department of Health and Human Services.

I also authorize any person, partnership, corporation, association, or governmental agency possessing information on such matters to release such information to the Department of Health and Human Services.

I certify that I have read the above statement and understand that this gives my permission for release of such information.

Print your name: Amanda Cason

Signature: Amanda Cason

Address: P.O Box 76 Langley SC 29834

Witnesses to Signature (if signed by an X): 1. _____

2. _____

Authorization For Release Of Information And Appointment Of Authorized Representative For Medicaid Applications/Reviews And Appeals

You can choose an authorized representative.

You can give a trusted person permission to talk about your application with us, see your information, and act for you on matters related to your application, including getting information about your application and signing your application on your behalf. This person can also act for you on other matters including reviews, appeals and managed care processes. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Healthy Connections. If you're a legally appointed representative for someone on this application, submit proof with the application.
The Medicaid eligibility worker can release any information regarding my application/review and status to my authorized representative or any member of the organization indicated on this form.

1. Member name Amanda Cason	2. Social Security Number [redacted] - 253-44-2225
3. Name of authorized representative (First name, Middle name, Last name) Gilbert B. Rgalo SR	

4. Home address (Leave blank if you don't have one.)	5. Apartment or suite number
Langley	

6. City	7. State	8. ZIP code
	SC	29834

9. Phone number	10. Other phone number
(803) 522 5968	( )

11. Organization name (if applicable)	12. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

13. Your signature Gilbert Rgalo SR	14. Date (mm/dd/yyyy) 3-5-14

Please print this form, then sign it on the line above before submitting.
If signing with an "X," please have two people sign below as witnesses.

Witness: [signature] LMSW Witness: _____

☐ The Member is incapacitated and is unable to sign.* Please provide the reason(s) below:

_____

_____

***SCDHHS reserves the right to verify the member's inability to sign.**

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

Authorization For Release Of Information And Appointment Of Authorized Representative For Medicaid Applications/Reviews And Appeals

You can choose an authorized representative.

You can give a trusted person permission to talk about your application with us, see your information, and act for you on matters related to your application, including getting information about your application and signing your application on your behalf. This person can also act for you on other matters including reviews, appeals and managed care processes. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Healthy Connections. If you're a legally appointed representative for someone on this application, submit proof with the application.
The Medicaid eligibility worker can release any information regarding my application/review and status to my authorized representative or any member of the organization indicated on this form.

1. Member name	2. Social Security Number
Gilbert B Ryals Sr	253-44-2225

3. Name of authorized representative (First name, Middle name, Last name)

Amanda J. Cason

4. Home address (Leave blank if you don't have one.)	5. Apartment or suite number

6. City	7. State	8. ZIP code
Langley	SC	29834

9. Phone number

(803) 522 5968

10. Organization name (if applicable)	11. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

12. Your signature	13. Date (mm/dd/yyyy)
Gilbert B Ryals	3-5-14

Please print this form, then sign it on the line above before submitting.
If signing with an "X," please have two people sign below as witnesses.

Witness: [illegible] Witness: _____

The Member is incapacitated and is unable to sign.* Please provide the reason(s) below:

*SCDHHS reserves the right to verify the member's inability to sign.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820.** Para obtener una copia de este formulario en Español, llame **1-888-549-0820.** If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583.**

Healthy Connections

South Carolina Department of Health and Human Services

Additional Information for Select Medicaid Programs

Medicaid Addendum for: Aged, Blind, or Disabled (ABD), Inmate Services, Breast and Cervical Cancer Program (BCCP), Optional State Supplementations (OSS), Qualified Medicare Beneficiaries (QMB) or Katie Becket (also known as TEFRA)

☐ ABD ☐ BCCP ☐ Inmate Services ☐ OSS ☐ QMB ☐ TEFRA

You recently applied for Medicaid with the State of South Carolina. The application you completed did not capture all the information that we need to make a decision. Please complete and return this form so we can process your application. **If applying for TEFRA, you only need to give us information about the applicant's income and resources.** All of the rights and responsibilities agreed to when the original application was signed are still in effect. If there are any questions about those rights and responsibilities or the addendum itself, please call us toll free at 1-888-549-0820 for assistance.

1. Who is applying for assistance?

Name(First, Middle, Last):	Social Security Number:	Date of Birth:
Gilbert B Rials Sr	253-44-2225	03-03-1932
Name (First, Middle, Last):	Social Security Number:	Date of Birth:
Name (First, Middle, Last):	Social Security Number:	Date of Birth:

2. Are you or the person you are applying for currently in a Residential Care Facility or Boarding Home?
☐ Yes ☑ No.
If yes, what is the name of the facility? _____ Date entered? _____

3. Most forms of income we need to know about were captured on the prior application. Please list if anyone in the home has any of the additional types of income.

If yes, check all boxes that apply and complete the table below. N/A

☐ Child Support ☐ Money from Friends and Relatives
☐ Veterans Assistance ☐ Workers Comp/Long Term or Short Term Disability

Person receiving Money	Income Source/Type	How Often Received	Amount Received

4. Does anyone in your family own the following? You must send proof of assets/resources with this addendum. N/A

If yes, check all boxes that apply and complete the table below.

☐ Cash on Hand ☐ Checking Account ☐ Savings Account ☐ Burial Plot
☐ Certificate of Deposit ☐ Annuities/Trusts ☐ Stocks and Bonds ☐ Home Property
☐ Other Property ☐ Life/Burial insurance ☐ Burial Contracts ☐ Vehicles
☐ Retirement Accounts ☐ Other: _____

Questions five through seven are only for those people who are currently inmates at a correctional facility. If you are an inmate at a correctional facility please provide the following information. N/A

5.

Name of Correctional Facility:		Date Incarcerated:
Name of Hospital Where Services Received	Date of Admission: Date of Discharge:	Address where you lived before incarceration:

6. If you have been incarcerated for longer than 30 days, you can skip this question and go to questions #7.
Did you work or receive earnings before you were incarcerated? ☐ Yes ☐ No
If living with your spouse before you were incarcerated, was your spouse employed? ☐ Yes ☐ No

7. Tell us about your income before you were incarcerated. Enter GROSS amounts.
(This information will need to be verified by staff of correctional facility)

☐ Earnings ☐ Monthly Benefits ☐ Other

Type of Income	Amount Paid	How often paid

- Staff of the correctional facility can attest to income or earnings received from or through the facility. The following signature attests to incomes verified in question six.

Correctional Facility Staff Person: _____ Date: _____
Phone Number: _____

Healthy Connections

South Carolina Department of Health and Human Services

Application for Medicaid and Affordable Health Coverage

things to know

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A new tax credit that can immediately help pay your premium for health coverage.
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP).

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit **HealthCare.gov**.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete the Authorized Representative Form (1282), which can be downloaded at **SCDHHS.gov**.

Apply faster online

- Apply faster online at **SCDHHS.gov** or **HealthCare.gov**.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and how to get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to **https://www.SCDHHS.gov/internet/pdf/SCDHHSNoticeofPrivacyPractices080107.pdf**.

What happens next?

Send your complete, signed application to the address on page 12.
If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your application for health coverage.
If you don't hear from us, visit **SCDHHS.gov** or call 1-888-549-0820.
Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** SCDHHS.gov
- **Phone:** Call our Help Center at **1-888-549-0820.**
- **In person:** There may be counselors in your area who can help. **Visit our website** or call **1-888-549-0820** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-888-549-0820.**

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820.** Para obtener una copia de este formulario en Español, llame **1-888-549-0820.** If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583.**

STEP 1 Tell us about yourself.

We need one adult in the family to be the contact person for your application.

1. First name, Middle name, Last name and Suffix: Gilbert B Ryals Sr
2. Home address (Leave blank if you don't have one.): 160 Pelzer St.
3. Apartment or suite number:
4. City: Langley
5. State: SC
6. ZIP code: 29834
7. County: Aiken
8. Mailing address (if different from home address): PO Box 76
9. Apartment or suite number:
10. City: Langley
11. State: SC
12. ZIP code: 29834
13. County: Aiken
14. Phone number: (803) 593-5968
15. Other phone number: Wk Daughters Amanda 803 663 4204
16. Do you want to get information about this application by email? Yes No
    Email address: ajrcason@gmail.com
17. What is your preferred spoken or written language (if not English)? English

Is Someone Helping You Fill Out This Application?

Complete the following section if you are filling out this form on behalf of the applicant (the person listed in **STEP 1**).

1. Application start date (mm/dd/yyyy): 1-23-14
2. First name, Middle name, Last name, & Suffix: Amanda J Ryals (Daughter)
3. Organization Name (if applicable):
4. ID Number (if applicable):

STEP 2 Tell us about your family.

Who do you need to include on this application?
Tell us about **all** the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

DO include:
- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:
- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family.

Start with yourself, then add other adults and children. If you have more than 4 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820.** Para obtener una copia de este formulario en Español, llame **1-888-549-0820.** If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583.**

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about whom to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix: Gilbert B Ryals Sr.
2. Relationship to you? SELF
3. Date of birth (mm/dd/yyyy): 03-03-1952
4. Sex: ✓ Male · Female
5. Social Security number (SSN): 253-44-9995

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
· YES. If yes, please answer questions a–c. ✓ NO. If no, SKIP to question c.

a. Will you file jointly with a spouse? Yes No
If yes, name of spouse:

b. Will you claim any dependents on your tax return? Yes No
If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? Yes No
If yes, please list the name of the tax filer:
How are you related to the tax filer?

7. Are you pregnant? Yes No If yes, a. How many babies are expected during this pregnancy?
b. What is your due date?

8. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
✓ YES. If yes, answer all the questions below. NO. If no, SKIP to the income questions on page 4. Leave the rest of this page blank.

9. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? ✓ Yes No
10. Do you need to live in a medical facility or nursing home or need nursing services at home? ✓ Yes No
11. Have you been diagnosed with and are receiving treatment for any of the following? Yes ✓ No
· Breast Cancer · Cervical Cancer · Atypical Breast Hyperplasia · Precancerous Cervical Lesion (CIN 2/3)
12. Are you a U.S. citizen or U.S. national? ✓ Yes No
13. **If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?** Yes No
If YES, fill in your document type and ID number below.
a. Immigration document type:
b. Document ID number:
c. Have you lived in the U.S. since 1996? Yes No
d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? Yes No
14. Do you want help paying for medical bills from the last 3 months? ✓ Yes No
15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? Yes ✓ No
16. Are you a full-time student? Yes ✓ No
17. Were you in foster care in South Carolina at age 18 or older?
18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)**
Mexican Mexican-American Chicano/a Puerto Rican Cuban Other:
19. **Race (OPTIONAL—check all that apply)**

✓ White	American Indian or Alaska native	Filipino	Vietnamese	Guamanian or Chamorro
Black/African-American	Asian Indian	Japanese	Other Asian	Samoan
	Chinese	Korean	Native Hawaiian	Other Pacific Islander
			Puerto Rican	Other:

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STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

- **Employed** — If you're currently employed, tell us about your income. Start with question 20.
- ✓ **Not Employed** — SKIP to question 30.
- **Self-Employed** — SKIP to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number ( )

22. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

23. Average hours worked each week

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

24. Employer name and address

25. Employer phone number ( )

26. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

27. Average hours worked each week

28. **In the past year, did you:** Change jobs Stop working Start working fewer hours None of these

29. **If self-employed, answer the following questions:**
a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?
$

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

- None
- Unemployment $ ____ How often? ____
- Pensions $ ____ How often? ____
- ✓ Social Security $ 1000.00 How often? 3rd month
- Retirement accts $ ____ How often? ____
- Alimony received $ ____ How often? ____
- Net farming/fishing: $ ____ How often? ____
- Net rental/royalty: $ ____ How often? ____
- Other income: Type: Food Stamps $ 50.00 How often? Once a month
- Type: ____ $ ____ How often? ____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If PERSON 1 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

- Alimony paid $ ____ How often? ____
- Student loan interest $ ____ How often? ____
- Other deductions: $ ____ How often? ____ Type: ____

32. **YEARLY INCOME: Complete only if PERSON 1's income changes from month to month.**
If you don't expect changes to PERSON 1's monthly income, add another person on the following pages.

PERSON 1's total income this year
$ ____

PERSON 1's total income next year (if you think it will be different)
$ ____

THANKS! This is all we need to know about you.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820.** Para obtener una copia de este formulario en Español, llame **1-888-549-0820.** If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583.**

STEP 2: PERSON 2

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about whom to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex: Male Female

5. Social Security number (SSN) - -

We need this if PERSON 2 wants health coverage and has an SSN.

6. Does PERSON 2 live at the same address as you? Yes No

If no, list address:

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, please answer questions a–c. NO. If no, SKIP to question c.

a. Will PERSON 2 file jointly with a spouse? Yes No

If yes, name of spouse:

b. Will PERSON 2 claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents:

c. Will PERSON 2 be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer:

How is PERSON 2 related to the tax filer?

8. Is PERSON 2 pregnant? Yes No If yes, a. How many babies are expected? b. What is your due date?

9. **Does PERSON 2 you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

YES. If yes, answer all the questions below.

NO. If no, SKIP to the income questions on page 4. Leave the rest of this page blank.

10. Does PERSON 2 have a disabling physical/mental/emotional health condition that causes limitations in activities? Yes No

11. Does PERSON 2 need to live in a medical facility or nursing home or need nursing services at home? Yes No

12. Has PERSON 2 been diagnosed with and are receiving treatment for any of the following? Yes No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

13. Is PERSON 2 a U.S. citizen or U.S. national? Yes No

14. **If PERSON 2 isn't a U.S. citizen or U.S. national, does PERSON 2 have eligible immigration status?** Yes No
If YES, fill in PERSON 2's document type and ID number below.

a. Immigration document type:

b. Document ID number:

c. Has PERSON 2 lived in the U.S. since 1996? Yes No

d. Is PERSON 2, their spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

15. Does PERSON 2 want help paying for medical bills from the last 3 months? Yes No

16. Does PERSON 2 live with at least one child under 19, and is PERSON 2 the main person taking care of this child? Yes No

17. Is PERSON 2 a full-time student? Yes No

18. Was PERSON 2 in foster care in South Carolina at age 18 or older? Yes No

19. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)**
Mexican Mexican-American Chicano/a Puerto Rican Cuban Other:

20. **Race (OPTIONAL—check all that apply)**

White	American Indian or Alaska native	Filipino	Vietnamese	Guamanian or Chamorro
Black/African-American	Asian Indian	Japanese	Other Asian	Samoan
	Chinese	Korean	Native Hawaiian	Other Pacific Islander
			Puerto Rican	Other:

Now, tell us about any income from PERSON 2 on the next page.

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STEP 2: PERSON 2

Current Job & Income Information

- **Employed** — If you're currently employed, tell us about your income. Start with question 20.
- **Not Employed** — SKIP to question 30.
- **Self-Employed** — SKIP to question 29.

CURRENT JOB 1:

21. Employer name and address

22. Employer phone number ( )

23. Wages/tips (before taxes) ○ Hourly ○ Weekly ○ Every 2 weeks ○ Twice a month ○ Monthly ○ Yearly

24. Average hours worked each week

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

25. Employer name and address

26. Employer phone number ( )

27. Wages/tips (before taxes) ○ Hourly ○ Weekly ○ Every 2 weeks ○ Twice a month ○ Monthly ○ Yearly

28. Average hours worked each week

29. **In the past year, did you:** ○ Change jobs ○ Stop working ○ Start working fewer hours ○ None of these

30. **If self-employed, answer the following questions:**
a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?
$

31. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

- ○ None
- ○ Unemployment $ _____ How often? _____
- ○ Pensions $ _____ How often? _____
- ○ Social Security $ _____ How often? _____
- ○ Retirement accts $ _____ How often? _____
- ○ Alimony received $ _____ How often? _____
- ○ Net farming/fishing: $ _____ How often? _____
- ○ Net rental/royalty: $ _____ How often? _____
- ○ Other income:
  - Type: _____ $ _____ How often? _____
  - Type: _____ $ _____ How often? _____

32. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 30b).

- Alimony paid $ _____ How often? _____
- Student loan interest $ _____ How often? _____
- Other deductions: $ _____ How often? _____
  Type: _____

33. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**
If you don't expect changes to PERSON 2's monthly income, add another person on the following pages.

PERSON 2's total income this year
$ _____

PERSON 2's total income next year (if you think it will be different)
$ _____

THANKS! This is all we need to know about PERSON 2.

Go to the next page to provide information about PERSON 3 if necessary.

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STEP 2: PERSON 3

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about whom to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex: Male Female

5. Social Security number (SSN) - -

We need this if PERSON 3 wants health coverage and has an SSN.

6. Does PERSON 3 live at the same address as you? Yes No

If no, list address:

7. **Does PERSON 3 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, please answer questions a–c.

NO. If no, SKIP to question c.

a. Will PERSON 3 file jointly with a spouse? Yes No

If yes, name of spouse:

b. Will PERSON 3 claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents:

c. Will PERSON 3 be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer:

How is PERSON 3 related to the tax filer?

8. Is PERSON 3 pregnant? Yes No If yes, a. How many babies are expected? b. What is the due date?

9. **Does PERSON 3 you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

YES. If yes, answer all the questions below.

NO. If no, SKIP to the income questions on page 4. Leave the rest of this page blank.

10. Does PERSON 3 have a disabling physical/mental/emotional health condition that causes limitations in activities? Yes No

11. Does PERSON 3 need to live in a medical facility or nursing home or need nursing services at home? Yes No

12. Has PERSON 3 been diagnosed with and are receiving treatment for any of the following? Yes No
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

13. Is PERSON 3 a U.S. citizen or U.S. national? Yes No

14. **If PERSON 3 isn't a U.S. citizen or U.S. national, does PERSON 2 have eligible immigration status?** Yes No
If YES, fill in PERSON 3's document type and ID number below.

a. Immigration document type:

b. Document ID number:

c. Has PERSON 3 lived in the U.S. since 1996? Yes No

d. Is PERSON 3, their spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

15. Does PERSON 3 want help paying for medical bills from the last 3 months? Yes No

16. Does PERSON 3 live with at least one child under 19, and is PERSON 2 the main person taking care of this child? Yes No

17. Is PERSON 3 a full-time student? Yes No

18. Was PERSON 3 in foster care in South Carolina at age 18 or older? Yes No

19. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)**
Mexican Mexican-American Chicano/a Puerto Rican Cuban Other:

20. **Race (OPTIONAL—check all that apply)**

White	American Indian or Alaska native	Filipino	Vietnamese	Guamanian or Chamorro
Black/African-American	Asian Indian	Japanese	Other Asian	Samoan
	Chinese	Korean	Native Hawaiian	Other Pacific Islander
			Puerto Rican	Other:

Now, tell us about any income from PERSON 3 on the next page.

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STEP 2: PERSON 3

Current Job & Income Information

Employed
If you're currently employed, tell us about your income. Start with question 20.

Not Employed
SKIP to question 30.

Self-Employed
SKIP to question 29.

CURRENT JOB 1:

21. Employer name and address

22. Employer phone number ( )

23. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

24. Average hours worked each week

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

25. Employer name and address

26. Employer phone number ( )

27. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

28. Average hours worked each week

29. **In the past year, did you:** Change jobs Stop working Start working fewer hours None of these

30. **If self-employed, answer the following questions:**
a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?
$

31. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

None

Unemployment $ _____ How often? _____

Pensions $ _____ How often? _____

Social Security $ _____ How often? _____

Retirement acc'ts $ _____ How often? _____

Alimony received $ _____ How often? _____

Net farming/fishing: $ _____ How often? _____

Net rental/royalty: $ _____ How often? _____

Other income:

Type: _____ $ _____ How often? _____

Type: _____ $ _____ How often? _____

32. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If PERSON 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 30b).

Alimony paid $ _____ How often? _____

Student loan interest $ _____ How often? _____

Other deductions: $ _____ How often? _____

Type: _____

33. **YEARLY INCOME:** **Complete only if PERSON 3's income changes from month to month.**
If you don't expect changes to PERSON 3's monthly income, add another person on the following pages.

PERSON 3's total income this year
$ _____

PERSON 3's total income next year (if you think it will be different)
$ _____

THANKS! This is all we need to know about PERSON 3.

Go to the next page to provide information about PERSON 4 if necessary.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

STEP 2: PERSON 4

Complete Step 2 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about whom to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)	4. Sex: Male Female	5. Social Security number (SSN)	**We need this if PERSON 4 wants health coverage and has an SSN.**

6. Does PERSON 4 live at the same address as you? Yes No

If no, list address:

7. **Does PERSON 4 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, please answer questions a–c. NO. If no, SKIP to question c.

a. Will PERSON 4 file jointly with a spouse? Yes No

If yes, name of spouse:

b. Will PERSON 4 claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents:

c. Will PERSON 4 be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer:

How is PERSON 4 related to the tax filer?

