DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Ries	12-21-06

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 060420	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Cleared 1/10/07, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 1-5-07
	[ ] 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.			

JIM DEMINT
SOUTH CAROLINA

DEPUTY MAJORITY WHIP

340 RUSSELL SENATE OFFICE BUILDING
WASHINGTON, DC 20510
(202) 224-6121
demint.senate.gov

United States Senate

COMMITTEES:
COMMERCE, SCIENCE AND TRANSPORTATION

ENVIRONMENT AND PUBLIC WORKS

SPECIAL COMMITTEE ON AGING

JOINT ECONOMIC COMMITTEE

December 8, 2006

Mr. Robert M. Kerr
Director
Department Of Health And Human Services
PO Box 8206
Columbia, SC 29202-8206

Dear Mr. Kerr,

I am writing to refer a matter involving my constituent, Cynthia Thrift, and her request for assistance with Medicaid. Enclosed is a copy of her letter for your review.

I would greatly appreciate your responding directly to Ms. Thrift about this issue. I have informed Ms. Thrift that I would refer her to your agency in an effort to be helpful.

Thank you for your attention to this matter. Best regards.

Sincerely,

Jim DeMint
United States Senator

Log: Ries
approp. sign

previous enquiry from Sen Martin / Gov - verbal

CHARLESTON
112 CUSTOMS HOUSE
200 EAST BAY STREET
CHARLESTON, SC 29401
(843) 727-4525

GREENVILLE
105 NORTH SPRING STREET
SUITE 109
GREENVILLE, SC 29601
(864) 233-5366

COLUMBIA
1901 MAIN STREET
SUITE 1475
COLUMBIA, SC 29201
(803) 771-6112

From: "nobody@www.senate.gov" <nobody@www.senate.gov>
Date: 9/7/2006 4:03:15 PM
To: webmail@demint-iq.senate.gov
Subject: Contact Form Submission

<IP>67.35.194.20</IP>
<APP>SCCMAIL
<PREFIX>MRS</PREFIX>
<FIRST>Cynthia</FIRST>
<LAST>T</LAST>
<ADDR1>1137 Fox Squirrel Ridge Road</ADDR1>
<ADDR2></ADDR2>
<CITY>PICKENS</CITY>
<STATE>SC</STATE>
<ZIP>29671</ZIP>
<PHONE>8648787322</PHONE>

<EMAIL>cynthiathrift@bellsouth.net</EMAIL>

<ISSUE>HEA</ISSUE>

<MSG>September 6th, 2006

Dear Jr. Senator Jim Demint:

Please help our family. We need our application for Medicaid accepted. We applied last month and were denied stating our income is too high. I am positive we qualify according to the SC website but need help getting approved as our situation is different than the normal because of how our income is paid. My husband is a chef at Trillium Links in Cashiers, NC. His work is seasonal from April - November. There is no health insurance as it is a seasonal employer. His salary is $43,000 a year. This breaks down to the required gross amount but since we are paid out in 8 months we have been denied for approval although this is the only income we will be having for the entire year. We have to put aside money each month to make it through the off season as no temporary job is guaranteed.
We are expecting our third baby this October. We have no health insurance. We cannot even afford a one night stay in the hospital from out of pocket expense. We need the Medicaid assistance. We only request the program for pregnancy and delivery. We are in a dire situation for finances and cannot take on any new bills.
Please help us get approved. My husband and I have always been hard working citizens who have paid into Sc state and federal taxes all of our lives. I am a stay at home mother now as we have two other children. We are trying to do the right things and live a decent life on one income. We can't believe the stress, anxiety and fear that comes with not having health insurance. If you could help us and see that our application is approved we would be most grateful as we are at our wit's end and have not where else to turn.

