DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

Relogged from Myers to Jacobs per Myers on 6/9/08

TO	DATE
Jacobs — not Medicaid enrolled as far as I can discern	6-9-08

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000542	[X] Prepare reply for the Director's signature DATE DUE 6-18-08
2. DATE SIGNED BY DIRECTOR Cleared 6/18/08, letter attached ✓	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	6-9-08

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000642	[X] Prepare reply for the Director's signature DATE DUE 6-16-08
2. DATE SIGNED BY DIRECTOR _____	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

JOE WILSON
2ND DISTRICT, SOUTH CAROLINA

ASSISTANT REPUBLICAN WHIP

COMMITTEES:
ARMED SERVICES
EDUCATION AND LABOR
FOREIGN AFFAIRS
HOUSE POLICY

Congress of the United States
House of Representatives

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

DINO TEPPARA
CHIEF OF STAFF
AND COUNSEL

June 6, 2008

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

RE: Mr. James L. Coleman

Dear Ms. Forkner,

I am writing to you on behalf of the above named constituent who has contacted me regarding his hemodialysis costs. Enclosed is a copy of all correspondence for your perusal. Any assistance that you could offer would be most appreciated.

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

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

Yours very truly,

Joe Wilson

JOE WILSON
Member of Congress

JW/jmc
Enclosure

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

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

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

TOLL FREE 1-888-381-1442

MAR 2 6 2008

Congressman Joe Wilson
!799 Sunset Blvd.
West Columbia, S.C. 29169

Mr. James L. Coleman
311 Bozard Mill Road
Leesville, S.C. 29070
SS # 249084152
March 15, 2008

Dear Congressman Wilson:

I initiated hemodialysis treatments at The Bryan-Dorn Hospital on November 23, 1999. (Please find a copy of the HCFA-2728 enclosed.) On March 21, 2000, I transferred to The Lexington Dialysis Center.

Lexington Dialysis assisted me in keeping my Medicare intact by getting American Kidney Fund to pay the Medicare premiums when I got behind on premium payments. Then Lexington Dialysis helped me enroll in a Blue Cross /Blue Shield Medigap Policy through American Kidney Fund, which would pay the portion of my hemodialysis costs not covered by Medicare. I used the American Kidney Fund Grant for my own needs rather than using these funds to pay the intended Blue Cross/Blue Shield Premiums. Then in January, 2008, Lexington Dialysis was informed by Medicare that I quit paying Medicare premiums after October 2007, which left me, having no health insurance coverage.

Lexington Dialysis telephoned Carolyn Corbett, VA Hospital Social Worker, in January, 2008. A request was made for the VA to fund hemodialysis costs from November, 2007. Mrs. Corbett indicated that the VA would fund patient's hemodialysis costs beginning Februry 1, 2008.

Lexington Dialysis is questioning why retroactive payments cannot be made for November, December, and January, 2008?

Sincerely;

James Leon Coleman
Lexington Dialysis Patient

cc: Mrs. Carolyn Corbett, LMSW VA Hospital

MM DD YY

3. Current Status of Transplant
☐ Functioning ☐ Non-Functioning

4. If Nonfunctioning, Date of Return To Regular Dialysis
__/__/__ MM DD YY

35. Current Dialysis Treatment Site
☐ Hospital Inpatient ☐ Dialysis Facility/Center ☐ Home

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)

36. Name of Training Provider

37. Medicare Provider Number of Training Provider

38. Date Training Began
__/__/__ MM DD YY

39. Type of Training
☐ Hemodialysis ☐ IPD ☐ CAPD ☐ CCPD

40. This Patient is Expected to Complete *(or has completed)* Training and Will Self-dialyze on a Regular Basis.
☐ Yes ☐ No