8. Is PERSON 4 pregnant? Yes No If yes, a. How many babies are expected? b. What is the due date?

9. **Does PERSON 4 you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

YES. If yes, answer all the questions below. NO. If no, SKIP to the income questions on page 4. Leave the rest of this page blank.

10. Does PERSON 4 have a disabling physical/mental/emotional health condition that causes limitations in activities? Yes No
11. Does PERSON 4 need to live in a medical facility or nursing home or need nursing services at home? Yes No
12. Has PERSON 4 been diagnosed with and are receiving treatment for any of the following? Yes No
- Breast Cancer
- Cervical Cancer
- Atypical Breast Hyperplasia
- Precancerous Cervical Lesion (CIN 2/3)

13. Is PERSON 4 a U.S. citizen or U.S. national? Yes No
14. **If PERSON 4 isn't a U.S. citizen or U.S. national, does PERSON 2 have eligible immigration status?** Yes No
If YES, fill in PERSON 4's document type and ID number below.

a. Immigration document type:

b. Document ID number:

c. Has PERSON 4 lived in the U.S. since 1996? Yes No

d. Is PERSON 4, their spouse or parent a veteran or an active-duty member of the U.S. military? Yes No

15. Does PERSON 4 want help paying for medical bills from the last 3 months? Yes No
16. Does PERSON 4 live with at least one child under 19, and is PERSON 2 the main person taking care of this child? Yes No
17. Is PERSON 4 a full-time student? Yes No
18. Was PERSON 4 in foster care in South Carolina at age 18 or older? Yes No
19. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)**
Mexican Mexican-American Chicano/a Puerto Rican Cuban Other:
20. **Race (OPTIONAL—check all that apply)**

White	American Indian or Alaska native	Filipino	Vietnamese	Guamanian or Chamorro
Black/African-American	Asian Indian	Japanese	Other Asian	Samoan
	Chinese	Korean	Native Hawaiian	Other Pacific Islander
			Puerto Rican	Other:

Now, tell us about any income from PERSON 4 on the next page.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820.** Para obtener una copia de este formulario en Español, llame **1-888-549-0820.** If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583.**

STEP 2: PERSON 4

Current Job & Income Information

- **Employed**
  If you're currently employed, tell us about your income. Start with question 20.
- **Not Employed**
  SKIP to question 30.
- **Self-Employed**
  SKIP to question 29.

CURRENT JOB 1:

21. Employer name and address

22. Employer phone number ( )

23. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

24. Average hours worked each week

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

25. Employer name and address

26. Employer phone number ( )

27. Wages/tips (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

28. Average hours worked each week

29. **In the past year, did you:** Change jobs Stop working Start working fewer hours None of these

30. **If self-employed, answer the following questions:**
a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?
$

31. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

None
Unemployment $ _____ How often? _____
Pensions $ _____ How often? _____
Social Security $ _____ How often? _____
Retirement acc'ts $ _____ How often? _____
Alimony received $ _____ How often? _____
Net farming/fishing: $ _____ How often? _____
Net rental/royalty: $ _____ How often? _____
Other income:
Type: _____ $ _____ How often? _____
Type: _____ $ _____ How often? _____

32. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If PERSON 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 30b).

Alimony paid $ _____ How often? _____
Student loan interest $ _____ How often? _____
Other deductions: $ _____ How often? _____
Type: _____

33. **YEARLY INCOME:** **Complete only if PERSON 4's income changes from month to month.**
If you don't expect changes to PERSON 4's monthly income, add another person on the following pages.

PERSON 4's total income this year
$ _____

PERSON 4's total income next year (if you think it will be different)
$ _____

THANKS! This is all we need to know about PERSON 4.

If you have more than four people to include, ask for and complete DHHS Form 3400-01 for each additional person.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

If NO, skip to Step 4.

YES. If YES, please complete SCDHHS Form 3400-Appendix B (American Indian or Alaska Native Family Member). This form is available on the SCDHHS website at **scdhhs.gov/Getting-Started.**

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following? If available, please provide a copy of the insurance card.

YES. If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have. **NO.**

Medicaid _____

CHIP _____

Medicare _____

Claim number: _____

Date Medicare coverage started: _____

TRICARE (Don't check if you have direct care of Line Of Duty)

VA health care programs: _____

Peace Corps: _____

Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? Yes No

Is this a retiree health plan? Yes No

Other:

Name of health insurance: _____

Policy number: _____

Is this a limited-time benefit plan (like a school accident policy)?

Yes No

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

YES. If YES, you'll need to complete and include Appendix A. Is this a state employee benefit plan? Yes No

NO. If NO, continue to Step 5.

STEP 5 Read and sign this application.

Please read the following rights and responsibilities. If you disagree with a statement, additional questions may appear or your eligibility for programs may be impacted. A signature is required to complete the application process and submit your application to the agency.

1. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by calling (803) 898-2605 or writing to the Office for Civil Rights, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206.
2. I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and may not have to cooperate.
3. I assign and give my rights to any payments from a liable third party to the SCDHHS up to the payment amount that Healthy Connections 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 health insurance, legal settlements, or other third parties. I also understand that I have a duty to cooperate in identifying and providing information to assist Healthy Connections in pursuing third parties who may be liable to pay for care and services.

(Rights and responsibilities continued on next page)

4. I understand that I must cooperate fully with state and federal workers if my case is reviewed. I also understand that, as a condition of eligibility, I must apply for and take steps to obtain any other benefits, including but not limited to annuities, pensions, retirement, disability and other benefits.
5. As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:
   - A person of any age who was a patient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
   - A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

   I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.
6. I know that I must tell SCDHHS if any information I listed on this application changes and is different than what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.
7. The information I provide on this application and in future interaction with SCDHHS will be used to check my eligibility for help paying for health coverage, if I choose to apply. If the information I provide doesn't match our electronic data, I may be asked to send proof. I know that, unless I specifically ask to be excluded, information collected will be securely stored in order to be sure that services provided to my family and me are sufficient and necessary.
8. If I think SCDHHS, the agency that administers Healthy Connections, the state's Medicaid and CHIP programs, has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair review of the action. I must submit a written request for such a hearing to SCDHHS. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.
9. I know that personal health information I provide or that is later gathered by SCDHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will receive a Notice of Privacy Practices along with my Healthy Connections Card(s).

Does any child on this application have a parent living outside of the home? ○ Yes ○ No

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

_____ is incarcerated.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Medicaid or the Health Insurance Marketplace to use income data, including information from tax returns. Medicaid will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

○ 5 years (the maximum number of years allowed), or for a shorter number of years:

○ 4 years ○ 3 years ○ 2 years ○ 1 year ○ Don't use information from tax returns to renew my coverage.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here, as long as you have provided the information required on DHHS Form 1282 - Authorized Representative. **By signing, I state that I have read and agree to the rights and responsibilities stated on this application.**

Signature	Date (mm/dd/yyyy)
Gilbert B Rojas Jr	3-5-14

Please print this form, then sign it on the line above before submitting.

STEP 6 Mail the completed application.

Mail your signed application to:

SCDHHS - Central Mail
PO Box 100101
Columbia SC 29202-3101

If you want to register to vote, you can complete a voter registration form at **scvotes.org**.

NEED HELP WITH YOUR APPLICATION? Visit **SCDHHS.gov** or call us at **1-888-549-0820.** Para obtener una copia de este formulario en Español, llame **1-888-549-0820.** If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583.**

APPENDIX A

Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.
Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE information

1. Employee name (First, Middle, Last)	2. Employee Social Security number

EMPLOYER information

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number ( )
7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)	12. Email address
( )	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

- **YES.** If YES, continue below.
- **NO.** If NO, stop here and go to Step 5 on the application.

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? Yes No

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): if the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Yearly

16. What change will the employer make for the new plan year (if known)?

- Employer won't offer health coverage
- Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs [Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986]

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

EMPLOYER COVERAGE TOOL

Health Coverage from Jobs

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.
Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form.
Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Employee Social Security number
	- -

EMPLOYEE Information

The **employee** needs to fill out this section.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number ( )
7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) ( )	12. Email address

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

YES. If YES, continue below. **NO.** If NO, stop here and go to Step 5 on the application.

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? Yes No

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Yearly

16. What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage
Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs [Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986]

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Trinity Hospital of Augusta
2260 Wrightsboro Road
Augusta, GA 30904
706 481 7000

PSYCHIATRIC EVALUATION

NAME: GILBERT B RYALS

MRN:	0010064729	ROOM:	242	DOB:	03/03/1932
ACCOUNT#:	0003657551	BED:	1	AGE:	81 Y
SERVICE CODE:	PSY			SEX:	M
ADM DATE:	02/25/2014	DIS DATE:		DOS:	02/26/2014

DICTATING PHYSICIAN: DAVID STEINER, MD
ATTENDING PHYSICIAN: DAVID STEINER
PRIMARY CARE PHYSICIAN: PRIMARY UNKNOWN

CHIEF COMPLAINT: None voiced.

HISTORY OF PRESENT ILLNESS: This is an 81-year-old Caucasian male admitted via the Augusta VA emergency department. I spoke with his daughter, Amanda Cason, and got history as this patient has severe dementia and is unable to give me history at this point. He has been living with the daughter for about a year. He had been living on his own. Been going downhill cognitively for couple years and has been unable to manage himself, and was brought into the emergency department on February 24. We agreed to accept him that night, but they were unable to transport until the next day, so he arrives on February 25. The daughter says that beginning in June or July of this past year, he had been getting increasingly behaviorally disordered. He would go out of the house, takes things, throw things away, become increasingly difficult to manage. The local VA outpatient services put him on Klonopin and Seroquel, but that did not help. More recently, he has been going into a neighbor's house and actually stealing things, and what precipitated the admission is that he went into a neighbor's house, who happened to be a judge and the judge basically told the daughter that she had to do something. In addition, he has been physically assaultive. He has been hitting her with pots and pans. She has been scared that he is going to assault the grandchildren, and she feels it is not safe having him in-house for her or for him as he is leaving the house and going other peoples homes. He also threatened that he would burn the house down and threatening to kill other people on the day that he was brought to the emergency department. So those were other precipitating factors. He was brought in on an involuntary commitment at October 2013. He is unable to give me any history.

