** INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY **

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March 23, 2015 2:45:19 PM EDT	000 000 0000	458	12	Received

Mar 23 15 02:33p Andrew Jennings 000-000-0000 p.1

To Office of the Honorable Governor Niki Haley
From Andrew Jennings
Subject SNAP E & T
CASE NO 02198118
Date March 23, 2015

Please review enclosed documentation. I have tried in vain to properly Represent these poor disabled adults who are members of my church. I get put off in every department. Please let me know what I should Do next. Sorry to bother you and if it were for me I would just say To heck with it.
Can you **PLEASE** give me some assistance.
Thank you for your time.

Respectfully,

Andrew L Jennings

Andrew L Jennings
PO Box 2120
Leesville, SC 29070
Phone: 803-532-5267 email: ajennings10@att.net

POA and authorized representative for Dale Jones
And Rebecca Jones

898-7313

Fax to 803-714-7616 Phone: 803-616-1309

To SNAP E & T PROGRAM

FROM **Andrew Jennings POA and authorized Representative for Dale Jones and Rebecca Jones**

Subject Case No 02198118

Date **March 23, 2015**

Enclosed is the documentation for Rebecca Jones concerning her Capacity to be involved with the E & T program. She has already Completed evaluation by the South Carolina Vocational Rehabilitation Department and copy of their evaluation concerning her inability to Work. Also a copy of the Area Client Services Manager (Niki Ostrander) and her telephone number if you wish to obtain the results directly. This documentation has been presented on at least three Occasions. I would appreciate if you would confirm receipt by e mail To me ajennings10@att.net. Please review your recent decision to Reduce Mr. Dale Jones (a paraplegic) food stamp allocation, and Let me know as soon as possible.
I will also forward a copy of this request to the Governor. It is hard To have a great day in South Carolina when the left hand does not Know what the right is doing.

Respectfully,

Andrew Jennings

Andrew Jennings
POA and authorized representative for Dale Jones And Rebecca Jones

Cc: Governor Niki Haley

Enabling eligible South Carolinians with disabilities to prepare for, achieve and maintain competitive employment.

SCVRD

SOUTH CAROLINA
VOCATIONAL REHABILITATION
DEPARTMENT

Niki Ostrander
Area Client Services Manager

516 Percival Road, Columbia, SC 29206
(803) 782-4239 • Fax (803) 782-3573
Nostrander@scvrd.state.sc.us • scvrd.net

03/16/15

DALE JONES
C/O ANDREW L JENNINGS
PO BOX 2120
LEESVILLE SC 29070

CASE NO: 02198118

CASELOAD ID: 321X27
COUNTY: RICHLAND
PHONE NO: 8037147300

SNAP E & T DECREASE

DEAR REBECCA JONES,

YOUR SNAP BENEFITS WILL DECREASE TO 16.00 BECAUSE REBECCA FAILED TO COMPLY WITH THE EMPLOYMENT AND TRAINING PROGRAM BY NOT SCHEDULING, ATTENDING, OR COMPLETING A REQUIRED ACTIVITY FOR THE SNAP EMPLOYMENT & TRAINING PROGRAM. .

REBECCA WILL BE DISQUALIFIED FROM THE PROGRAM FOR THE MONTHS OF APR. 1, 2015 THROUGH APR. 30, 2015. THIS INDIVIDUAL MAY BE ELIGIBLE TO RESUME PARTICIPATION IN THE PROGRAM EARLIER IF HE/SHE BECOMES EXEMPT FROM SNAP EMPLOYMENT AND TRAINING. OTHERWISE, THIS INDIVIDUAL MAY BE ADDED BACK INTO YOUR SNAP CASE ON OR AFTER MAY 1, 2015ES BY BOTH:

1. NOTIFYING THE AGENCY OF YOUR WISH TO ADD THE DISQUALIFIED INDIVIDUAL BACK INTO YOUR BUDGET, AND
2. THE DISQUALIFIED INDIVIDUAL MUST AGREE TO COMPLY WITH ALL EMPLOYMENT AND TRAINING PROGRAM ACTIVITIES.

IF YOU HAVE ANY QUESTIONS OR WISH TO COMPLY WITH THE E & T PROGRAM PLEASE CALL DSS CONNECT AT 1-800-616-1309.

FAIR HEARING RIGHTS ARE EXPLAINED ON THE BACK OF THIS NOTICE.

IF YOU WISH TO COMPLY, PLEASE CONTACT US WITHIN 10 DAYS OF THE DATE OF THIS NOTICE.