Medicaid Letter of Action and Recipient ID: 3780258805

Sincerely,

Cynthia and Adrien Thrift

From: Jan Polatty
To: Laura Saunders
Date: 12/13/2006 4:47:53 PM
Subject: Re: Cynthia Thrift

Hey, Laura - I'm checking on the other inquires; however, I did remember this one! Yeah!!!! 1 down - more to go!!! Just kidding, you know I enjoy what I do and also helping you guys over there! I hope your Dad is doing well. Miss you! Jan

>>> "Laura Saunders" <lsaunders@oepp.sc.gov> 10/19/06 1:00 PM >>>
thank you so much, Jan!!

>>> "Jan Polatty" <POLATTYJ@scdhhs.gov> 10/19/2006 12:45 PM >>>
Hey, Laura!

This is actually our 2nd Request for assistance to Ms. Thrift. Sen. Larry Martin's office contacted us in Sept., and we have twice had the supervisor check for income verification and to look at all Medicaid program options. Ms. Thrift is upset that the rules and regulations are such that since Mr. Thrift is not self-employed and is on a salary, the income must be based on his last four weeks of salary payments - which puts them over the income limit. We did not call her, as she was certainly not please with us having already told her this information in Sept..... we did advise her on Community Health Centers, Free Clinic, etc.

I'll consider this closed unless I hear otherwise from you.
Thanks!!!!!!! Jan

>>> "Laura Saunders" <lsaunders@oepp.sc.gov> 10/13/06 1:10 PM >>>
Hi there,
Hope all is well today. So, I have a lot and I'm sorry to have let them pile up. Call me with any questions and thanks so much.
Laura

Cynthia Thrift
864-878-7322
-her family denied under low income families Medicaid stating too high income. Is there any way y'all can take a second look? Her husband works seasonally and is only paid 8 months out of the year, three kids,Ms. Thrift said that the Medicaid office told her their situaton was quite different b/c of the seasonal work.
**this is the one I called you about this morning, call me back if you can.

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.

420

State of South Carolina

Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

January 10, 2007

Ms. Cynthia Thrift
1137 Fox Squirrel Ridge Road
Pickens, South Carolina 29671

Dear Ms. Thrift:

This letter is in response to your email dated September 6, 2006, that was referred to our agency, The Department of Health and Human Services.

After reviewing your case situation, we are regretful to inform you that you are not eligible for Medicaid based on your family's income. Your Medicaid case was budgeted correctly according to our Medicaid policy and the decision wherein you are over the income limit for our Optional Coverage for Pregnant Women and Infant (OCWI) Medicaid Program was correct.

Thank you for your correspondence and if we can be of further assistance, please feel free to contact us.

Sincerely,

Gary Ries
Deputy Director

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

Restoril® 7.5mg (IV)
temazepam capsules, USP

Gary, You asked us to take another look at this how he is paid. We have determined that they are truly ineligible. Gy

Mark Sanford
Governor

Robert M. Kerr
Director

Ms. Cynthia Thrift
1137 Fox Squirrel Ridge
Pickens, South Carolina 2

Dear Ms. Thrift:

This letter is in response t
The Department of Health

After reviewing your case
based on your family's in
policy and the decision w
Women and Infant (OCW

Thank you for your corre

Yours truly,

Gary Ries
Deputy Director, Eligibility
Department of Health and Human Services

gency,

for Medicaid
our Medicaid
or Pregnant

to contact us.

www.restoril.com

Bureau of Eligibility Policy & Oversight
P. O. Box 8206, Columbia, South Carolina, 29202-8206
Telephone (803) 898-2635 Fax (803) 255-8350

CONFIDENTIAL INFORMATION ENCLOSED

MEDICAID ELIGIBILITY
DHHS - PICKENS
P O BOX 160
PICKENS, SC 29671
(864) 898-5815
(864) 878-7403 FAX

FAX COVER SHEET

DATE / TIME SENT: 1-4-07 3:10

SENT TO: Betty Moses

ORGANIZATION:

FAX #:

OF PAGES: 28
(including this page)