PAST PSYCHIATRIC HISTORY: The daughter knows of no prior psychiatric problems. No prior treatment. The only medicines she thinks he had been on some other medicines for this, but she is not sure.

SUBSTANCE ABUSE: The daughter reports that he drank when she was younger but has quit for many many years. She does not know that he had alcohol dependency or alcohol abuse problems.

FAMILY PSYCHIATRIC HISTORY: He has one son, who is institutionalized for schizophrenia.

SOCIAL HISTORY: He has been divorced for many years. Worked as a carpenter, was in the military. He has VA benefits. He is now living with the daughter, who is supportive and I was told she has POA and I did not ask her when we talked.

MEDICAL HISTORY: He has coronary artery disease, hypertension, hyperlipidemia, peptic ulcer disease, chronic back pain, and sensorineural hearing loss, and has a history of a gunshot wound to the right side and history of skin cancer. Hypertension.

MEDICATIONS ON ADMISSION WERE:
1. Clonazepam 0.5 mg at bedtime.
2. Seroquel 50 mg b.i.d.
3. Lanoxin 125 mcg daily.
4. Lipitor 80 mg daily.
5. Aricept 10 mg at bedtime.
6. Lisinopril 20 mg daily.

ALLERGIES: HE HAS NO REPORTED DRUG ALLERGIES.

PHYSICAL ASSESSMENT: Please see the medical H and P dictated for his physical assessment.

MENTAL STATUS EXAM: This gentleman was alert sitting up in his bed, wearing oxygen.

Of note is that he apparently had a minor aspirations, where his 02 sats dropped after lunch, but he is okay now. Chest x-ray is pending, and he is breathing comfortably. He is oriented only to person, not to place or time. Speech is a bit rambling and is difficult to understand. There are no auditory, visual, olfactory, or tactile hallucinations. No delusions, paranoia, or grandiosity. Insight is impaired. Judgment is impaired. There are no delusions. He denies suicidal or homicidal thoughts.

LABORATORY DATA: As mentioned above, chest x-ray is pending. He had a workup at the VA urinalysis was unremarkable. Only 1 WBC, negative leukocyte esterase, or nitrates. TSH was normal at 0.66. Glucose

was 93, BUN 24, creatinine 1.0, calcium 10.0. Everything was normal except for triglycerides were little bit elevated at 303. CBC was also within normal limits. I do not see if they did a blood alcohol or urine drug screen.

DIAGNOSES: Axis I: Psychosis with history of schizophrenia.

Axis II: Deferred.

Axis III: Possible aspiration, coronary artery disease, hypertension, hyperlipidemia, peptic ulcer disease, back pain, sensory or hearing loss.

Axis IV: Stressors living situation.

Axis V: Admitting GAF is 24.

PLAN:
1. Patient is admitted to the Trinity Hospital's Generations Gero Psychiatric Treatment program.
2. I am going to stop his Seroquel and Klonopin and begin Celexa, and we will going to look what our placement options are.
3. Awaiting on chest x-ray, Dr. Prasatik, _____ aspiration. He did start him on Levaquin. I talked to the daughter as above.

Print CC:

Fax CC:

D Date / Time: 02/26/2014 03:26 PM ET
T Date / Time: 02/26/2014 10:06 PM ET
R Date / Time:
S Job #: THA70961091
D Job #: 6080824
MT: 1103476

Authenticated by DAVID STEINER MD On 03/02/2014 07:09:18 PM

TEST: History and Physical
Collected Date & Time: 02/25/14 17:43

Result Name	Results	Units	Reference Range
History and Physical	Trinity Hosp		

Trinity Hospital of Augusta
2260 Wrightsboro Road
Augusta, GA 30904
706 481 7000
HISTORY AND PHYSICAL

NAME: GILBERT B RYALS
MRN: 0010064729 ROOM: 242 DOB: 03/03/1932
ACCOUNT#: 0003657551 BED: 1 AGE: 81 Y
SERVICE CODE: PSY SEX: M
ADM DATE: 02/25/2014 DIS DATE: DOS: 02/25/2014
DICTATING PHYSICIAN: ERIK PRASATIK, MD
ATTENDING PHYSICIAN: DAVID STEINER
PRIMARY CARE PHYSICIAN: PRIMARY UNKNOWN

CHIEF COMPLAINT: Dementia, behavioral disturbances.
HISTORY OF PRESENT ILLNESS: 81-year-old male with dementia, coronary artery disease, hypertension, hyperlipidemia, and history of hearing loss, presents for evaluation of dementia and behavioral disturbances. The patient apparently had been having trouble with some agitated behavior for quite some time, and increasing aggressiveness to his daughter with whom he lives. Yesterday, he was taken to the ER at the VA Hospital. He had been having some increased agitation, walking around the neighborhood, he broke into _____ something. He lives with his daughter, who stated that he had been refusing to take his medications. He has also threatened her that he would burn the house down, and apparently threatened to kill her yesterday per the notes reviewed. He denies any specific such complaints. He denies any chest pain, shortness of breath, nausea, vomiting, or headache.
REVIEW OF SYSTEMS: See history of present illness. Rest negative.
PAST MEDICAL HISTORY:
1. Dementia.
2. Coronary artery disease.
3. Hypertension.
4. Hyperlipidemia.
5. History of peptic ulcer disease.
6. Chronic back pain.
7. Hearing loss.

PAST SURGICAL HISTORY: A gunshot wound to the right side, history of skin cancer.
SOCIAL HISTORY: Lives at home with daughter. Past history of alcohol use. No tobacco use. No illicit drug use.

NAME: GILBERT B RYALS
MRN: 0010064729 DOB: 03/03/1932 ADM DATE: 02/25/2014
ACCOUNT#: 0003657551 DIS DATE:

FAMILY HISTORY: Negative for diabetes or coronary artery disease.

MEDICATIONS:
1. Clonazepam.
2. Atorvastatin.
3. Digoxin.
4. Donepezil.
5. Lisinopril.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

PHYSICAL EXAMINATION:

Vital Signs: Blood pressure 124/67, heart rate 73, respirations 16, temperature 97.7.

General: Patient is a well-developed, well-nourished, alert and oriented to person and hospital.

Lungs: Clear.

Abdomen: Benign.

HEENT: Oropharynx clear. Mucous membranes are moist.

Neck: Supple. No thyromegaly.

Lymph Nodes: No supraclavicular or cervical lymphadenopathy.

Cardiac Exam: Regular rhythm. No murmurs.

Lungs: Clear bilaterally.

Abdomen: Nondistended, nontender. Normal bowel sounds.

Musculoskeletal: No clubbing, cyanosis, or edema.

Neurologic: Grossly nonfocal. Strength 5/5 throughout. Sensation grossly intact. I did not assess gait. He is oriented to person and hospital. No current blood work available. Blood work from back in 2008, showed a normal chemistry panel. Normal CBC and normal urinalysis.

IMPRESSION:
1. Dementia, behavioral disturbances.
2. Hypertension.
3. Questionable history of coronary artery disease.
4. History of irregular heartbeat.
5. Hyperlipidemia.
6. History of peptic ulcer disease in the 1950s.

PLAN: Patient is currently stable from medical standpoint. We will consider obtaining some baseline labs. If they have not been obtained at the VA, we will follow as needed for medical management.

NAME: GILBERT B RYALS
MRN: 0010064729 DOB: 03/03/1932 ADM DATE: 02/25/2014
ACCOUNT#: 0003657551 DIS DATE:

Print CC:

Fax CC:

D Date / Time: 02/25/2014 01:23 PM ET
T Date / Time: 02/25/2014 06:38 PM ET
R Date / Time:
S Job #: THA70932332
D Job #: 6080762
MT: 917887

"1PN"

DATE	TIME		Unacceptable Abbreviations		
			U and/or IU	MS, MSO4	gr
			QD	MgSO4	ss
			QOD	x 3 d	ug
			Trailing zero (2.0)	Lack of leading zero (.5)	

DATE	TIME	
3/4/14	0830	No complaints
		Staff reports
		he did fine behaviorally yesterday
		& last night - slept well. 9 hr
		Mood good.
	MSE	: alert, OX1 ; speech garbled
		no insight, no SI or HI, well
		groomed, no SI, affect constricted
		no halluc or delusions
	VS	BP 124/78, P-65, Resp 17, afeb
	A/P	1.) Dementia c behavioral disturbances
		- cont. celexa
		2.) insomnia - slept well - cont
		trazodone PRN
		3) Placement - spoke c SW this
		am
		[signature]

Progress Notes
1536-119026HMS 03/07, 04/07 (Rev. 01/09, 06/10) Page 1 of 1

Patient Label
TRINITY HOSPITAL OF AUGUSTA
RYALS GILBERT B 242-1
DOB: 1932-03-03 81 M PSYC MR#: 10064729
DAVID STEINER DOS: 2014-02-25
Patient Account #: 3657551 Printed on 3/2/14 at 5:00

1PN

DATE	TIME	
3/3/14	1545	No complaints, events of 3/1 (2/28) reviewed - CT - nothing acute; no further episodes - Staff reports he's been up some at night but no aggression or hallucinations
	VS	BP 125/67, P-64, resp 17, afeb
	MSE	alert, up, Ox1, no insight, no hallucinations or delusions. No SI or HI, well groomed sitting calmly, affect fairly flat
	A/P	1) Dementia c behavioral disturbances - seems okay - cont. Celexa
		2) insomnia - ↑ PRN trazodone to 100 qhs
		3) Spoke c SW daughter is looking for placement - PPD placed - call placed to daughter

Unacceptable Abbreviations

U and/or IU	MS, MSO4	gr
QD	MgSO4	ss
QOD	x 3 d	ug
Trailing zero (2.0)	Lack of leading zero (.5)	

Patient Label
TRINITY HOSPITAL OF AUGUSTA
RYALS GILBERT B 242-1
DOB: 1932-03-03 81 M PSYC MR#: 10064729
DAVID STEINER DOS: 2014-02-25
Patient Account #: 3657551 Printed on 2/27/14 at 23:23

1PN

DATE	TIME	
3/2/14	1830	Psych NO Complaint noise: Client Oriented to person only. Continues to seek a ride to Clw, SC. Denies thoughts of suicide. NO HS. NO delusions NO hallucinations. NO pain. Conversation Lucid mostly of day. Memory impaired. No insight. Speech garbled at times. NO respiratory distress. 97.5-66-18-125/67 O2 Sat 100% A/P- Monitor & Behavioral Ctrl Cont Celexa, current plan of care