Page 7 Richland County
Fax: 1-803-714-7616
8- Heaven

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
Rebecca D. Jones	251 -65 - 3575
Wage Earner (If Different)	Social Security Number
N/A	N/A - -

Part I **APPOINTMENT OF REPRESENTATIVE**

I appoint this person, Andrew Jennings
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☒ Title II (RSDI) ☒ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☒ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative is N/A
(Name of Principal Representative)

Signature (Claimant)	Address
Rebecca D. Jones	505 Hillcrest Dr Columbia SC 29203
Telephone Number (with Area Code)	Fax Number (with Area Code) / Date
(803) 532-5267	( ) - / 10/09/2014

Part II **ACCEPTANCE OF APPOINTMENT**

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☐ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency ☐ YES ☐ NO

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

Signature (Representative)	Address
Andrew Jennings	PO Box 2120 Leesville SC 29070
Telephone Number (with Area Code)	Date
(803) 532- 5267	10-01-2014

A. Jennings
PO Box 2120
Leesville, SC 29070

Part III **FEE ARR**

(Select an option, sign and date this section.)

☐ **Charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Charging a fee but waiving direct payment** of the fee from withheld past-due benefits —I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Waiving fees and expenses from the claimant and any auxiliary beneficiaries** —By checking this block I certify that my fee will be paid by a third-party, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☒ **Waiving fees from any source** —I am waiving my right to charge and collect any fee, under sections 206 and 1631(d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date
Andrew Jennings	10/09/2014

Printed: 16-Jun-14

SCVR 316
Rev. 01/2011

SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT
Psychological Review Report

Applicant Name: Jones, Rebecca	**SSN:** 251-65-3575
Caseload Number: 713	**Date of Request:** 04/16/2012
Counselor Name: RIGBY, SUMMER	**Org Code:** 1301

Administrative Team Support Specialist:

Current Reported Symptoms:

anxiety and worries about losing uncle due to deaths of 5 family members in past 7 years. Recd school records. No diagnosis but some poor grades. Didnt have IEP or psych eval done in school

RECORDS ATTACHED:

☐ **Survey (SCVR 4)**	☐ **List of State /County Offenses**	☐ **SCVR 208**
☐ **List of Federal Offenses**	☐ **SCDC/SCDPPPS Release (if appropriate)**	
☐ **Other (Include Record Source/Date)**		

TO BE COMPLETED BY SCVRD PSYCHOLOGISTS:

Current Diagnosis(es) (Based on review of records, applicant report, & consultation with counselor):

Axis I:
300.00 Anxiety D/O NOS

Axis II:
V71.09 No Diagnosis on Axis II

Functional Limitations:
Poor concentration / distractibility which could lead to mistakes and accidents while on the job.
Short-term memory impairment leading to inability to follow instructions in completing work tasks.
Somatic complaints and fatigue leading to increased absenteeism and decreased productivity.

Reviewers Comments:
Last Pact Testing Does Not Appear to Support LD. Grades Support Slow Learner. Refer for Mental Health tx / Counseling / Stress Mgt. Classes / Medication Mgt. of sx.

Service Recommendations (if applicable):

Supervision Requirements: ☒ **SLS** ☐ **RLS** ☐ **ALS** **Comments:**

☐ **Refer to a Local Provider**	☐ **Requesting Additional Records**

Completed by: KATHLEEN MOORE SCVRD Psychologist Date: 04/16/2012

Reviewer Comments Continued:

SCVR 316
Rev. 01/2011

SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT

Psychological Review Report

Printed: 16-Mar-12

SCVR 316a
Rev 09/05
(Forms Choosen)

SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT
Suggested Clinical Interview Checklist

Biographical Information: Name: Becky Jones	Yes	No
Marital:		
Are you married?	☐	☒
Single?	☒	☐
Widowed?	☐	☒
Divorced?	☐	☒
What caused your divorce(s)?		
Do you have dependents?	☐	☒
How many?		
Are you paying child support?	☐	☒
Are you current with your child support?	☐	☒
If not, *how much* is owed?		
Have you ever served time for nonsupport?	☐	☒
When/Where?		
Familial:	**Yes**	**No**
Are you close to your siblings and parents?	☐	☒
Describe *factors* leading to estrangement….**brother, mother, and father are deceased**		
Is there a history of Mental Illness and/or Substance Abuse in your family?	☒	☐
Elaborate…..**uncle (father's side): alcohol; mother smoked pot**		
School:	**Yes**	**No**
Did you earn a high school diploma?	☒	☐
If not, how many years did you complete?		
Did you earn a high school certificate (rather than a diploma)? [Obtain Records]*	☐	☒
Were you involved in special education programming [did you have an IEP, a Learning Disability, and/or were you in E.D., OHI, or Resource placement] [Obtain Records]* while in school?	☐	☒
Elaborate (Describe Disability):		
Did you have behavioral problems in school (suspensions/expulsions)?	☐	☒
At what "age" did the behavioral problems begin?		
Elaborate (Describe Things Client Did):		
Were you ever in an "alternative school?" [Obtain Records]*	☐	☒
Why? / Where? Elaborate:		
Do you possess certification or coursework towards a certificate and/or degree?	☐	☒
Elaborate… **attended Kenneth Schuler for 13 months and graduated but never took boards due to "not having a passion for it"**		
Military Service:	**Yes**	**No**
Were you ever in the military?	☐	☒
If so, what branch?		
How long did you serve?		
What type of discharge did you receive?		
What lead to your discharge? [drug use, arrested, etc]		
Employment History:	**Yes**	**No**
Are you unemployed?	☐	☒
How long have you been unemployed? **never worked**		
Have you ever been terminated from a position?	☐	☒