41. Date When Patient Completed, or is Expected to Complete, Training
__/__/__ MM DD YY

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

42. Printed Name and Signature of Physician personally familiar with the patient's training

43. UPIN of Physician in Item 42

E. PHYSICIAN IDENTIFICATION

44. Attending Physician *(Print)*
Steven J. Rosansky

45. Physician's Phone No.
(803) 776-4080

46. UPIN of Physician in Item 44
11A Physician

PHYSICIAN ATTESTATION

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

47. Attending Physician's Signature of Attestation *(Same as Item 44.)*

48. Date
2 / 24 / 99 MM DD YY

49. Remarks

F. OBTAIN SIGNATURE FROM PATIENT

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

50. Signature of Patient *(Signature by mark must be witnessed.)*
X Gemma L. Coleman

51. Date
1 / 19 / 99 MM DD YY

G. PRIVACY ACT STATEMENT

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-70-0520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Privacy Act Issuance, 1991 Compilation, Vol. 1, pages 436-437, December 31, 1991 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for a research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health. Additional disclosures may be found in the *Federal Register* notice cited above. You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

H. FOR ESRD NETWORK USE ONLY IN CASES REFERRED TO ESRD MEDICAL REVIEW BOARD

52. Network Confirmed as ESRD	53. Authorized Signature	54. Date	55. Network Number
☐ Yes ☐ No		__/__/__ MM DD YY	

1. Name (Last, First, Middle Initial)
Coleman, James Leon

2. Health Insurance Claim Number

3. Social Security Number
249-08-4152

4. Full Address (Include City, State, and Zip)
307 Bozard Mill Road
Lexington, SC 29070

5. Phone Number
(803) 532-6086

6. Date of Birth
6 / 27 / 19[illegible]
MM DD YYYY

7. Sex
☐ Male ☐ Female

8. Ethnicity
☐ Hispanic: Mexican ☐ Hispanic: Other ☑ Non-Hispanic

9. Race (Check one box only)
☐ White
☑ Black
☐ American Indian/Alaskan Native
☐ Asian
☐ Pacific Islander
☐ Mid-East/Arabian
☐ Indian sub-Continent
☐ Other or Multiracial
☐ Unknown

10. Medical Coverage (Check all that apply)
a. ☐ Medicaid
b. ☐ DVA
c. ☐ Medicare
d. ☐ Employer Group Health Insurance
e. ☐ Other Medical Insurance
f. ☐ None

11. Is Patient Applying for ESRD Medicare Coverage? (If YES, enter address of social security office)
☐ Yes ☐ No
ADDRESS 1835 Assembly St.
CITY Columbia
STATE SC
ZIP 29201

12. Primary Cause of Renal Failure (Use code from back of form)
4059D

13. Height
5 INCHES / 10 OR CENTIMETERS

14. Dry Weight
128 lbs POUNDS / 58.2 kg OR KILOGRAMS

15. Employment Status (6 mos prior and current status)

Prior	Current	
☑	☑	Unemployed
☐	☐	Employed Full Time
☐	☐	Employed Part Time
☐	☐	Homemaker
☐	☐	Retired due to Age/Preference
☐	☐	Retired (Disability)
☐	☐	Medical Leave of Absence
☐	☐	Student

16. Co-Morbid Conditions (Check ALL that apply currently or during last 10 years) *See instructions
a. ☐ Congestive heart failure
b. ☐ Ischemic heart disease, CAD*
c. ☐ Myocardial infarction
d. ☐ Cardiac arrest
e. ☐ Cardiac dysrhythmia
f. ☐ Pericarditis
g. ☐ Cerebrovascular disease, CVA, TIA*
h. ☐ Peripheral vascular disease*
i. ☑ History of hypertension
j. ☐ Diabetes (primary or contributing)
k. ☐ Diabetes, currently on insulin
l. ☐ Chronic obstructive pulmonary disease
m. ☐ Tobacco use (current smoker)
n. ☐ Malignant neoplasm, Cancer
o. ☑ Alcohol dependence
p. ☑ Drug dependence*
q. ☐ HIV positive status ☐ Can't Disclose
r. ☐ AIDS ☐ Can't Disclose
s. ☐ Inability to ambulate
t. ☐ Inability to transfer