Unacceptable Abbreviations

U and/or IU	MS, MSO4	gr
QD	MgSO4	ss
QOD	x 3 d	ug
Trailing zero (2.0)	Lack of leading zero (.5)	

DATE	TIME	
3/1/14	2/00	Psych H/w "I'm just waiting 'til 6 or 7 o'clock in the morning, catch the bus to go to South Carolina. I live in Langley, but the bus only go to Clearwater. I'm in Richmond county on vacation. I ain't in the hospital" MSE: Alert oriented to person only. Affect bright mood congruent NO SI, HI. NO delusion, NO hallucinations. NO insight. Judgement impaired. Had couple episodes today where he became unresponsive for a short period of time. Rapid Response team called. CT Scan done. A/P - Dementia c Behavioral disturbance Consult to - Inpatient? Celexa

Unacceptable Abbreviations

U and/or IU	MS, MSO4	gr
QD	MgSO4	ss
QOD	x 3 d	ug
Trailing zero (2.0)	Lack of leading zero (.5)	

DATE	TIME	
2/28/14	0730	No complaints
		mentally clear
		obs. No aggression, somewhat labile
		but not fighting,
	VS	BP 145/71, p-76, resp 16, afeb
	MSE	alert, OX4, no insight, well groomed
		no SI/HI, calm, no insight, no paranoia
	10/30	D [illegible] with husband [illegible]
		[illegible] - cont tx
		[signature]

Unacceptable Abbreviations

U and/or IU	MS, MSO4	gr
QD	MgSO4	ss
QOD	x 3 d	ug
Trailing zero (2.0)	Lack of leading zero (.5)	

Patient Label
TRINITY HOSPITAL OF AUGUSTA
RYALS GILBERT B 242-1
DOB: 1932-03-03 81 M PSYC MR#: 10064729
DAVID STEINER DOS: 2014-02-25
Patient Account #: 3657551 Printed on 2/27/14 at 6:25

'1PN'

DATE	TIME		Unacceptable Abbreviations
2/27/14	0700	No complaints staff reports	U and/or IU; QD; QOD; Trailing zero (2.0); MS, MSO4; MgSO4; x 3 d; Lack of leading zero (.5); gr; ss; ug
		no further hypoxia. No behavioral	
		problems. Slept 4 hrs - broken sleep	
	VS	P-92, Resp 18; temp. 98; BP 117/68	
	MSE	alert, ox2, no insight calm, well	
		groomed, no SI/HI; no A/V hallucinations	
		speech still hard to understand, no	
		LOA or FOI, MMSE 17/30	
CXR - no reading	1065	Hgb 11.0, cardiac profile unremarkable	
		digoxin < 0.2, BMP WNL	
	AP	1) Dementia & behavioral disturbance	
		cont celexa	
		2) disorientation - seems okay	
		3) speech to see	
		4) placement	

Patient Label
TRINITY HOSPITAL AUGUSTA
RYALS GILBERT B 242/ 1
03/03/1932 81 M PSY MR#:010064729
STEINER DAVID A DOS:02/25/14
PAT#: 3657551

"2PSYERD"

Score	Max Score		
0	5	I.	**Orientation**
3	5		What is the (Year) (Season) (Month) (Date) (Day)? Where are we (Country) (State) (County) (City) (Hospital)? DS. GA
		II.	**Registration**
2	3		Name three objects, allotting one second to say each. Then ask the patient to name all three objects after you have said them. Give one point for each correct answer. Repeat them until he repeats all three (6 trials). Count trials and record numbers. (Apple... Book... Coat...) # of trials 3
		III.	**Attention and Calculation**
5	5		Begin with 100 and count backward by 7 (stop after 5 answers): 93, 86, 79, 72, 65. If the patient will not perform this task, ask him to spell the "WORLD" BACKWARDS (DLROW). Record the patient's spelling DLROW. Score one point for each correctly placed letter.
		IV.	**Recall**
1	3		Ask the patient to repeat the objects above (see "Registration"). Give one point for each correct answer.
		V.	**Language**
2	2		Naming: Show a pencil and a watch. Ask the patient to name them.
0	1		Repetition: Repeat the following: "No ifs, ands, or buts."
3	3		Three-Stage Command: Follow the command, "Take a paper in your right hand, fold it in half and put it on the table."
1	1		Reading: Read and obey the following: "CLOSE YOUR EYES." (Show the patient the written item on the next page.)
0	1		Writing: Write a sentence on the next page: (must contain subject, verb and be sensible).
0	1		Copying: Copy the design of the intersection pentagons (on the next page).
			SCORING
			Scores above 26 – Normal cognitive functioning 20-26 – Mild impairment 11-20 – Moderate impairment 10 or below – Severe impairment
17	30		**Total Score**

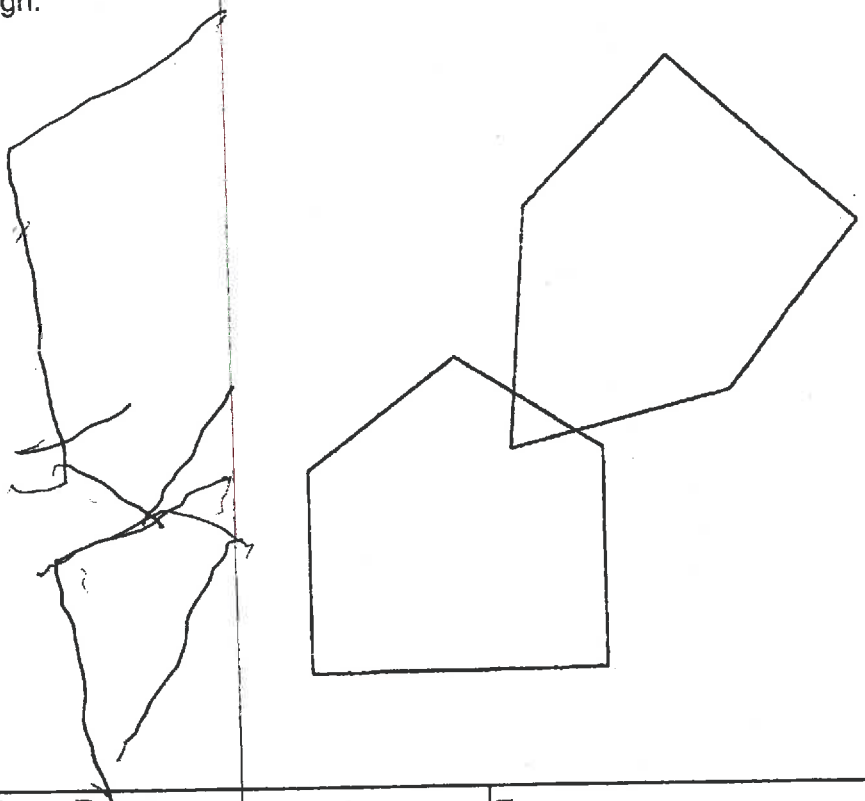
Signature (Person Administering Test) [signature] | Date 26 Feb 14 | Time 1800

Mini-Mental Status Exam
1536-S000228HMS 09/12

CLOSE YOUR EYES

Write a sentence: See the Dog run.

Copy Design:



Patient Label

1PN

DATE	TIME	
2/26/14	1800	Psych admit
		82 y/o WM admitted
		via VA from home for dementia
		c paranoia + aggression
		Psych eval elicited
		MSE- alert, OX1, rambling speech
		no insight, no hallucinations or delusions
		olg personality here so far
		He had a ? minor aspiration earlier
		this afternoon
		Spoke c daughter + got hx
		son c schizophrenia - pt has no
		past hx
		MSE: alert, OX1, rambling speech
		see above
		Dx I Dementia c behavioral disturbance
		II diverticulosis ; esophagitis
		HTN, PUD IV moderate V 24
		P 1) D/C Seroquel 2) celexa 3) D/C Klonopin
		4) Placed b- daughters wishes
		6080824

Unacceptable Abbreviations		
U and/or IU	MS, MSO4	gr
QD	MgSO4	ss
QOD	x 3 d	ug
Trailing zero (2.0)	Lack of leading zero (.5)	

Patient Label

TRINITY HOSPITAL AUGUSTA
RYALS GILBERT B 242/ 1
03/03/1932 81 M PSY MR#:010064729
STEINER DAVID A DOS:02/25/14
PAT#: 3657551

Date: 3/4/14 Room # 242

	0700 Initial	1900 Initial
Safety Precautions		
Falls	DH	MP
Suicide		
Assault		
Elopement		
Seizure		
Fall Risk Score _____		
Precautions/alarms in place		MP
Appearance		
Neatly groomed	DH	MP
Disheveled		
Appropriately dressed	DH	MP
Inappropriately Dressed		
Eye Contact		
Appropriate	DH	MP
Fair		
Poor/None		
LOC		
Alert	DH	MP
Drowsy		
Lethargic		
Orientation		
Person	DH	MP
Place	DH	MP
Date	DH	
Time	DH	
None		
Concentration		
Follows conversation	DH	MP
Follows directions	DH	MP
Difficulty with directions		
Difficulty with conversation		
Anxiety		
No complaints	DH	MP
Excessively worried		
Somatic complaints		
Confusion		
None		
Mild: Easily reoriented	DH	MP
Moderate		
Severe: Unable to reorient		
Increased after 4 pm		

	0700 Initial	1900 Initial
Energy Level		
No Complaints	DH	MP
Tired/Fatigued		
Excessive Energy		
Affect		
Congruent with mood	DH	MP
Not congruent with mood		
Flat		
Blunted		
Situational Brightening		
Elated		
Behaviors		
Social/Pleasant	DH	MP
Argumentative		
Verbally abusive		
Poor Impulse controls		
Attempts to elope		
Intrusive		
Isolative/Withdrawn		
Tearful/sad		
Disrobing		
Screaming/calling out		
Agitated		
Pacing		MP
Sexual Remarks		
Inappropriate touching		
Inappropriate laughter		
Easily redirects		
Difficult to redirect		
Physically Aggressive		
quiet		MP
Risk of Harm to Self		
Throwing self to floor		
Cutting self		
Biting Self		
Risk of Harm to Others		
Homicidal		
Denies		MP
Ideation: developing plan		
Plan: developed		
Able to carry out plan		
Suicide Assessment		
Safety Plan		
Denies suicidal thoughts		MP
Expressing passive death wish		