Printed: 16-Mar-12

SCVR 316a
Rev 09/06
(Forms Chooser)

SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT
Suggested Clinical Interview Checklist

Why (drug use/ behavior)? ____	☐	☒
Do you change employment frequently?		
Longest period of time in a stable position within the last several years: ____		
Arrest History:	**Yes**	**No**
Age of *First Arrest*: na		
At what age did you first begin engaging in arrestable offenses? ____	Answer Question	Answer Question
List types of offenses (truancy, vandalism, etc.): ____		
Do you have a *juvenile* record? [Obtain Records from DJJ (Psychological)]*	☐	☒
List offenses/time served/dates, probationary sentences, PTI, and/or community service completed:		
Year: Offense:		
____ ____		
____ ____		
____ ____		
More Comments: ____		
Have you served time in *Federal Prison*?	☐	☒
List offenses/time served/**dates**, probationary sentences, PTI, and/or community service completed:		
Year: Offense: Year: Offense:		
____ ____ ____ ____		
____ ____ ____ ____		
____ ____ ____ ____		
More Comments: ____		
Have you served time in a *state* or *county* facility? [Obtain SCDC/SCDPPPS Signed Release]	☐	☒
List offenses/time served/**dates**, probationary sentences, PTI, and/or community service completed:		
Year: Offense: Year: Offense:		
____ ____ ____ ____		
____ ____ ____ ____		
____ ____ ____ ____		
Attach a list of offenses with dates if necessary…LEMS / NCIC / SLED Checks, & County Provided Lists are appreciated. Lists of offenses can be found in the Warden's Jacket at SCDC and obtained from PPP with a signed release.		
More Comments: ____		
Have you been arrested, resulting in **no time** served and/or the **charges** were later **dropped** or are **still pending**, etc.	☐	☒
List arrests:		
Year: Offense: Year: Offense:		
____ ____ ____ ____		
____ ____ ____ ____		
____ ____ ____ ____		
More Comments: ____		
Substance Abuse History:	**Yes**	**No**
Have you experienced any problems with alcohol and/or drugs in the past or present?	☐	☐
(Include Narcotics used for pain management)		
List substances used below w/required diagnostic data:		
Substance(s) Used (Alcohol, Cannabis, etc.) / **Date of Last Use** (mm,yy) / **Frequency of Use** (Daily/Weekly) / **Amount Used** (In Grams, In $ Amounts)		
____ ____ ____ ____		
____ ____ ____ ____		

Printed: 16-Mar-12

SCVR 316a
Rev 09/06
(Forms Chooser)

SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT
Suggested Clinical Interview Checklist

Have you experienced substance related arrests in the past? When? Explain:	☐	☒
Did you have any positive drug screens in the past (employment related, probation/parole, etc)? When? Explain:	☐	☒
Have you been treated in the past for a substance related problem? [Obtain Records]* List **treatment facilities** and approximate **dates** (hospitals, detoxification centers, out-patient addictions treatment groups, etc.):	☐	☒

Year:	Treatment Facility

More Comments:

Physical Health	Yes	No
Are you currently on medication? [Obtain Records]* List medications you are currently taking: (Prescribed Narcotics/Pain Medication?) List current healthcare providers:	☐	☐
Have you been on medication, received medical treatment, or were you hospitalized in the past? [Obtain Records]*	☐	☒

List **medications taken**, **conditions treated**, **healthcare providers/hospitals**, and **dates** of past treatment below:

