

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Roberts/FOIA</i>	DATE <i>12-16-13</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000201</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Coy, Mr. [unclear] Cleared 1/10/14, letter attached.</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____ <input checked="" type="checkbox"/> FOIA DATE DUE <i>1-6-14</i> <input type="checkbox"/> 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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TO <i>Roberts/FOIA</i>	DATE <i>12-16-13</i>
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APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

105000

Brenda James




From: Byron Roberts
Sent: Monday, December 16, 2013 4:30 PM
To: Brenda James
Cc: Jan Polatty; Marie Brown; Rick Hepfer
Subject: FW: Tammy Morris Medicaid Application
Attachments: morris.lettertokeck.pdf

Importance: High

Brenda,

The attached letter should be logged in as a FOIA request. Thx

Byron

Byron Roberts
General Counsel
Robertsb@scdhhs.gov
803.898.2795
www.scdhhs.gov
  



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From: Anthony Keck
Sent: Monday, December 16, 2013 3:02 PM
To: Byron Roberts
Subject: Fw: Tammy Morris Medicaid Application
Importance: High

What is this?

From: Patricia L Harrison <plh.cola@att.net>
Sent: Monday, December 16, 2013 2:39:26 PM
To: Anthony Keck; John Supra
Cc: Byron Roberts
Subject: Tammy Morris Medicaid Application

Dear Gentlemen, this is matter about which I spoke with Kathleen Snider last week. We are also mailing the application to the address listed on the application. Ms. Morris does not have access to internet. Please pass on this letter, application and attachments to Ms. Snider.

Ms. Morris has been unemployed since April and her children have not had health insurance. She has been afraid of additional retaliation if she were to apply for Medicaid benefits. I have agreed to have all communications between the Medicaid agencies and Ms. Morris to come through my office. Please contact me at 256 2017 or email me at plh.cola@att.net if you need additional information to process this application and advise me when their eligibility for benefits has been established.

As you can see from my letter, we are also requesting information through FOIA.

Thank you for your prompt attention to this matter.

Sincerely,

Patricia Logan Harrison

**Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205**

Telephone 803 256 2017

Fax 803 256 2213

December 16, 2013

Mr. Anthony Keck
South Carolina Department of Health and Human Services
PO Box 8296
Columbia, South Carolina 29202-8206

Ms. Kathleen Snider
Bureau Chief Compliance and Performance Review
South Carolina Department of Health and Human Services
PO Box 8296
Columbia, South Carolina 29202-8206

Mr. John Supra
Deputy Director for Operations and Information Management
South Carolina Department of Health and Human Services
PO Box 8296
Columbia, South Carolina 29202-8206

RE: Medicaid Application of Tammy Morris and follow up to FOIA request

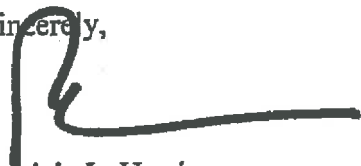
Dear Gentlemen and Ms. Snider:

I am enclosing the Medicaid application of Tammy Morris for her children, which is also being sent by mail to the PO Box 100101, the address contained . Also enclosed is my letter dated August 13, 2012 and Ms. Snider's reply. As I shared with Ms. Snider the other day, Ms. Morris has been unemployed for a number of months and she needs immediate Medicaid eligibility for her children. I would appreciate your assistance in expediting this application and please let me know if additional information is needed. Also, as requested on the enclosed statement, please direct all communication regarding this application and any other communications through my office. Please advise me when the children's eligibility for Medicaid has been established.

I am requesting copies of all records related to Ms. Morris and the investigation described in my August 13, 2012 letter. I am also requesting copies of all letters, memoranda and other writings related to the allegations contained in that letter. Please provide copies of all documents

related to overbilling by First Choice or other managed care providers since 2010 and any efforts DHHS has made to recoup those overpayments. In the event that these records should cost more than \$100, please contact me. Thank you very much for your assistance.

Sincerely,

A handwritten signature in black ink, appearing to be 'P. Harrison', with a long horizontal stroke extending to the right.

Patricia L. Harrison

cc: Tammy Morris

I have retained Patricia Logan Harrison, Esquire to assist me in matters related to my children's application for Medicaid benefits. Their applications are attached. I am requesting that all communications related to my children or me be directed through the Law Offices of Patricia Logan Harrison.

Sammy Monis

December 11, 2013



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 premiums 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 Appendix C.



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 if you can 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 www.healthcare.gov/privacy/.



What happens next?

Send your complete, signed application to the address on page 7. 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.)

First name, Middle name, Last name, & Suffix

Tammy Renee Morris

Home address (Leave blank if you don't have one.)

140-B Greenfield Rd.

3. Apartment or suite number

B

City

Columbia

5. State

SC

6. ZIP code

29223

7. County

Richland

Mailing address (if different from home address)

9. Apartment or suite number

10. City

11. State

12. ZIP code

13. County

14. Phone number

(803) 466-0153

15. Other phone number

(803) 360-5555

16. Do you want to get information about this application by email? ☐ Yes ☒ No

17. Mailing address:

18. What is your preferred spoken or written language (if not English)?

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.)

Who to 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 2 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 1 for more information about who 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 <u>Tammy Renee Morris</u>		2. Relationship to you? <u>SELF</u>
Date of birth (mm/dd/yyyy) <u>8-30-1971</u>	4. Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	
Social Security number (SSN) <u>524-25-4034</u>		

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 too 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.

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: _____

Are you pregnant? ☐ Yes ☒ No If yes, a. How many babies are expected during this pregnancy? _____

b. What is your Due Date? _____

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 3. Leave the rest of this page blank.

Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☒ No

d. Do you need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☒ No

1. 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)

2. Are you a U.S. citizen or U.S. national? ☒ Yes ☐ No

3. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?