	0700 Initial	1900 Initial
Speech Pattern		
Clear	DH	
Rapid/loud		
Repetitive		
Pressured		
Rate/tone/volume WNL		MP
Mechanical		
Expressive aphasia		
Garbled		
Response Internal Stimuli		
None reported	DH	MP
Auditory		
Visual		
Other		
Thought Content		
Intact/goal oriented @ times		MP
Delusional		
Circumstantial		
Disorganized @ Times	DH	MP
Recurrent themes		
Suspicious/guarded responses		
Mood		
Elated		
Angry		
Dysphoric		
Calm/pleasant	DH	MP
Hopeless/helpless		
Discouraged		
Sleep		
Number Hours slept through night		9
PRN for Sleep Given		
Broken Sleep Pattern		
Nap during day		
ADL's		
Independent		MP
Assisted cooperative	DH	
Assisted combative		
Orthopedic		
Heel/toe gait, erect posture		
Steady gait	DH	MP
Pain		
Rate Pain 1-10	0	
Intervention completed – see note		

Skin			Cardiovascular			Gastrointestinal		
Bruising			Peripheral pulses palpable		MP	Bowel sounds present		
Rash			Good capillary refill		MP	Abdomen soft	DH	MP
Treatments			No calf tenderness			Nausea/vomiting		
Warm/pink	DH	MP	Heart sounds audible/regular			Bowel movement normal pattern		
			Pulse strong/regular 50-90	DH	MP			
Respiratory			BP between 100/50-170/90		MP	**Medications**		
Regular unlabored	DH	MP				Compliant	DH	MP
Clear breath sounds			**Fluid Balance**			Non-compliant		
Room Air	DH	MP	Good skin turgor	DH		PRN Given (Detailed in note)		
Sputum Clear			Edema			Medication Changes		
Respirations between 12-20		MP	Voiding 3-4 times /day					
			Urine clear/yellow		MP			

Initials	Signature	Date	Time	Initials	Signature	Date	Time
DH	Deb Hullon	3/4/14	0900				
MP	MP Lambert RN	3/4/14	2000				

Please remember that a flow sheet does not take the place of a written note.

Date/Time:	
3/4/14 0900	Pt resting in room after breakfast - denies pain or anxiety. Pleasant and conversational - Hullon
3/4/14 1200	Ate approximately 75% breakfast - hygiene just now. Appropriately dressed + compliant with meds this Asm. Hullon
1530	Playing cards, participating in activities in dining room. Hullon
3/4/14 2100	Pt OOB during shift change in dining area socializing c staff. He is pleasantly confused: AOx2. He is cooperative c pt. care and his VS are WNL. He says he is doing great today and started talking about his watch. There are no issues/complaints at this time. No signs of agitation/aggression/violent behavior. He took his medication whole c no problems swallowing. No HTN noted. He is well groomed and appropriately dressed. His IV plug in R AC was taken out c no s/s of infection/infiltration. Eye contact was maintained. ADLs are independent but dressing is usually assisted c 1-2 staff members. He says he's had his watch for 60 years and he's always watched the long second hand. No appetite/desire for food at this time. Will continue to assess and follow POC. MP Lambert RN

2NN

Date: 3/3/14 Room # 242

	0700 Initial	1900 Initial		0700 Initial	1900 Initial		0700 initial	1900 Initial
Safety Precautions			***Energy Level***			***Speech Pattern***		
Falls	DB	MP	No Complaints	DB		Clear	DB	MP
Suicide			Tired/Fatigued		MP	Rapid/loud		
Assault			Excessive Energy			Repetitive		
Elopement						Pressured		
Seizure			***Affect***			Rate/tone/volume WNL	DB	MP
Fall Risk Score _____			Congruent with mood	DB	MP	Mechanical		
Precautions/alarms in place	DB	MP	Not congruent with mood			Expressive aphasia		
			Flat			Garbled @ times	DB	MP
Appearance			Blunted					
Neatly groomed	DB	MP	Situational Brightening			***Response Internal Stimuli***		
Disheveled			Elated			None reported	DB	MP
Appropriately dressed		MP				Auditory		
Inappropriately Dressed			***Behaviors***			Visual		
			Social/Pleasant	DB	MP	Other		
Eye Contact			Argumentative					
Appropriate	DB	MP	Verbally abusive			***Thought Content***		
Fair			Poor Impulse controls			Intact/goal oriented		
Poor/None			Attempts to elope			Delusional		
			Intrusive			Circumstantial		
LOC			Isolative/Withdrawn		MP	Disorganized		
Alert	DB	MP	Tearful/sad			Recurrent themes	DB	MP
Drowsy			Disrobing			Suspicious/guarded responses		
Lethargic			Screaming/calling out					
			Agitated			***Mood***		
Orientation			Pacing			Elated		
Person	DB	MP	Sexual Remarks			Angry		
Place			Inappropriate touching			Dysphoric		
Date			Inappropriate laughter			Calm/pleasant	DB	MP
Time			Easily redirects		MP	Hopeless/helpless		
None			Difficult to redirect			Discouraged		
			Physically Aggressive					
Concentration						***Sleep***		
Follows conversation	DB	MP	***Risk of Harm to Self***			Number Hours slept through night		
Follows directions	DB	MP	Throwing self to floor			PRN for Sleep Given		
Difficulty with directions			Cutting self			Broken Sleep Pattern		
Difficulty with conversation			Biting Self			Nap during day		
Anxiety			***Risk of Harm to Others***			***ADL's***		
No complaints	DB	MP	Homicidal			Independent		MP
Excessively worried			Denies	DB	MP	Assisted cooperative	DB	
Somatic complaints			Ideation: developing plan			Assisted combative		
			Plan: developed					
Confusion			Able to carry out plan			***Orthopedic***		
None						Heel/toe gait, erect posture		
Mild: Easily reoriented		MP	***Suicide Assessment***			Steady gait	DB	MP
Moderate @ times	DB	MP	Safety Plan					
Severe: Unable to reorient			Denies suicidal thoughts	DB	MP	***Pain***		
Increased after 4 pm			Expressing passive death wish			Rate Pain 1-10 0	DB	
						Intervention completed – see note		

Skin		
Bruising		
Rash		
Treatments		
Warm/pink	DB	MP
Respiratory		
Regular unlabored	DB	MP
Clear breath sounds	DB	
Room Air		MP
Sputum Clear		
Respirations between 12-20	DB	MP

Cardiovascular		
Peripheral pulses palpable	DB	MP
Good capillary refill		MP
No calf tenderness		
Heart sounds audible/regular	DB	
Pulse strong/regular 50-90	DB	MP
BP between 100/50-170/90	DB	MP
Fluid Balance		
Good skin turgor fair	DB	
Edema		
Voiding 3-4 times /day		
Urine clear/yellow		MP

Gastrointestinal		
Bowel sounds present	DB	
Abdomen soft	DB	MP
Nausea/vomiting		
Bowel movement normal pattern		
Medications		
Compliant	DB	MP
Non-compliant		
PRN Given (Detailed in note)		
Medication Changes		

Initials	Signature	Date	Time	Initials	Signature	Date	Time
DB	Denise Bryant	3-3-14	8am				
MP	[signature] RN	3/3/14	2000				

Please remember that a flow sheet does not take the place of a written note.

Date/Time:	
3-3-14 8am	Pt. awake, alert and oriented to self only. Pt. made announcement "Today is my birthday and I am 55 yrs old." Pt very pleasant and cooperative. "I am doing well." D Bryant
8am	No behavioral disturbances noted this am but remains confused @ times easily reorients. D Bryant, RN
9am	Participating in group session (bowling). D Bryant
945	RFA IV plug intact - flushed and patent. D Bryant
12.23 pm	PPD placed to (L) LFA - Pt tol procedure well. D Bryant
2PM	Participating in group session - enjoying c peers. D Bryant
6PM	Tol evening meal well. O'ccas confused reorients easily. Resting quietly in bed shortly after dinner meal. D Bryant, RN
3/3/14 2100	Pt. in bed during shift change social c staff members and writer. He was cooperative c pt. care and stated that he's leaving tomorrow. He knows that it is his birthday as well. He is not displaying any violent behavior at this time. He took his medication whole c no swallowing issues. He is well groomed and maintains eye contact during conversation. He is cooperative c pt. care. Vital signs are within normal limits. He brings up the fact that he's leaving tomorrow quite frequently. it is a recurrent theme. "I'm heading down that 110 mile trail tomorrow". He is independent with toileting. will continue to assess and follow POC ——— [signature] RN
3/3/14 2345	Pt is sleeping soundly: His eyes are closed with chest movements from breathing. will continue to assess and follow POC ——— [signature] RN

Daily Nurses Notes
1536-S000210HMS 08/12 Page 2 of 2

Patient Label
TRINITY HOSPITAL OF AUGUSTA
RYALS GILBERT B 242-1
DOB: 1932-03-03 82 M PSYC MR#: 10064729
DAVID STEINER DOS: 2014-02-25
Patient Account #: 3657551 Printed on 3/3/14 at 2:55

"2NN"

Date: 3-2-14 Room # 242

	0700 Initial	1900 Initial
Safety Precautions		
Falls	KE	ll
Suicide		
Assault		
Elopement		
Seizure		
Fall Risk Score _____		
Precautions/alarms in place		ll
Yellow non Skid Socks		ll
Appearance		
Neatly groomed		ll
Disheveled		
Appropriately dressed	KE	ll
Inappropriately Dressed		
Pajama		
Eye Contact		
Appropriate		
Fair		ll
Poor/None		
LOC		
Alert		ll
Drowsy		
Lethargic	KE	
Fidgety @ times		
Orientation		
Person	KE	ll
Place		
Date		
Time		
None		
is aware of family members		
Concentration		
Follows conversation	KE	ll
Follows directions	KE	
Difficulty with directions		
Difficulty with conversation		ll
Anxiety		
No complaints	KE	ll
Excessively worried		
Somatic complaints		
Confusion		
None		
Mild: Easily reoriented		
Moderate	KE	ll
Severe: Unable to reorient		
Increased after 4 pm		