Year	Healthcare Provider	Medications Prescribed	Conditions Treated

Mental Health	Yes	No
Are you currently on psychiatric medication? [Obtain Records]* List medications you are currently taking: List current mental healthcare providers (inpatient and/or outpatient counseling):	☐	☐
Are you currently experiencing any mental health complaints? (Use the **DSM-IV** to assist with listing symptoms of a particular psychiatric disorder.) List current **symptoms** and duration: When did these symptoms first start?	☐	☒
Have you been on medication, received mental health treatment, or were you hospitalized in the past for a psychiatric condition? [Obtain Records]* List **medications taken**, **conditions treated**, **healthcare providers/hospitals**, and **dates** of past treatment below:	☐	☒

Year	Healthcare Provider	Medications Prescribed	Conditions Treated

300.00 ANXIETY DISORDER NOS CHECKLIST

(Check all symptoms that apply. A Total of 5 symptoms must be checked for a diagnosis to be made.)

Duration

☑ must check — The symptoms noted below must have been in existence for at least a 6 month time period for a diagnosis in this category to be made.

Generalized Symptoms

☑ The client reports persistent worry.

☑ The client reports restlessness.

☐ The client reports becoming easily fatigued.

☐ The client reports difficulty concentrating.

☐ Irritability.

☑ Muscle tension.

☐ The client can have difficulty sleeping.

☐ The client might feel easily aroused, hyper-vigilant, or easily startled.

Panic Attacks

☑ The client may experience anxiety associated with accelerated heart rate, sweating, shaking, nausea, abdominal distress, and/or dizziness, etc.....commonly referred to as a panic attack.

Social Anxiety/Agoraphobia

☑ The client may fear social situations.....

Specific Phobia

☐ The client may fear exposure to specific stimuli, such as blood, heights, elevators, snakes, spiders, enclosed places, contact to illnesses, loud sounds, etc.....

Obsessions/Compulsions (OCD)

☐ The client may experience recurrent undesirable thoughts and/or impulses which may result in recurrent/repetitive "***behaviors***" which act to suppress the initial thoughts/impulses. Examples of theses ***behaviors*** would be: ***repetitive hand washing, repetitively checking locks, etc.***

PTSD

☐ The client my have been exposed to a traumatic event in the past where potential harm to self or others could have taken place which is now manifesting itself as fear, recurrent nightmares, flashbacks, and/or recurrent recollections precipitated by everyday environmental stimuli.

☐ List any other pertinent symptoms below. Pages 429 - 484 of the DSM-IV-TR lists all Anxiety Disorders with symptoms.

309.## ADJUSTMENT DISORDER, (CHRONIC) CHECKLIST

(Check all symptoms that apply)

- [x] must check — Emotional and/or behavioral symptoms have developed within a three-month time period - as a response - to an identifiable stressor. These symptoms must have persisted for at least 6 months to date. **Describe the situation, the stressor, and how the stressor has affected the client:**
- [x] The stressor has lead to symptoms of ***depression***, such as sadness, weight changes, changes in sleep patterns, fatigue, low self-esteem, etc. Specify any additional symptoms: ___
- [x] The stressor has lead to symptoms of ***anxiety***, such as restlessness, feeling tense, difficulty sleeping, fear of certain situations, persistent worry, etc. Specify any additional symptoms: ____
- [ ] The stressor has lead to disturbances in ***conduct***, such as engaging in illegal behavior, illicit affairs, risky behavior, unethical behavior, etc. Specify any additional symptoms: ____
- [ ] List any other pertinent symptoms below. Pages 679 - 683 of the DSM-IV-TR can assist with listing symptoms of Adjustment Disorders. ___

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SCVR 316a
Rev 09/06
(Forms Choosen)

SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT
Suggested Clinical Interview Checklist

More Comments: __

Vocational Rehabilitation History		Yes	No
Have you had a previous case with this agency? When was this case closed? ___ What condition(s) lead to VR eligibility with your last case? ____ Obtain previous records used for eligibility (if case closure was w/in the last 3 years). What is your current vocational goal? __	[Obtain Records]*	☐	☒
Have you received "VR" services in another state? Where? ____	[Obtain Records]*	☐	☒
Are you currently receiving SSI/SSDI? If so, though "*presumed eligible*," obtaining prior records could assist with providing appropriate services, deciding whether a TWE would be appropriate, etc. Elaborate: **uncle receives SSI and that is their sole source of income currently**		☐	☒
Did you have a workman's comp. case in the past? When? ____	[Obtain Records]*	☐	☒
Have you applied for or received services from DDSN (DMR/DSN)?	[Obtain Records]*	☐	☒

Note: Records assigned an **asterisk "*"** above should be obtained **prior** to requesting a **psychological review.**

Additional Comments: ___

Last Updated on 8/9/06