17. Was pre-dialysis/transplant EPO administered?
☐ Yes ☑ No

18. Laboratory Values Prior to First Dialysis Treatment or Transplant *See Instructions.

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a. Hematocrit (%)	26.5	11/23	e. Serum Creatinine (mg/dl)	9.5	11/23/99
b. Hemoglobin (g/dl)*	9.0	11/23	f. Creatinine Clearance (ml/min)*	9.5 Not done	11/23/99
c. Serum Albumin (g/dl)	2.9	11/24	g. BUN (mg/dl)*	86	11/23/99
d. Serum Albumin Lower Limit (g/dl)	2.8	11/16	h. Urea Clearance (ml/min)*	Not done	

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT.

19. Name of Provider
VA Medical Center, Columbia, SC

20. Medicare Provider Number
NA

21. Primary Dialysis Setting
☑ Hospital Inpatient ☐ Dialysis Facility/Center ☐ Home
Initial inpatient - Outpatient

22. Primary Type of Dialysis
☐ Hemodialysis ☐ IPD ☐ CAPD ☐ CCPD ☐ Other

23. Date Regular Dialysis Began
1 / 23 / 99
MM DD YY

24. Date Patient Started at Current Facility
11 / 23 / 99
MM DD YY

25. Date Dialysis Stopped
___ / ___ / ___
MM DD YY

26. Date of Death
___ / ___ / ___
MM DD YY

Log #0642

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

June 18, 2008

Mr. James L. Coleman
311 Bozard Mill Road
Leesville, South Carolina 29070

Dear Mr. Coleman:

Congressman Joe Wilson contacted our agency on your behalf regarding retroactive funding for your hemodialysis costs. Unfortunately, we were unable to reach you by phone.

Since the Bryan Dorn VA Medical Center is currently funding your hemodialysis costs, we contacted them to determine if payments could be made retroactively but unfortunately, we were informed they would not be able to fund the costs prior to February 1, 2008. If you have further questions regarding your hemodialysis funding, please contact Ms. Carolyn Corbett, your VA social worker, at (803) 776-4000, Ext. 6453 and she will be happy to assist you.

Medicaid's Specified Low Income Medicare Beneficiaries (SLMB) program pays the Medicare Part B premium for eligible individuals. In order to qualify, monthly income must be below $1400 and resources must be below $6000 for a couple. If you apply for SLMB and are found eligible, we will notify Medicare and you will be automatically enrolled into Medicare Part B and we will pay the $96.40 premium. If you believe you may qualify for SLMB benefits, please complete the enclosed application and return it to the Lexington County Medicaid Office located at 605 West Main Street, Lexington, SC 29072. If you have any questions about the SLMB program, please contact Ms. Jennifer Lynch at 1-888-549-0820, Ext. 3965 and she will be happy to assist you.

We have enclosed information on other programs and organizations that can assist residents in South Carolina with their healthcare services, prescriptions and daily living needs. Please call the contact number on each for more information. We hope this information helps you.

Sincerely,

Alicia Jacobs
Acting Deputy Director

AJ/col
Enclosures

cc: Ms. Carolyn Corbett, LMSW, Bryan Dorn VA Medical Center

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

Log # 0642

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

June 18, 2008

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

Dear Congressman Wilson:

Thank you for contacting our agency on behalf of Mr. James L. Coleman regarding retroactive funding for his hemodialysis costs.

We contacted the Bryan Dorn VA Medical Center to determine if payments could be made retroactively since they are currently funding Mr. Coleman's hemodialysis costs. We were informed they would not be able to fund the costs prior to February 1, 2008. We were unable to reach Mr. Coleman by phone, but responded to him in writing and provided him with a contact person at the Bryan Dorn VA Medical Center should he have further questions, as well as, an application for Medicaid's Specified Low Income Medicare Beneficiaries program which pays the Medicare Part B premium for eligible individuals.

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

Sincerely,

Emma Forkner

Emma Forkner
Director

EF/jcol