☐ 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

4. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☒ No

5. 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

6. Are you a full-time student? ☐ Yes ☒ No

17. Were you in foster care in South Carolina at age 18 or older? ☐ Yes ☒ No

8. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

9. Race (OPTIONAL—check all that apply.)

<input checked="" type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
			<input type="checkbox"/> Other _____	

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 (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:

Employer name and address

21. Employer phone number

() - - - - -

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

Average hours worked each Week

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

Employer name and address

25. Employer phone number

() - - - - -

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

Average hours worked each Week

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

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?

\$ - - - - -

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 payment, or Supplemental Security Income (SSI).

☒ None☐ Unemployment \$ - - - - - How often? - - - - -☐ Pensions \$ - - - - - How often? - - - - -☐ Social Security \$ - - - - - How often? - - - - -☐ Retirement accounts \$ - - - - - How often? - - - - -☐ Alimony received \$ - - - - - How often? - - - - -☐ Net farming/fishing \$ - - - - - How often? - - - - -☐ Net rental/royalty \$ - - - - - How often? - - - - -☐ Other income

Type: - - - - - \$ - - - - - How often? - - - - -

Type: - - - - - \$ - - - - - How often? - - - - -

1. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage 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? - - - - -☐ Other deductions \$ - - - - - How often? - - - - -☐ Student loan interest \$ - - - - - How often? - - - - -

Type: - - - - -

2. YEARLY INCOME: Complete only if your income changes from month to month.

If you don't expect changes to your monthly income, skip to the next person.

Your total income this year Worked January - March 2013 Your total income next year (if you think it will be different)About 8,000 for the three months employed. \$ Not Sure - Seeking employment

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 yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you are one. See page 1 for more information about who 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 Michael Ross Woodle		2. Relationship to you? Children's Father
3. Date of birth (mm/dd/yyyy) 10-23-1967	4. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	
5. Social Security number (SSN) 251-57-3311 We need this if you want health coverage and have an SSN.		
6. Does PERSON 2 live at the same address as you? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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.)		
<input checked="" type="checkbox"/> YES. If yes, please answer questions a-c. <input type="checkbox"/> NO. If no, skip to question c.		
a. Will PERSON 2 file jointly with a spouse? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
If yes, name of spouse: _____		
b. Will PERSON 2 claim any dependents on his or her tax return? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list name(s) of dependents: Matthew Woodle, Benjamin Woodle, Myles Woodle		
c. Will PERSON 2 be claimed as a dependent on someone's tax return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, a. How many babies are expected during this pregnancy? _____		
b. What is PERSON 2's Due Date? _____		
9. Does PERSON 2 need health coverage? (Even if they have insurance, there might be a program with better coverage or lower costs.)		
<input checked="" type="checkbox"/> YES. If yes, answer all the questions below. <input type="checkbox"/> NO. If no, SKIP to the income questions on page 5. Leave the rest of this page blank.		
10. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
11. Do you need to live in a medical facility or nursing home or need nursing services at home? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
12. Have you been diagnosed with and are receiving treatment for any of the following? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
14. If PERSON 2 isn't a U.S. citizen or U.S. national, do they have eligible immigration status?		
<input type="checkbox"/> Yes. Fill in their document type and ID number below.		
a. Document type _____	b. Document ID number _____	
c. Has PERSON 2 lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No	d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Does PERSON 2 want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	16. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	17. Was PERSON 2 in foster care in South Carolina at age 18 or older? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
18. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)		
<input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____		
19. Race (OPTIONAL—check all that apply.)		
<input checked="" type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese
<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Vietnamese
		<input type="checkbox"/> Other Asian
		<input type="checkbox"/> Native Hawaiian
		<input type="checkbox"/> Guamanian or Chamorro
		<input type="checkbox"/> Samoan
		<input type="checkbox"/> Other Pacific Islander
		<input type="checkbox"/> Other _____

Now, tell us about any income from PERSON 2 on the back. ➡

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

Current Job & Income Information

☒ **Employed**

If PERSON 2 is currently employed, tell us about this income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

1. Employer name and address

HR Allen Inc.

21. Employer phone number

(803) 796-7069

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

\$17.00

3. Average hours worked each Week

40

CURRENT JOB 2: (If PERSON 2 has more jobs and need more space, attach another sheet of paper.)

4. Employer name and address

25. Employer phone number

() - -

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

7. Average hours worked each Week

8. In the past year, did PERSON 2: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☒ None of these

9. 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?

\$

10. 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 payment, or Supplemental Security Income (SSI).

☒ None

☐ Unemployment \$ How often?

☐ Net farming/fishing \$ How often?

☐ Pensions \$ How often?

☐ Net rental/royalty \$ How often?

☐ Social Security \$ How often?

☐ Other income

☐ Retirement accounts \$ How often?

Type: \$ How often?

☐ Alimony received \$ How often?

Type: \$ How often?

11. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

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 29b).

☐ Alimony paid \$ How often?

☐ Other deductions \$ How often?

☐ Student loan interest \$ How often?

Type:

12. 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 or skip to the next section.

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.

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

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 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 1 for more information about who 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 <u>Matthew Kendal Woodle</u>		2. Relationship to you? <u>Son</u>
Date of birth (mm/dd/yyyy) <u>12-4-2000</u>	4. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security number (SSN) <u>658-09-8201</u> We need this if you want health coverage and have an SSN.		
Does PERSON 2 live at the same address as you? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
If no, list address: _____		
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.)		
<input type="checkbox"/> YES. If yes, please answer questions a-c. <input checked="" type="checkbox"/> NO. If no, skip to question c.		
a. Will PERSON 2 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, name of spouse: _____		
b. Will PERSON 2 claim any dependents on his or her tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list name(s) of dependents: _____		
c. Will PERSON 2 be claimed as a dependent on someone's tax return? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list the name of the tax filer <u>Michael Woodle</u>		
How is PERSON 2 related to the tax filer <u>Son</u>		
Is PERSON 2 pregnant? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, a. How many babies are expected during this pregnancy? _____		
b. What is PERSON 2's Due Date? _____		

Does PERSON 2 need health coverage?
(Even if they 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 5. Leave the rest of this page blank.

1. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☒ No

2. Do you need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☒ No

3. 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)

4. Is PERSON 2 a U.S. citizen or U.S. national? ☒ Yes ☐ No

5. If PERSON 2 isn't a U.S. citizen or U.S. national, do they have eligible immigration status?

☐ Yes. Fill in their document type and ID number below.

a. Document type _____ b. Document ID number _____

c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

6. Does PERSON 2 want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	16. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	17. Was PERSON 2 in foster care in South Carolina at age 18 or older? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
--	--	--

8. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

9. Race (OPTIONAL—check all that apply.)

<input checked="" type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
				<input type="checkbox"/> Other _____

Now, tell us about any income from PERSON 2 on the back. ➡

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STEP 2: PERSON 2

Current Job & Income Information

Employed

If PERSON 2 is currently employed, tell us about this income. Start with question 20.

☒ Not employed
Skip to question 30.

☐ Self-employed
Skip to question 29.

CURRENT JOB 1:

Employer name and address

21. Employer phone number

() -

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

Average hours worked each Week

CURRENT JOB 2: (If PERSON 2 has more jobs and need more space, attach another sheet of paper.)

Employer name and address

25. Employer phone number

() -

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

Average hours worked each Week

In the past year, did PERSON 2: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

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?

\$

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 payment, or Supplemental Security Income (SSI).

None

Unemployment \$ How often?

Pensions \$ How often?

Social Security \$ How often?

Retirement accounts \$ How often?

Alimony received \$ How often?

☐ Net farming/fishing \$ How often?

☐ Net rental/royalty \$ How often?

☐ Other income

Type: \$ How often?

Type: \$ How often?

DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

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 29b).

Alimony paid \$ How often?

Student loan interest \$ How often?

☐ Other deductions \$ How often?

Type:

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 or skip to the next section.

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.

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

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STEP 2: PERSON 2

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 are one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

First name, Middle name, Last name, & Suffix <u>Benjamin ROSS Woodlee</u>		2. Relationship to you? <u>Son</u>
Date of birth (mm/dd/yyyy) <u>11-5-2003</u>	4. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security number (SSN) <u>057-10-2508</u> We need this if you want health coverage and have an SSN.		
Does PERSON 2 live at the same address as you? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
If no, list address: _____		
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.)		
<input type="checkbox"/> YES. If yes, please answer questions a-c. <input checked="" type="checkbox"/> NO. If no, skip to question c.		
a. Will PERSON 2 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, name of spouse: _____		
b. Will PERSON 2 claim any dependents on his or her tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list name(s) of dependents: _____		
c. Will PERSON 2 be claimed as a dependent on someone's tax return? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list the name of the tax filer <u>Michael Woodlee</u>		
How is PERSON 2 related to the tax filer <u>Son</u>		
Is PERSON 2 pregnant? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, a. How many babies are expected during this pregnancy? _____		
b. What is PERSON 2's Due Date? _____		

Does PERSON 2 need health coverage?

(Even if they 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 5. Leave the rest of this page blank.

Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Do you need to live in a medical facility or nursing home or need nursing services at home? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Have you been diagnosed with and are receiving treatment for any of the following? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Breast Cancer	Cervical Cancer
Atypical Breast Hyperplasia	Precancerous Cervical Lesion (CIN 2/3)
Is PERSON 2 a U.S. citizen or U.S. national? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
If PERSON 2 isn't a U.S. citizen or U.S. national, do they have eligible immigration status?	
<input type="checkbox"/> Yes. Fill in their document type and ID number below.	
a. Document type _____	b. Document ID number _____
c. Has PERSON 2 lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Does PERSON 2 want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	16. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	17. Was PERSON 2 in foster care in South Carolina at age 18 or older? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

Race (OPTIONAL—check all that apply.)

White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
			<input type="checkbox"/> Other _____	

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

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STEP 2: PERSON 2

Current Job & Income Information

☐ Employed

If PERSON 2 is currently employed, tell us about this 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

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

3. Average hours worked each Week

CURRENT JOB 2: (If PERSON 2 has more jobs and need more space, attach another sheet of paper.)

4. Employer name and address

25. Employer phone number

() -

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

7. Average hours worked each Week

3. In the past year, did PERSON 2: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

3. 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?

\$

1. 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 payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment \$ How often?

☐ Pensions \$ How often?

☐ Social Security \$ How often?

☐ Retirement accounts \$ How often?

☐ Alimony received \$ How often?

☐ Net farming/fishing \$ How often?

☐ Net rental/royalty \$ How often?

☐ Other income

Type: \$ How often?

Type: \$ How often?

1. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

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 29b).

☐ Alimony paid \$ How often?

☐ Student loan interest \$ How often?

☐ Other deductions \$ How often?

Type:

1. 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 or skip to the next section.

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.

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

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STEP 2: PERSON 2

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 1 for more information about who 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 <u>MYLES Coby Woodle</u>		2. Relationship to you? <u>Son</u>
Date of birth (mm/dd/yyyy) <u>8-24-2007</u>	4. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security number (SSN) <u>658-26-9629</u> We need this if you want health coverage and have an SSN.		
Does PERSON 2 live at the same address as you? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
If no, list address: _____		
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.)		
<input type="checkbox"/> YES. If yes, please answer questions a-c. <input checked="" type="checkbox"/> NO. If no, skip to question c.		
a. Will PERSON 2 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, name of spouse: _____		
b. Will PERSON 2 claim any dependents on his or her tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list name(s) of dependents: _____		
c. Will PERSON 2 be claimed as a dependent on someone's tax return? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list the name of the tax filer <u>Michael Woodle</u>		
How is PERSON 2 related to the tax filer <u>Son</u>		
Is PERSON 2 pregnant? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, a. How many babies are expected during this pregnancy? _____		
b. What is PERSON 2's Due Date? _____		

Does PERSON 2 need health coverage?

(Even if they 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 5. Leave the rest of this page blank.

Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Do you need to live in a medical facility or nursing home or need nursing services at home? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Have you been diagnosed with and are receiving treatment for any of the following? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)	
Is PERSON 2 a U.S. citizen or U.S. national? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
If PERSON 2 isn't a U.S. citizen or U.S. national, do they have eligible immigration status?	
<input type="checkbox"/> Yes. Fill in their document type and ID number below.	
a. Document type _____	b. Document ID number _____
c. Has PERSON 2 lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Does PERSON 2 want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	16. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	17. Was PERSON 2 in foster care in South Carolina at age 18 or older? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

Race (OPTIONAL—check all that apply.)

<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
			<input type="checkbox"/> Other _____	

Now, tell us about any income from PERSON 2 on the back. ➡

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STEP 2: PERSON 2

Current Job & Income Information

☐ Employed

If PERSON 2 is currently employed, tell us about this income. Start with question 20.

☒ Not employed

Skip to question 30.

☐ Self-employed

Skip to question 29.

CURRENT JOB 1:

0. Employer name and address

21. Employer phone number

() -

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

3. Average hours worked each Week

CURRENT JOB 2: (If PERSON 2 has more jobs and need more space, attach another sheet of paper.)

4. Employer name and address

25. Employer phone number

() -

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

7. Average hours worked each Week

8. In the past year, did PERSON 2: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

9. 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?

\$

10. 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 payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment \$ How often?

☐ Net farming/fishing \$ How often?

☐ Pensions \$ How often?

☐ Net rental/royalty \$ How often?

☐ Social Security \$ How often?

☐ Other income

☐ Retirement accounts \$ How often?

Type: \$ How often?

☐ Alimony received \$ How often?

Type: \$ How often?

11. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

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 29b).

☐ Alimony paid \$ How often?

☐ Other deductions \$ How often?

☐ Student loan interest \$ How often?

Type:

12. 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 or skip to the next section.

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.

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

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STEP 3

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

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

☒ If No, skip to Step 4.

☐ Yes. If yes, go to Appendix B.

STEP 4

Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

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 or Line of Duty)

☒ VA health care programs Michael Woodle

☐ 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-benefit plan (like a school accident policy)?

☐ Yes ☐ No

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 & sign this application.

Please read the following terms and conditions. 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.

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 visiting www.hhs.gov/ocr/office/file or I can contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD).

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.

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.

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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.

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 mentally retarded, 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.

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.

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.

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.

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.
(name of person)

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.

Medicaid will 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 in Appendix C.

Signature

Sammy R. Monis

Date (mm/dd/yyyy)

12-10-2013

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

STEP 6

mail completed application.

Mail your signed application to:

SCDHHS – CEP
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) <u>Michael Ross Woodle</u>	2. Employee Social Security number <u>251-57-5311</u>
--	--

EMPLOYER Information

3. Employer name <u>HR Allen Inc.</u>		4. Employer Identification Number (EIN)
5. Employer address <u>3511 Delree St.</u>		6. Employer phone number <u>(803) 796-7069</u>
7. City <u>W. Columbia</u>	8. State <u>SC</u>	9. ZIP code
10. Who can we contact about employee health coverage at this job? <u>Andrea (Andy)</u>		
11. Phone number (if different from above)	12. Email address	
<u>()</u>		

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

☒ Yes (Continue)

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: Matthew Woodle Name: Benjamin Woodle Name: Myles Woodle

☐ No (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

4. Does the employer offer a health plan that meets the minimum value standard?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5. 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? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input checked="" type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly	
6. What change will the employer make for the new plan year (if known)?	
<input type="checkbox"/> Employer won't offer health coverage	
<input type="checkbox"/> 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 will the employee have to pay in premiums for that plan? \$ _____	
b. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> 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 10 less than 60 percent of such costs (Section 36B(c)(2)(C)(i) 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 1-800-753-8353.

Cash Payroll

11/14/13 to 12/05/13

		<== Paid Hours ==>				<===== Earnings =====>				<===== Deductions =====>						
Employee No	Check No	Reg	Qty	Oth	Reg Wages	OVT Wages	Taxable Add	Tx Unl Fring	Gross Pay	FICA	State	Union	Misc	Net Pay	Check Date	
Name		Ovt					Non-Tax Add	Emp Fringe	Tot Taxable	Federal	Local					
1940 Woodie, Michael R.	83012	37.00	0.00	0.00	629.00	0.00	0.00	0.00	629.00	48.12	18.68	0.00	0.00	558.26	11/14/2013	
		0.00	0.00	0.00	0.00	0.00	0.00	0.00	629.00	1.94	0.00	0.00	0.00			
1940 Woodie, Michael R.	83240	40.00	0.00	0.00	680.00	0.00	0.00	0.00	680.00	52.02	23.25	0.00	0.00	597.69	11/21/2013	
		0.00	0.00	0.00	0.00	0.00	0.00	0.00	680.00	7.04	0.00	0.00	0.00			
1940 Woodie, Michael R.	83488	40.00	0.00	0.00	680.00	0.00	0.00	0.00	680.00	52.02	23.25	0.00	0.00	597.69	11/27/2013	
		0.00	0.00	0.00	0.00	0.00	0.00	0.00	680.00	7.04	0.00	0.00	0.00			
1940 Woodie, Michael R.	83690	36.00	0.00	0.00	612.00	0.00	0.00	0.00	612.00	48.82	18.48	0.00	0.00	548.45	12/5/2013	
		0.00	0.00	0.00	0.00	0.00	0.00	0.00	612.00	0.24	0.00	0.00	0.00			
Totals Posted:		153.00			2,601.00			0.00		198.98			0.00			
		0.00			0.00			0.00		16.26			0.00			
Direct Deposits: 4			0.00				0.00		2,601.00		84.67			2,301.09		
Void Direct Deposits: 0			0.00				0.00		2,601.00		0.00					

PATRICIA L. HARRISON
ATTORNEY AT LAW
611 HOLLY STREET
COLUMBIA, SOUTH CAROLINA 29205

TELEPHONE (803) 256-2017

FAX (803) 256-2213

August 13, 2012

HAND DELIVERED
URGENT - REQUIRES IMMEDIATE ATTENTION

Mr. Anthony Keck
South Carolina Department of Health and Human Services
Main and Laurel Streets
Columbia, South Carolina

Re: Tammy Morris

Dear Mr. Keck:

I am writing this letter to give you and your agency the opportunity to make corrections which, if not corrected, may lead to the improper use of legal process for purposes of retaliation against a state employee. **Time is of the essence to prevent the mother of four school aged children from being arrested based on erroneous information and analysis provided by your agency.** Also, I write to formally inform DHHS of what appears to me to be gross overbilling by one of your managed care providers, First Choice. This overpayment was not discovered by your internal audit staff when they faxed the detailed claims reports of Tammy Morris and her children to the Attorney General.