	0700 Initial	1900 Initial
Energy Level		
No Complaints	KE	ll
Tired/Fatigued		
Excessive Energy		
Affect		
Congruent with mood		
Not congruent with mood		
Flat		
Blunted		
Situational Brightening		
Elated		
Behaviors		
Social/Pleasant	KE	
Argumentative		
Verbally abusive		
Poor Impulse controls		
Attempts to elope		
Intrusive		
Isolative/Withdrawn		
Tearful/sad		
Disrobing		
Screaming/calling out		
Agitated Restless at times KE		
Pacing		
Sexual Remarks		
Inappropriate touching		
Inappropriate laughter		
Easily redirects	KE	
Difficult to redirect		
Physically Aggressive		
Risk of Harm to Self		
Throwing self to floor		
Cutting self		
Biting Self		
Risk of Harm to Others		
Homicidal		
Denies	KE	
Ideation: developing plan		
Plan: developed		
Able to carry out plan		
Suicide Assessment		
Safety Plan	KE	
Denies suicidal thoughts		
Expressing passive death wish		

	0700 Initial	1900 Initial
Speech Pattern		
Clear		
Rapid/loud		
Repetitive		
Pressured	KE	ll
Rate/tone/volume WNL		
Mechanical		
Expressive aphasia		
Garbled	KE	ll
Response Internal Stimuli		
None reported	KE	ll
Auditory		
Visual		
Other		
Thought Content		
Intact/goal oriented		
Delusional		
Circumstantial		
Disorganized	KE	ll
Recurrent themes		
Suspicious/guarded responses		
Mood		
Elated		
Angry		
Dysphoric	KE	ll
Calm/pleasant		
Hopeless/helpless		
Discouraged		
Sleep		
Number Hours slept through night		
PRN for Sleep Given		
Broken Sleep Pattern		ll
Nap during day	KE	
ADL's		
Independent	KE	
Assisted cooperative		ll
Assisted combative		
Orthopedic		
Heel/toe gait, erect posture		
Steady gait ambulates 3 incident	KE	ll
Pain		
Rate Pain 1-10 denies	0	0
Intervention completed – see note		

Skin			Cardiovascular			Gastrointestinal		
Bruising			Peripheral pulses palpable			Bowel sounds present	KE	
Rash			Good capillary refill			Abdomen soft	KE	
Treatments			No calf tenderness			Nausea/vomiting		
Warm/pink	KE	[illegible]	Heart sounds audible/regular	KE		Bowel movement normal pattern		
			Pulse strong/regular 50-90	KE	[illegible]			
Respiratory			BP between 100/50-170/90	KE	[illegible]	**Medications**		
Regular unlabored	KE	[illegible]				Compliant	KE	[illegible]
Clear breath sounds	KE		**Fluid Balance**			Non-compliant		
Room Air 99-100%	KE	[illegible]	Good skin turgor Fair	KE	[illegible]	PRN Given (Detailed in note)		
Sputum Clear			Edema Slight	KE		Medication Changes		
Respirations between 12-20	KE	[illegible]	Voiding 3-4 times /day		[illegible]			
			Urine clear/yellow					

Initials	Signature	Date	Time	Initials	Signature	Date	Time
KE	[signature]	3-2-14	1400	KE			
[illegible]	[signature]	3/3/14	0030				

Please remember that a flow sheet does not take the place of a written note.

Date/Time:	
3-2-14/1400	Pt. is a 81 y/o caucasian male admitted on 2/25/14 with a diagnosis of Dementia with behavior disturbances. Pt was transferred from the VA hospital with increased aggression towards staff and his daughter. Reports say that pt. had been grabbing at the RN's and made attempts to kiss them. Pt. also threatened to burn his daughters house down and kill her. Pt has a history of not taking all of his prescribed medications. Pt is alert + oriented X1 name only. His speech is garbled and difficult to understand due to pt having only a few teeth and no dentures. Pt also is hard of hearing when staff are talking with him. Pt is very independent and wants to do for himself. Pt does need assistance with bathing to ensure that he entirely cleaned. Pt ambulates well on his own and would prefer to walk on his own. Pt will stay in his room resting in bed, and will get up several times to walk around the bed or use the bathroom. Pt will spend half hour or so after he has eaten all of his meals. He is very regulated in completing this pattern all morning, afternoon + evening. According to Pt. history, Pt is a Veteran and served in the Korean War. Pt has been very compliant with all medications, following directions, completing meals s̄ incident. Pt has not displayed any aggressive behaviors, and he has made no threats to staff or family. Pt had a good visit with his daughter, brother and brother-in-law. Pt has a Heplock in his Ⓛ hand. Skin intact no redness noted. Pt has had no complaints R/T chest pain, dyspnea, physical pain at this time. IV site flushed with 10cc of sterile water. Pt has O2 @ 2L per Nasal Cannula. Pt O2 sat at 99-100% perfusion. Pt continues on Q15 per unit protocol. [signature]
3/3/14 ~~0030~~ 0100	Patient, 82 y/o caucasian male, direct admit from VA ER, lives at home with daughter. Dx. Dementia with Behavioral

Patient Label
TRINITY HOSPITAL OF AUGUSTA
RYALS GILBERT B 242-1
DOB: 1932-03-03 81 M PSYC MR#: 10064729
DAVID STEINER DOS: 2014-02-25
Patient Account #: 3657551 Printed on 3/2/14 at 10:26

"1PN"

DATE	TIME	Disturbances. Behaviors
3/3/14	0400	at home, trasspassing
		on neighbors property
		reportedly physical aggression towards daughter
		and also threatening behaviors. No verbal or physical
		aggression noted on this shift at this time. Compliant
		with all bed-time medication, Trazadone 50mg po given
		@ 2400 for insomnia. Patient up and down during
		the night, pleasantly confused, redirectable and
		able to orientate to place and time but forgetful.
		Appeared to be responding to internal stimuli at
		times. Staff observed patient talking outloud saying
		"No, I cant drive home, they stole my truck, so you
		gonna have to come get me." Answers questions appropriately
		the majority of times, smiles occassionally during interaction
		and at times can appear to be flat. Consumed 100%
		of a ham sandwich and Chips for bedtime Snack. Continent
		of bowel and bladder. Cooperative with staff
		assistance when needed for dressing and grooming. Presently
		sleeping quietly in bed, appears to be comfortable. No s/s of
		distress or discomfort noted. Vital Signs Stable, 7.984, 94, 16, 146/74
		98% sat on room air. Will cont. to monitor patient & follow poc S. Lavern

Unacceptable Abbreviations

U and/or IU	MS, MSO4	gr
QD	MgSO4	ss
QOD	x 3 d	ug
Trailing zero (2.0)	Lack of leading zero (.5)	

"2NN"

Date: 3-1-14 Room #

	0700 Initial	1900 Initial		0700 Initial	1900 Initial		0700 Initial	1900 Initial
Safety Precautions			***Energy Level***			***Speech Pattern***		
Falls	DEB		No Complaints	DEB		Clear	DEB	
Suicide			Tired/Fatigued			Rapid/loud		
Assault			Excessive Energy			Repetitive		
Elopement						Pressured		
Seizure			***Affect***			Rate/tone/volume WNL	DEB	
Fall Risk Score _____			Congruent with mood	DEB		Mechanical		
Precautions/alarms in place	DEB		Not congruent with mood			Expressive aphasia		
			Flat			Garbled		
Appearance			Blunted					
Neatly groomed	DEB		Situational Brightening			***Response Internal Stimuli***		
Disheveled			Elated			None reported		
Appropriately dressed	DEB					Auditory		
Inappropriately Dressed			***Behaviors***			Visual		
Shaved pt.	DEB		Social/Pleasant	DEB		Other		
Eye Contact			Argumentative					
Appropriate	DEB		Verbally abusive			***Thought Content***		
Fair			Poor Impulse controls			Intact/goal oriented		
Poor/None			Attempts to elope			Delusional		
			Intrusive			Circumstantial		
LOC			Isolative/Withdrawn			Disorganized	DEB	
Alert	DEB		Tearful/sad			Recurrent themes		
Drowsy			Disrobing			Suspicious/guarded responses		
Lethargic			Screaming/calling out					
			Agitated			***Mood***		
Orientation			Pacing			Elated		
Person	DEB		Sexual Remarks			Angry		
Place			Inappropriate touching			Dysphoric		
Date			Inappropriate laughter			Calm/pleasant	DEB	
Time			Easily redirects			Hopeless/helpless		
None			Difficult to redirect			Discouraged		
			Physically Aggressive					
Concentration						***Sleep***		
Follows conversation	DEB		***Risk of Harm to Self***			Number Hours slept through night		
Follows directions	DEB		Throwing self to floor			PRN for Sleep Given		
Difficulty with directions			Cutting self			Broken Sleep Pattern		
Difficulty with conversation			Biting Self			Nap during day 2 hr	DEB	
Anxiety			***Risk of Harm to Others***			***ADL's***		
No complaints	DEB		Homicidal			Independent		
Excessively worried			Denies	DEB		Assisted cooperative	DEB	
Somatic complaints			Ideation: developing plan			Assisted combative		
			Plan: developed					
Confusion			Able to carry out plan			***Orthopedic***		
None						Heel/toe gait, erect posture		
Mild: Easily reoriented			***Suicide Assessment***			Steady gait	DEB	
Moderate – responds easily	DEB		Safety Plan					
Severe: Unable to reorient			Denies suicidal thoughts	DEB		***Pain***		
Increased after 4 pm			Expressing passive death wish			Rate Pain 1-10 0	DEB	
						Intervention completed – see note		

Patient Label

TRINITY HOSPITAL AUGUSTA
RYALS GILBERT B 242/ 1
03/03/1932 81 M PSY MR#:01006472
STEINER DAVID A DOS:02/25/14
PAT#: 3657551

Skin			Cardiovascular			Gastrointestinal		
Bruising			Peripheral pulses palpable	Deb		Bowel sounds present	Deb	
Rash			Good capillary refill			Abdomen soft	Deb	
Treatments			No calf tenderness			Nausea/vomiting		
Warm/pink	Db		Heart sounds audible/regular	DB		Bowel movement normal pattern		
			Pulse strong/regular 50-90	DB				
Respiratory			BP between 100/50-170/90	DB		**Medications**		
Regular unlabored	DB					Compliant	DB	
Clear breath sounds	DB		**Fluid Balance**			Non-compliant		
Room Air 99%	DB		Good skin turgor Poor	Deb		PRN Given (Detailed in note)		
Sputum Clear			Edema			Medication Changes		
Respirations between 12-20			Voiding 3-4 times /day	Deb				
			Urine clear/yellow					

Initials	Signature	Date	Time	Initials	Signature	Date	Time
Db	Denise G. Bryant, RN	3-1-14	830a				
Initials	Signature	Date	Time	Initials	Signature	Date	Time

Please remember that a flow sheet does not take the place of a written note.