SPECIAL INSTRUCTIONS

SIGNATURE: Suzanne E Roach

Page: 1 Document Name: un tled

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MEDELD01 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 08/23/06
MEDSPROD                  MEDICAID ELIGIBILITY DECISION             ACTION:
                     DATES-FROM: 08 / 2006 THRU: __ / ____          PAGE: 2 OF 3
HH NAME:    CYNTHIA L THRIFT                                  HH NUMBER: 100910417
BG NUMBER: 19336689          CATEGORY: OCWIPW              ACTION TYPE: MAINTENANCE
BG: D  BGP: D.      WKR: SROAC    SUZANNE ROACH             ACTION DATE: 08/23/06
   COUNTABLE BG MEMBERS:  5
   COUNTABLE INCOME:        5606.66        COUNTABLE RESOURCES:          0.00
       INCOME LIMIT:        3608.00        RESOURCE LIMIT:           30000.00
            POV-LVL:          +2.87 %       HLTH INS PREM:                0.00
   RECURRING INC:      0.00    TOTAL ALLOC:      0.00   OSS AWARD:       0.00
MEETS NON-FINANCIAL?     (Y/N): Y          ACT ON DECISION COMPLETE? (Y/N): Y
MEETS INCOME?            (Y/N): N          DECISION ACCEPTED DATE:     08/23/06
MEETS RESOURCES?         (Y/N): Y          NEXT REVIEW DATE:           ________
MEETS OTHER CONDITIONS? (Y/N): Y           ANTICIPATED CLOSURE DATE:   ________
REASON(S) FOR DENIAL/CLOSURE/CHANGE:
051 Your income is more than policy allows.
___ ____________________________________________________________________________
ELIGIBILITY DECISION APPEALED? (Y/N) _      CONTINUE BENEFITS?       (Y/N): _
APPEAL REQUEST DATE: ________               COUNTY DECISION UPHELD? (Y/N): _
UPDATED: USER ID: SROAC     DATE: 08/23/06  SYSTEM ID: ELD3000  DATE: 08/23/06
ME900115 BUDGET GROUP PERIOD INFORMATION FOUND
      PF1->HELP  PF3->NEXT SCR  PF6->RETURN  PF10->MENU  PF13->FIELD HELP
PF15->MAKE DECISION PF16->BG DET PF21->HIST- PF22->HIST+ PF24->ACT ON DECISION
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Date: 8/23/2006 Time: 9:44:18 AM

Page: 1 Document Name: un tled

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MEDELD01 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 08/23/06
MEDSPROD                MEDICAID ELIGIBILITY DECISION             ACTION:
                    DATES-FROM: 08 / 2006 THRU: __ / ____         PAGE: 2 OF 3
HH NAME:   CYNTHIA L THRIFT                                  HH NUMBER: 100910417
BG NUMBER: 19336692          CATEGORY: PHC                ACTION TYPE: MAINTENANCE
BG: D  BGP: D       WKR: SROAC    SUZANNE ROACH           ACTION DATE: 08/23/06
   COUNTABLE BG MEMBERS:  4
   COUNTABLE INCOME:        5606.66        COUNTABLE RESOURCES:          0.00
       INCOME LIMIT:        2500.00        RESOURCE LIMIT:           30000.00
            POV-LVL:          +3.36 %       HLTH INS PREM:                0.00
   RECURRING INC:      0.00    TOTAL ALLOC:      0.00    OSS AWARD:      0.00
MEETS NON-FINANCIAL?    (Y/N): Y          ACT ON DECISION COMPLETE? (Y/N): Y
MEETS INCOME?           (Y/N): N          DECISION ACCEPTED DATE:    08/23/06
MEETS RESOURCES?        (Y/N): Y          NEXT REVIEW DATE:          08/24/07
MEETS OTHER CONDITIONS? (Y/N): Y          ANTICIPATED CLOSURE DATE:  ________
REASON(S) FOR DENIAL/CLOSURE/CHANGE:
051 Your income is more than policy allows.