The attached detailed claims reports were presented to Tammy Morris when the South Carolina Attorney General's Office demanded payment of \$23,428.68 in one lump sum payment. The investigator informed me that they intend to arrest her based entirely on information provided to him by your office. The information that DHHS provided to the Attorney General's Office presented to Ms. Morris contains the following errors:

1. Neither Ms. Morris nor her children received any Medicaid benefits during 2009, 2010, 2011 or 2012. Ms. Morris is unfamiliar with Kimberly Seymore, Farrion Lee Seymore, Bobby Rivers, Starta Crystal Owens or Chyenne Lewis, whose detailed claims reports were delivered to Ms. Waddle with the demand for payment to HHS. Exhibit 1. (I will leave it to you to address the HIPAA violations incurred thereby and to notify these individuals that their health care information was released to Ms. Morris.) After I called this error to the investigator's attention, he did drop the claims against Ms. Morris for claims your agency paid for these unrelated persons' care.
2. Someone made an anonymous report to your office that Ms. Morris has been married "for about 13-14 years" to Michael Woodle. She is not married to Mr. Woodle. We have

reason to believe that this false report may have been provided by a former deputy at DSS or another supervisory employee there in retaliation. Your agency provided this information to the Attorney General, who made the false allegation on the affidavit he provided to the Court stating that Mr. Woodle was Ms. Morris' "common law spouse." Based on the information your agency provided, this investigator falsely informed the Court that "the estimated total loss (as of the date of this document) to SCDHHS-Medicaid is approximately \$21,000.00."

3. I am not familiar with any legal basis for attempting to attribute income of Michael Woodle to determine Medicaid eligibility for Brandon Morris, who is not his child, but your agency's detailed claims report for Brandon Morris shows that First Choice billed South Carolina Medicaid for \$1,791 for Doxycycline and \$6,112.00 for Enalapril Maleate in December 2006, the first month they received Medicaid benefits. These charges are marked up 100 times the actual cost (based on the amount paid for these drugs in later months).
4. The payment of \$9,181 for Omnicef for Benjamin Morris - also during the month of December, 2006 - appears to be one hundred to two hundred times the retail cost of this drug. The South Carolina Attorney General was not interested in investigating these overpayments when I tried to bring them to his attention. Since your agency is attempting to collect these amounts from my client, we are requesting information on any overpayments by DHHS managed care companies of which your agency is aware. This request is made pursuant to FOIA. Has DHHS adjusted its detailed claims reports for individuals when you have discovered overpayments to providers, like the \$10.5 million overpayment to the managed care company where Ms. Felicity Myers was working when she left your agency?
5. For purposes of my analysis, I have not included any costs attributable to Brandon Morris, since Michael Woodle did not have any liability for the cost of his medical care.
6. During 2006, this family received Medicaid benefits for only one month, December. Ms. Morris and Mr. Woodle purchased a home at 111 Oak Cove Drive in Columbia, S.C. in October, 2006. During the last quarter of 2006, Mr. Woodle made one house payment, Ms. Morris became pregnant (with a child who was delivered in August the following year) and Mr. Woodle was arrested soon after the conception of this child. Ms. Morris did not know his whereabouts after his arrest and reported him missing to the Richland County Sheriff's Department. He was not present in the home when Ms. Morris completed the December 7, 2006 annual review form.

Even if Mr. Woodle had been in the home the entire fourth quarter of 2006, his income of \$2,924.96 (\$2,824.96 with the income disregard) per month did not exceed the income limit for the Partners for Healthy Children program for that quarter. All of the charges for the children were incurred during December, 2006, when they were clearly eligible, even considering Mr. Woodle's income. Although Ms. Morris did not know of Mr. Woodle's whereabouts during December, 2006, it is believed that his income was considerably

below this average monthly amount for the fourth quarter due to his incarceration.

Your agency simply took Mr. Woodle's average income for the year and attributed that amount to Ms. Morris for the month of December, in order to make it appear that she lied on the application for Medicaid benefits. There is no statute nor rule which would allow DHHS to attribute income earned by the children's father between January and November to the month of December.

7. There are three reasons why the Omnicef charge in Benjamin Woodle's detailed claims report is in error. First, Benjamin is allergic to this drug and his medical chart at Dr. Wessinger's office contains a warning not to prescribe Omnicef. Secondly, the price for this drug appears to have been inflated at least 100 times the retail price. Thirdly, as discussed above, the agency based its determination of his eligibility on income earned in earlier months by a nonrelated party who had no duty to support Brandon. We hope that your agency will investigate why this excessive payment was made to First Choice.
8. During 2007, Ms. Morris was pregnant with her fourth child, Myles, who was born in August. She lived at various places, as the home at 111 Oak Cove Drive was by that time in foreclosure. Even if Mr. Woodle had been present in the home the entire year, his monthly income for the first, third and fourth quarter was less than the allowable income limit. Those quarters should not be at issue. It is very difficult to read the copies the detailed claims reports the AG's Office provided to me, which were apparently faxed to them by your internal audit division. But, even if Mr. Woodle's income was countable during the second quarter, it appears that only \$694.40 in benefits would have been improperly billed to Medicaid for services provided to his children during that quarter if he was in the home. We are gathering evidence to document that Mr. Woodle was not in the home during the second quarter. (Ms. Morris did not receive any Medicaid benefits during the second quarter.)
9. There are no costs reported on the claims forms for Ms. Morris' children during 2008. She received Medicaid benefits in the amount of \$214.20 during the first quarter of that year. But, the combined income of Ms. Morris and Mr. Woodle (had he been in the home) was less than the income limit during the time when these benefits were received.