Date/Time:	
3-1-14 830am	Pt awake alert. Pleasantly confused but oriented to self. No behavioral disturbances noted. O2 sat 99% on r/a. B/P 121/55 - 69 - R. Skin warm dry. Color WNL for patient. Respirations even, unlabored. — D Bryant
9am	Lisinopril held this Am. Pt. [illegible] meal well. (ate 100%) No swallowing diff noted. — D Bryant
12N	Napping in bed for short period. Up in dayroom for lunch — D Bryant RN
2PM	Playing cards c staff. No changes noted. — D Bryant
3:45	Pt became unresponsive while [illegible] in chair, color pale. O2 sat ↓ 60's-80's then 92% - O2 2L applied via N/C. Jerking of R arm noted for approx 5 secs. Notified supervisor - pt returned to 100% O2 sat almost immediately. Placed call to Dr. Steiner. Made Mother aware. B/P ↓ 80/44 then ↑ to 120/70. Pt oriented c this time. BG 151
4PM	RRT notif. pt unresponsive color pale O2 sat ↓ 76. EKG performed. [illegible] to RRT (186) Dr. Steiner notified. CT head ordered and pt transp via w/c by supervisor + staff member. Pt ret from CT via w/c c O2 sats 96%. Made ready for dinner, tol well. Will continue to monitor. — D Bryant
1800	Spoke c pts daughter and made her aware of father's episode. (Amanda) — D Bryant, RN

Patient Label

TRINITY HOSPITAL AUGUSTA
RYALS GILBERT B 242/ 1
03/03/1932 81 M PSY MR#:010064729
STEINER DAVID A DOS:02/25/14
PAT#: 3657551

Skin			Cardiovascular			Gastrointestinal		
Bruising			Peripheral pulses palpable			Bowel sounds present		
Rash			Good capillary refill			Abdomen soft		
Treatments			No calf tenderness			Nausea/vomiting		
Warm/pink			Heart sounds audible/regular			Bowel movement normal pattern		
			Pulse strong/regular 50-90					
Respiratory			BP between 100/50-170/90			**Medications**		
Regular unlabored						Compliant		
Clear breath sounds			**Fluid Balance**			Non-compliant		
Room Air			Good skin turgor			PRN Given (Detailed in note)		
Sputum Clear			Edema			Medication Changes		
Respirations between 12-20			Voiding 3-4 times /day					
			Urine clear/yellow					

Initials	Signature	Date	Time	Initials	Signature	Date	Time
Initials	Signature	Date	Time	Initials	Signature	Date	Time

Please remember that a flow sheet does not take the place of a written note.

Date/Time:	
3-1-14 1800	Pt given Milk of Magnesia earlier in shift. No results noted ē pres. 1850. D Bryant
3/1/14 2200	Patient resting quietly in bed at this time, no S/S of distress or discomfort noted. Patient admitted for displaying physical aggression towards family, wander / trespassing- going into ~~other~~ neighbors houses, stealing items from [illegible], non-compliant with medications. Admitting Diagnose: Dementia with behavioral Disturbances. Early in shift Alert to self, requires frequent orientation to place, time, purpose. Follows directions. Poor eye contact, neat well groomed, shaven. Accepted hs meds without prompting. Trazodone 50mg po given for insomnia. Vital Signs Stable. T-98.7 P76, 18 BP 121/69- ~~O2 @~~ O2 sat @ 98%, O2 @ 2L via NC (prn). No aggression or aggitation noted at this time, Some confusion, disorganized thought process. Will cont the plan of care for the patient. will monitor. —— L Larcher
3/2/14 0050	Up to use bathroom at this time. Came out of room, stated that he forgot and didn't know where he was. Oriented patient to him being at Trinity Hospital, assured him he was still in Augusta GA, assisted patient back to room and to bed, will cont. to monitor patient —— L. Larche
3/2/14 0650	Patient showered this shift with the assistance of staff no aggression or aggitation noted this shift. Cooperative. Some confusion noted, redirectable and able to orientate to place and time. will cont. the plan of care — L. Larche

Patient Label

TRINITY HOSPITAL AUGUSTA
RYALS GILBERT B 242/ 1
03/03/1932 81 M PSY MR#:010064729
STEINER DAVID A DOS:02/25/14
PAT#: 3657551

Date: 2/28/14 Room # 242

	0700 Initial	1900 Initial		0700 Initial	1900 Initial		0700 Initial	1900 Initial
Safety Precautions			***Energy Level***			***Speech Pattern***		
Falls	TB	LHP	No Complaints	TB		Clear at times	TB	LHP
Suicide			Tired/Fatigued		LHP	Rapid/loud		
Assault			Excessive Energy			Repetitive		
Elopement						Pressured		
Seizure			***Affect***			Rate/tone/volume WNL	TB	LHP
Fall Risk Score _____			Congruent with mood	TB	LHP	Mechanical		
Precautions/alarms in place		LHP	Not congruent with mood			Expressive aphasia		
			Flat			Garbled at times	TB	LHP
Appearance			Blunted					
Neatly groomed		LHP	Situational Brightening			***Response Internal Stimuli***		
Disheveled	TB		Elated			None reported	TB	LHP
Appropriately dressed	TB	LHP				Auditory		
Inappropriately Dressed			***Behaviors***			Visual		
			Social/Pleasant	TB	LHP	Other		
Eye Contact			Argumentative					
Appropriate	TB	LHP	Verbally abusive			***Thought Content***		
Fair			Poor Impulse controls			Intact/goal oriented		
Poor/None			Attempts to elope			Delusional		
			Intrusive			Circumstantial		
LOC			Isolative/Withdrawn		LHP	Disorganized	TB	LHP
Alert	TB	LHP	Tearful/sad			Recurrent themes		
Drowsy	TB		Disrobing			Suspicious/guarded responses		
Lethargic			Screaming/calling out					
			Agitated			***Mood***		
Orientation			Pacing			Elated		
Person	TB	LHP	Sexual Remarks			Angry		
Place			Inappropriate touching			Dysphoric		
Date			Inappropriate laughter			Calm/pleasant	TB	LHP
Time			Easily redirects	TB	LHP	Hopeless/helpless		
None			Difficult to redirect			Discouraged		
			Physically Aggressive					
Concentration						***Sleep***		
Follows conversation		LHP	***Risk of Harm to Self***			Number Hours slept through night		B
Follows directions	TB	LHP	Throwing self to floor			PRN for Sleep Given		
Difficulty with directions			Cutting self			Broken Sleep Pattern		
Difficulty with conversation @ times	TB	LHP	Biting Self			Nap during day	TB	
Anxiety			***Risk of Harm to Others***			***ADL's***		
No complaints	TB	LHP	Homicidal			Independent		
Excessively worried			Denies	TB	LHP	Assisted cooperative	TB	LHP
Somatic complaints			Ideation: developing plan			Assisted combative		
			Plan: developed					
Confusion			Able to carry out plan			***Orthopedic***		
None						Heel/toe gait, erect posture		
Mild: Easily reoriented			***Suicide Assessment***			Steady gait	TB	LHP
Moderate	TB	LHP	Safety Plan					
Severe: Unable to reorient			Denies suicidal thoughts		LHP	***Pain***		
Increased after 4 pm			Expressing passive death wish			Rate Pain 1-10	6 TB	
						Intervention completed – see note		

Skin			Cardiovascular			Gastrointestinal		
Bruising			Peripheral pulses palpable		LHP	Bowel sounds present	TB	
Rash			Good capillary refill		LHP	Abdomen soft	TB	LHP
Treatments			No calf tenderness			Nausea/vomiting		
Warm/pink	TB	LHP	Heart sounds audible/regular	TB		Bowel movement normal pattern		
			Pulse strong/regular 50-90	TB	LHP			
Respiratory			BP between 100/50-170/90	TB	LHP	**Medications**		
Regular unlabored	TB	LHP				Compliant	TB	LHP
Clear breath sounds			**Fluid Balance**			Non-compliant		
Room Air		LHP	Good skin turgor			PRN Given (Detailed in note)		
Sputum Clear			Edema			Medication Changes		
Respirations between 12-20	TB	LHP	Voiding 3-4 times /day	TB				
O_2 2L PRN		LHP	Urine clear/yellow		LHP			

Initials	Signature	Date	Time	Initials	Signature	Date	Time
TB	T. Bell RN						
LHP	RN	2/28/14	2000				

Please remember that a flow sheet does not take the place of a written note.

Date/Time:	
2/28/14 0900	pt is sleeping in bed. Woke pt to give meds. pt compliant c meds. pt is pleasant and slightly confused. Re-oriented pt. No complaints. T. Bell RN
2/28/14 1145	pt is sitting in day room eating lunch. pt is sitting alone and not being very social. pt is calm and has no complaints. T. Bell RN
2/28/14 2100	Pt. in bed during shift change. He is alerted and oriented to self only. He is pleasantly confused and cooperative c pt. care. He took his medication whole with no swallowing issues. VS WNL: 98-T, 87-P, 18-R, 114/61-BP, 99-02. Cognitive impairment noted: He tends to need more prompting c direction, and reorientation to where he is. There are no signs of aggression/agitation. Fall precautions in place: no skid socks, 15 minute checks, side rails x3, bed low/locked. Will continue to access and follow POC RN

Log Letter 308

SOUTH CAROLINA
Healthy Connections
MEDICAID

Nikki Haley GOVERNOR
Anthony Keck DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

March 25, 2014

Ms. Amanda Cason
P.O. Box 76
Langley, SC 29834

Dear Ms. Cason:

Representative J. Roland Smith contacted our Agency on behalf of your father, Mr. Gilbert B. Ryals, Sr. application for Medicaid benefits.

Our records indicate that Mr. Ryals' application for Nursing Home assistance was received on March 6, 2014. His application is currently being reviewed to determine if he qualifies. According to federal guidelines, this determination may take up to forty-five (45) days. Ms. Carolyn Roach in our Office of Member Relations will monitor the processing of this application.

If you have questions, please contact Ms. Roach at 803-898-3967 and she will be happy to assist you.

We appreciate your continued interest and support of the South Carolina Healthy Connections Medicaid program. If I may be of further assistance on this or any other matter, please let me know.

Sincerely,

John R. Supra
Deputy Director and CIO

JRS:j