ELIGIBILITY DECISION APPEALED? (Y/N) _      CONTINUE BENEFITS?       (Y/N): _
APPEAL REQUEST DATE: ________               COUNTY DECISION UPHELD? (Y/N): _
UPDATED: USER ID: SROAC     DATE: 08/23/06  SYSTEM ID: ELD3000  DATE: 08/23/06
ME900115 BUDGET GROUP PERIOD INFORMATION FOUND
     PF1->HELP  PF3->NEXT SCR  PF6->RETURN  PF10->MENU  PF13->FIELD HELP
PF15->MAKE DECISION PF16->BG DET PF21->HIST- PF22->HIST+ PF24->ACT ON DECISION
```

Date: 8/23/2006 Time: 9:45:00 AM

PW- PhC

RECEIVED
AUG 2 3 2006
DHHS-MEDICAID

South Carolina Department of Health and Human Services
Application for the South Carolina Medicaid Program
This application is developed specifically for Families, Pregnant Women and Children

Date Received by DHHS

1. Tell us who you are and where you live.

Last Name	First Name			Middle Initial
THRIFT	Cynthia			L.
Mailing Address (Include Apartment/Lot Number)	**City**	**State**	**Zip Code**	**County**
1137 Fox Squirrel Ridge Road	Pickens	SC	29671	
Street Address, if different (Include Apartment/Lot Number)	**City**	**State**	**Zip Code**	**County**
		SC		

Telephone Number(s) where we can reach you, include area code:
Phone # (864) 878 7322 Second Phone # ( )

Tell us what language you use most: ☑ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Sign Language ☐ Vietnamese ☐ Other

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

- All persons applying for Medicaid, claiming to be a US citizen must provide proof of citizenship and identity.
- A non-citizen applying for Medicaid must provide Bureau of Citizenship and Immigration Services (BCIS) documents to support his/her legal entry into the US.
- A non-citizen applying for Emergency Services Only is not required to provide these documents.

2. Tell us who in your family lives with you. *(List the person shown in Item 1 first.)*

Last Name	First Name	Middle Initial	Date of Birth (Mo/Day/Year)	Place of Birth (City, County, State)
THRIFT	Adrien	C.	10-11-1979	San Diego, CA

Full Name at Birth	Mother's Full Maiden Name
Adrien Carlton THRIFT (husband)	Victoria Andre

Are you applying for Medicaid?	Sex:	Marital Status:	Medicare Number, if applicable:	Social Security Number
☐YES ☑NO	☑M ☐F	☐S-Single ☑M-Married ☐D-Divorced ☐W-Widowed ☐X-Married and Separated		569-99-8217

Are you a US citizen?	Are you disabled?	Are you pregnant?	Are you a foster child?	Do you have unpaid medical bills for your care from the past 3 months?
☑YES ☐NO	☐YES ☑NO	☐YES ☑NO If yes, when is the due date?	☐YES ☑NO	☐YES ☑NO If yes, would you like to apply for Medicaid to cover one or more of the months? ☑YES ☐NO If yes, you must provide proof of income and resources for those months.

National Origin: ☑White ☐African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian ☐ American/Oriental ☐ Refugee Entrant ☐Other

Retro to 10-1-06

Next Person

Last Name	First Name	Middle Initial	Date of Birth (Mo/Day/Year)	Place of Birth (City, County, State)
THRIFT	Cynthia	L.	11-28-1980	Lewis, Delaware

Full Name at Birth	Mother's Full Maiden Name
Cynthia Lauren Bennett	Belinda Carol Sharitz

Applying for Medicaid?	Relationship to you?	Sex:	Marital Status:	Medicare Number, if applicable:	Social Security Number
☑ YES ☐ NO	Self	☐ M ☑ F	☐ S-Single ☑ M-Married ☐ D-Divorced ☐ W-Widowed ☐ X-Married and Separated		249-67-9417

US Citizen?	Disabled?	Pregnant?	Foster child?	Does this person have unpaid medical bills from the past 3 months? / If yes, would you like to apply for Medicaid to cover one or more of the months?