The allegations of Medicaid fraud brought against my client, which are based solely on information and eligibility analysis provided by HHS, have caused harm, including extreme emotional distress, to Tammy Morris. This injury will only be exacerbated if she is arrested based on the referral by HHS to the Attorney General alleging Medicaid fraud. We are respectfully asking you to notify Investigator Stuart Andrews and Prosecutor Camille Guthrie of the Office of the Attorney General of these errors today so as to avoid further injury due to this scheme which involves the abuse of legal process against my client. In hopes of preventing further violation of my client's civil rights, I am delivering a copy of this letter to Mr. Keck's attorneys, Byron Roberts and Roy Laney.

While we are gathering evidence to support Ms. Morris' defense that Mr. Woodle was not present in the home during the second quarter of 2007, she is willing to tender payment of \$694.00 pending resolution of your agency's claim. This is simply an offer to prevent the arrest of this mother of four, who is likely to lose her job if she is arrested pursuant to information your agency provided the Attorney General. It is not an admission that these children were not eligible for these benefits. We will be happy to share the information we collect to show that he was not living in the home at that time and request a meeting to discuss this case.

Sincerely,



Patricia L. Harrison

cc: Tammy Morris (via hand delivery)
Attorney General MWilson (via fax and hand delivery)
Camille Guthrie (via fax and hand delivery)
Stuart Register, (via fax and hand delivery)
Lillian Kellar, DSS (via fax and mail)
Roy Laney, Esq. (via email, fax and hand delivery)
Byron Roberts, Esq. (via email, fax and hand delivery)



LAN WILSON
ATTORNEY GENERAL

May 9, 2012

Ms. Tammy R. Morris
308 S. Shields Road
Columbia, South Carolina 29223

Ms. Morris,

Per our conversation I am mailing to you a copy of the "Detailed Claims Report" that shows an itemized listing of the charges that Medicaid paid for during the period from 2006 forward. During our investigation we have established probable cause to believe you were ineligible for Medicaid benefits and further that you unlawfully provided false and/or misleading information to Medicaid in order to acquire certain benefits. The total loss to the victim (Medicaid) is approximately \$23,428.68. During our discussion I pointed out several options to you and you indicated that you would prefer to voluntarily pay back the victim (Medicaid) if possible. If you choose to do this it must be purely voluntary on your part. In cases where an individual in your situation chooses to reimburse Medicaid, you must do so in a single "lump sum" payment. Normally this payment is made within thirty (30) to sixty (60) days and I can again explain to you the details of how the funds are transferred from you to Medicaid. I also realize that you may need to seek out the advice of lawyer or to possibly involve family members to guide you and assist you in the acquisition of a bank loan. We certainly understand this but we urge you to act quickly in this matter and remain in constant contact with us during these activities. Please contact me weekly as you know more about how you would like to proceed. If we do not hear from you it certainly limits our options in this matter.

Please feel free to contact me at (803) 223-3733 and I will answer any questions you may have to the best of my ability.

Sincerely,

W. Stuart Register
Special Investigator
S.C. Attorney General's Office
Post Office Box 11549
Columbia, South Carolina 29211
Email: sregister@scag.gov



ALAN WILSON
ATTORNEY GENERAL

Date: July 5, 2012

Ms. Patricia Harrison, Esquire
611 Holly Street
Columbia, South Carolina 29205

Dear Ms. Harrison,

Per our discussion on 06-12-12 at the SCAGO, I have voluntarily provided you with a full copy of our SCAGO case file and therefore no discovery motion will be necessary. You will see that I have obtained a corrected "Detailed Claims Report" (DCR) and I have made some highlighted notes (in yellow) that I hope will help you more fully understand this matter and assist your client. If you have Medicaid eligibility questions you should contact SCDHHS directly. In the enclosed packet I have included names and numbers of those who may assist you at SCDHHS or you are welcome to speak with anyone there of your own choosing. Since this is a criminal investigation you indicated that you might refer Ms. Morris to another attorney. If this occurs please let me know.

With kind regards, I am

Sincerely,

W. Stuart Register
Special Investigator
SCAGO - Medicaid Recipient Fraud Unit



State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

FAX COVER SHEET

"CONFIDENTIAL INFORMATION ENCLOSED"

DATE: _____
TO: Stewart Register
TELEPHONE #: (803) 223-3733
FAX #: 966 359-2001
FROM: Caprise Graham

*Ineligible per
SCDH#5-744*

*Questions?
Call Zanella Price
785-6242
-OR-*

Total Number of Pages Transmitted: _____ (Including Cover Sheet) *Myra*

COMMENTS:

*Shivers
(803) 785-2930*

WSP

Confidentiality Note

This message is intended for the use of the person or entity to which it is addressed and may contain information, including health information, that is privileged, confidential, and the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you have received this in error, please notify us immediately and destroy the related message. Thank you.

Division of Program Integrity
P. O. Box 100210 • Columbia, South Carolina 29202-3210
(803) 898-2640 • Fax (803) 255-8224

Chlorine Counts
Medical Total Pains
HMV Total Pains
Medical and HMV Total Pains
Medical and HMV Total Pains

From the no-budgeted budget sheets to the birth of the cost sheet.

**South Carolina Department of Health and Human Services
• Databases Online Report •**

[illegible]

860.8

[illegible]

Chatham County
 Medford Twp. Pa.
 RHO Twp. Pa.
 HMO Twp. Pa.
 Medford Twp. Pa.
 RHO Twp. Pa.
 HMO Twp. Pa.

127: 23

Database: p15621
Medstat

Run Date: Wed, May 08 2012 12:48:55 PM

Author: h2kcyoun

Record Listing Filename: \medstat\advantage\advantage21\fromtbl21cyoun\temp\equal DCR 2012-05-08 12:48:05.rtf
Description: A listing of records from all facility, professional, rti, and drug claims data. Includes U claims to not voids. E claims excluded by record type. Omitted
deleted and rejected lines. Omitted header lines noted as 0 in the database. Omitted J claims.

Subset: HCaptias Grahamcoy NEW STANDARD SUBSET

((Claim Type = DENTAL,HIC,MANUAL-XOVER-B,MED-TRANS,MEDICARE-B And Status Line = Delete Claim,Deny Claim And Line Number = 0) Or Claim
Type = BUY-IN,DRUGS,MANUAL-XOVER-A,MEDICARE-A,NURSE-HOME-INV,UB92) And Record Type = Encounter HMO,Encounter PEP,FFS,Non Claim
Filterable And Last Claim Indicator = Y And (Service Date MMDDYY = 12/01/2008-08/01/2007 And Person ID Unencrypted =
3780226883,9530224902,9530224903)

Time Period: No Time Period Defined

Tables: Notes:

UFG 001-00000 100 100 000-00000

[illegible]

Churn Count:	Medical Total Paid:	HMO Total Paid:	Medical and HMO Total Paid:
100	100	100	200
200	200	200	400
300	300	300	600
400	400	400	800
500	500	500	1000
600	600	600	1200
700	700	700	1400
800	800	800	1600
900	900	900	1800
1000	1000	1000	2000
1100	1100	1100	2200
1200	1200	1200	2400
1300	1300	1300	2600
1400	1400	1400	2800
1500	1500	1500	3000
1600	1600	1600	3200
1700	1700	1700	3400
1800	1800	1800	3600
1900	1900	1900	3800
2000	2000	2000	4000
2100	2100	2100	4200
2200	2200	2200	4400
2300	2300	2300	4600
2400	2400	2400	4800
2500	2500	2500	5000
2600	2600	2600	5200
2700	2700	2700	5400
2800	2800	2800	5600
2900	2900	2900	5800
3000	3000	3000	6000
3100	3100	3100	6200
3200	3200	3200	6400
3300	3300	3300	6600
3400	3400	3400	6800
3500	3500	3500	7000
3600	3600	3600	7200
3700	3700	3700	7400
3800	3800	3800	7600
3900	3900	3900	7800
4000	4000	4000	8000
4100	4100	4100	8200
4200	4200	4200	8400
4300	4300	4300	8600
4400	4400	4400	8800
4500	4500	4500	9000
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4700	4700	4700	9400
4800	4800	4800	9600
4900	4900	4900	9800
5000	5000	5000	10000
5100	5100	5100	10200
5200	5200	5200	10400
5300	5300	5300	10600
5400	5400	5400	10800
5500	5500	5500	11000
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5800	5800	5800	11600
5900	5900	5900	11800
6000	6000	6000	12000
6100	6100	6100	12200
6200	6200	6200	12400
6300	6300	6300	12600
6400	6400	6400	12800
6500	6500	6500	13000
6600	6600	6600	13200
6700	6700	6700	13400
6800	6800	6800	13600
6900	6900	6900	13800
7000	7000	7000	14000
7100	7100	7100	14200
7200	7200	7200	14400
7300	7300	7300	14600
7400	7400	7400	14800
7500	7500	7500	15000
7600	7600	7600	15200
7700	7700	7700	15400
7800	7800	7800	15600
7900	7900	7900	15800
8000	8000	8000	16000
8100	8100	8100	16200
8200	8200	8200	16400
8300	8300	8300	16600
8400	8400	8400	16800
8500	8500	8500	17000
8600	8600	8600	17200
8700	8700	8700	17400
8800	8800	8800	17600
8900	8900	8900	17800
9000	9000	9000	18000
9100	9100	9100	18200
9200	9200	9200	18400
9300	9300	9300	18600
9400	9400	9400	18800
9500	9500	9500	19000
9600	9600	9600	19200
9700	9700	9700	19400
9800	9800	9800	19600
9900	9900	9900	19800
10000	10000	10000	20000

Blut

17969

8911 + - Love | 111
gates

after the pregnancy is before delivery
for LIF.

Database: p15921

Modstat

Run Date: Wed, May 09 2012 12:43:24 PM

Author: b21cyoun

Record Listing Filename:AMEDSTATADVANTAGEGENREP821HOME821cyoun1stempl.egaf DCR 2012-05-09 12-42-44.riv

Description: A listing of records from all facility, professional, nh, and drug claims data. Includes U claims to not voids. E claims excluded by record type. Omitted deleted and rejected lines. Omitted header lines noted as 0 in the database. Omitted J claims.

Subset: //Caprise Gratham/CY NEW STANDARD SUBSET

((Claim Type = DENTAL_HIC, MANUAL-XOVER-A, MEDICARE-A, NURSE-HOME-INV, J882) And Record Type = Encounter-HMO, Encounter-PEP, FFS, Non Claim
Type = BUY-IN, DRUG, MANUAL-XOVER-A, MEDICARE-A, NURSE-HOME-INV, J882) And Record Type = Encounter-HMO, Encounter-PEP, FFS, Non Claim
Financials And Last Claim Indicator = Y And (Service Date MMDDYYYY = 11/01/2007-04/01/2008 And Person ID Unencycled = 9530224901)
Time Period: No Time Period Defined

Tables: Notes:

Claim Count:

130

Medicaid Total Paid:

\$2,618.73

HMO Total Paid:

\$20,630.26

Medicaid and HMO Total Paid

\$23,248.99

— for the kids

+ 179.69 — for the client

\$ 23,428.68 — grand total

Medication	Medication Total Paid:
3/17/2025-3/31/2025	\$1,000.00
Medication and HMO Total Paid:	\$1,000.00

Detailed Claims Report

SEYMORE, PARNON LEE Medicaid ID: 479000075 DOB: 1/18/2007 Gender: Male

[illegible]