☑ YES ☐ NO	☐ YES ☑ NO	☑ YES ☐ NO If yes, when is the due date? 10-31-06	☐ YES ☑ NO	☑ YES ☐ NO / ☑ YES ☐ NO **If yes, you must provide proof of income and resources for those months.**

National Origin:
☑ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental
☐ Refugee Entrant ☐ Other

Next Person

Last Name	First Name	Middle Initial	Date of Birth (Mo/Day/Year)	Place of Birth (City, County, State)
THRIFT	Hayden	C	12-15-03	Greenville SC

Full Name at Birth	Mother's Full Maiden Name
Hayden Christopher Bennett	Cynthia Lauren Bennett

Applying for Medicaid?	Relationship to you?	Sex:	Marital Status:	Medicare Number, if applicable:	Social Security Number
☑ YES ☐ NO	Son/child	☑ M ☐ F	☐ S-Single ☐ M-Married ☐ D-Divorced ☐ W-Widowed ☐ X-Married and Separated		657-16-9382

US Citizen?	Disabled?	Pregnant?	Foster child?	Does this person have unpaid medical bills from the past 3 months? / If yes, would you like to apply for Medicaid to cover one or more of the months?
☑ YES ☐ NO	☐ YES ☑ NO	☐ YES ☑ NO If yes, when is the due date?	☐ YES ☑ NO	☐ YES ☐ NO / ☐ YES ☑ NO **If yes, you must provide proof of income and resources for those months.**

National Origin:
☑ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental
☐ Refugee Entrant ☐ Other

Next Person

Last Name	First Name	Middle Initial	Date of Birth (Mo/Day/Year)	Place of Birth (City, County, State)
THRIFT	Ava	W.	7·15·85	Greenville, SC

Full Name at Birth	Mother's Full Maiden Name
Ava Wells THRIFT	Cynthia Lauren Bennett

Applying for Medicaid?	Relationship to you?	Sex:	Marital Status:	Medicare Number, if applicable:	Social Security Number
☑ YES ☐ NO	daughter/child	☐ M ☑ F	☐ S-Single ☐ M-Married ☐ D-Divorced ☐ W-Widowed ☐ X-Married and Separated		657·20·7600

US Citizen?	Disabled?	Pregnant?	Foster child?	Does this person have unpaid medical bills from the past 3 months?
☑ YES ☐ NO	☐ YES ☑ NO	☐ YES ☑ NO If yes, when is the due date?	☐ YES ☑ NO	☐ YES ☐ NO If yes, would you like to apply for Medicaid to cover one or more of the months? ☐ YES ☑ NO **If yes, you must provide proof of Income and resources for those months.**

National Origin:
☑ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental
☐ Refugee Entrant ☐ Other

Next Person

Last Name	First Name	Middle Initial	Date of Birth (Mo/Day/Year)	Place of Birth (City, County, State)

Full Name at Birth	Mother's Full Maiden Name

Applying for Medicaid?	Relationship to you?	Sex:	Marital Status:	Medicare Number, if applicable:	Social Security Number
☐ YES ☐ NO		☐ M ☐ F	☐ S-Single ☐ M-Married ☐ D-Divorced ☐ W-Widowed ☐ X-Married and Separated		

US Citizen?	Disabled?	Pregnant?	Foster child?	Does this person have unpaid medical bills from the past 3 months?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO If yes, when is the due date?	☐ YES ☐ NO	☐ YES ☐ NO If yes, would you like to apply for Medicaid to cover one or more of the months? ☐ YES ☐ NO **If yes, you must provide proof of income and resources for those months.**

National Origin:
☐ White ☐ African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian American/Oriental
☐ Refugee Entrant ☐ Other

Next Person

Last Name	First Name	Middle Initial	Date of Birth (Mo/Day/Year)	Place of Birth (City, County, State)

Full Name at Birth	Mother's Full Maiden Name

Applying for Medicaid? ☐YES ☐NO	Relationship to you?	Sex: ☐M ☐F	Marital Status: ☐S-Single ☐M-Married ☐D-Divorced ☐W-Widowed ☐X-Married and Separated	Medicare Number, if applicable:	Social Security Number