Clalm Counts

[illegible]

HMID Total Paid:

Medical and HMO

60

СРЕДНА

ಸಿಎಚ್.ಆರ್. ಬಿ.ಆರ್.ಎಸ್. ಸಂಸ್ಥೆ, ೨೦೨೨-೨೦೨೩
 ಸಂಸ್ಥೆಯ ವಿಳಾಸ: ೨೦೨೨-೨೦೨೩
 ಸಂಸ್ಥೆಯ ವಿಳಾಸ: ೨೦೨೨-೨೦೨೩

[illegible]

[illegible]

Claim Count:	1
Medicaid Total Paid:	\$513.20
HMO Total Paid:	\$14,442.00
Medicaid and HMO Total Paid:	\$14,955.20
Out of Pocket:	\$0.00

South Carolina Department of Health and Human Services Detailed Childs Report

[illegible]

Please give to Marc.

Finchen

③



September 6, 2012

Patricia L. Harrison
611 Holly Street
Columbia, South Carolina 29205

Re: Tammy Morris

Dear Ms. Harrison:

Your correspondence received by the South Carolina Department of Health and Human Services (SCDHHS) on August 13, 2012, was forwarded to me for response. With respect to your request for information pursuant to the Freedom of Information Act, you will receive a response under separate cover from the SCDHHS Office of General Counsel. Regarding Ms. Morris, SCDHHS staff have reviewed the details of her case and would like to reassure you and your client on several points.

Ms. Morris is not going to be arrested and the fraud case against her is being closed by the Medicaid Recipient Fraud Unit in the SC Attorney General's Office. Her case was initially referred to the Attorney General's office based on a SCDHHS fraud hotline complaint. When SCDHHS receives a Medicaid fraud complaint, Program Integrity staff conduct a preliminary investigation. If they confirm a credible allegation or suspicion of Medicaid fraud, the case is referred to the SC Attorney General's Office for a full investigation. That is our normal process.

In your client's case, the Attorney General's investigation may have established probable cause to believe she was ineligible for Medicaid benefits for certain periods of time. However, the amount of benefits paid during these periods in question was not correctly presented by Stuart Register, the AG investigator. The detailed claims reports from SCDHHS listed the services paid directly by SCDHHS, which would be the monthly managed care premiums plus any other services, such as dental or family planning, which were not covered by the managed care plan and thus were paid fee-for-service. The detailed claims reports also show the amounts paid by managed care organizations for services received by your client and her family. The overpayment by Medicaid, however, should have been based solely on the amount paid directly by SCDHHS. For the time frame under review, this amounted to \$2,798.42, not the \$23,428.68 that Mr. Register built his case on.

Because of this misunderstanding, the Attorney General's Office is closing the case and will send the case file back to us. Furthermore, we have since clearly instructed the Attorney General's office that beneficiary fraud overpayments should only be based upon the cost of services paid directly by SCDHHS.

Ms. Patricia Harrison
September 6, 2012
Page 2

Similarly, the First Choice payments you saw on the detailed claims report were transactions between First Choice and the various health care providers, and do not represent payments from SCDHHS to First Choice. First Choice is a capitated, full risk managed care organization, and is required to provide payment for the services needed by the beneficiary out of the premium payment made by SCDHHS. Because of the apparent outlier costs for some of these drugs, however, and your concern that the Omnicef drug should not have been prescribed or administered, the Division of Program Integrity is investigating these payments.

Thank you for informing us of the detailed claims reports involving recipients unrelated to Ms. Morris or Mr. Woodie. This matter has been referred to our Privacy Official, who will take the appropriate actions based on HIPAA and the Medicaid Confidentiality regulations.

Please do not hesitate to call me at (803) 898-1050 if you need any more information.

Sincerely,

A handwritten signature in black ink, appearing to read "Kathleen Snider".

Kathleen Snider, Bureau Chief
Compliance and Performance Review

KS/m



TO:

FROM:

SUBJECT: Cost of Processing FOIA Request #

The South Carolina Department of Health and Human Services has received and processed your FOIA request. The cost for processing this information is as follows:

Staff processing time at \$10.00 per hour _____ Hours \$ _____

Pages copied at \$.10 per page _____ Pages \$ _____

Pages faxed at \$.20 per page _____ Pages \$ _____

Shipping and Handling Costs \$ _____

Other costs associated with the FOIA request: _____ \$ _____

Total Amount Due SCDHHS: \$ _____

Please remit the above amount to the following address:

Bureau of Fiscal Affairs
South Carolina Department of Health and Human Services
Post Office Box 8297
Columbia, South Carolina 29202-8297

Please contact _____ should you have any questions.

Signature

Date:

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

January 10, 2014

Patricia L. Harrison
Attorney at Law
611 Holly Street
Columbia, SC 29205

Re: FOIA Request

Dear Ms. Harrison:

This is in response to the Freedom of Information Request contained at the bottom of the first page of your December 16, 2013, letter to Director Keck and others. As we have done in the past, we would again ask that your FOIA requests be sent under separate cover so they are not inadvertently overlooked.

Enclosed is Ms. Morris' investigative file as developed by the agency. I believe that it may be in some respects duplicative of information sent to you by Investigator Register back in 2012 (reference the attachments to your enclosed letter). We have redacted information (Social Security Numbers and dates of birth) where we understand it is required under federal law.

No follow-up or audit was conducted regarding the allegations in your August 13, 2012 letter.

Our expense for reproducing this information is twenty-eight and 25/100 dollars (\$28.25). These documents are true and accurate printouts directly from information kept in the normal course of Department business. Please make the check payable to the Department of Health and Human Services and send it to:

Department of Health and Human Services
Department of Receivables
Post Office Box 8297
Columbia, SC 29202-8297

I hope this information is helpful to you. Please contact me if there are any questions.

Sincerely,



Richard G. Hepfer
Deputy General Counsel

Enclosures

cc: Lynette Wilson, Receivables (w/o enclosures)