US Citizen? ☐YES ☐NO	Disabled? ☐YES ☐NO	Pregnant? ☐YES ☐NO If yes, when is the due date?	Foster child? ☐YES ☐NO	Does this person have unpaid medical bills from the past 3 months? ☐YES ☐NO If yes, would you like to apply for Medicaid to cover one or more of the months? ☐YES ☐NO **If yes, you must provide proof of income and resources for those months.**

National Origin:
☐White ☐African American ☐Mexican ☐Native American/American Indian ☐Puerto Rican ☐Cuban ☐Hispanic ☐Asian American/Oriental
☐Refugee Entrant ☐Other

Next Person

Last Name	First Name	Middle Initial	Date of Birth (Mo/Day/Year)	Place of Birth (City, County, State)

Full Name at Birth	Mother's Full Maiden Name

Applying for Medicaid? ☐YES ☐NO	Relationship to you?	Sex: ☐M ☐F	Marital Status: ☐S-Single ☐M-Married ☐D-Divorced ☐W-Widowed ☐X-Married and Separated	Medicare Number, if applicable:	Social Security Number

US Citizen? ☐YES ☐NO	Disabled? ☐YES ☐NO	Pregnant? ☐YES ☐NO If yes, when is the due date?	Foster child? ☐YES ☐NO	Does this person have unpaid medical bills from the past 3 months? ☐YES ☐NO If yes, would you like to apply for Medicaid to cover one or more of the months? ☐YES ☐NO **If yes, you must provide proof of income and resources for those months.**

National Origin:
☐White ☐African American ☐Mexican ☐Native American/American Indian ☐Puerto Rican ☐Cuban ☐Hispanic ☐Asian American/Oriental
☐Refugee Entrant ☐Other

Next Person

Last Name	First Name	Middle Initial	Date of birth (Mo/Day/Year)	Place of Birth (City, County, State)

Full Name at Birth	Mother's Full Maiden Name

Applying for Medicaid? ☐YES ☐NO	Relationship to you?	Sex: ☐M ☐F	Marital Status: ☐S-Single ☐M-Married ☐D-Divorced ☐W-Widowed ☐X-Married and Separated	Medicare Number, if applicable:	Social Security Number

US Citizen? ☐YES ☐NO	Disabled? ☐YES ☐NO	Pregnant? ☐YES ☐NO If yes, when is the due date?	Foster child? ☐YES ☐NO	Does this person have unpaid medical bills from the past 3 months? ☐YES ☐NO If yes, would you like to apply for Medicaid to cover one or more of the months? ☐YES ☐NO **If yes, you must provide proof of income and resources for those months.**

National Origin:
☐White ☐African American ☐Mexican ☐Native American/American Indian ☐Puerto Rican ☐Cuban ☐Hispanic ☐Asian American/Oriental
☐Refugee Entrant ☐Other

3. Tell us how much income your family has.

Enter GROSS pay before taxes and deductions, not take home pay. Enter zero ("0") if you are not working. You must send proof of income with this application.

Your Income from Employment	Other Parent/Spouse Income from Employment (if living in the home)
Name of person employed Adrien C. Thrift	Name of person employed
Employer Name Trillium Links Golf Resort	Employer Name
Employer Phone Number (including area code) 828.	Employer Phone Number (including area code)
Amount earned each pay period before taxes: $ +2853.33 gross $2314 net	Amount earned each pay period before taxes: $
Paid: ☐ Weekly ☑ Every two weeks ☐ Twice a month ☐ Monthly	Paid: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly
Hours worked each pay period 40+ Are you still employed? ☑ Yes ☐ No	Hours worked each pay period _____ Still employed? ☐ Yes ☐ No
If you are not currently working, where did you work last?	If not currently working, last place of employment?
Name of Self-Employment Business and/or Partnership	Name of Self-Employment Business and/or Partnership
If self employed, most recently completed income tax return must be provided including all forms and schedules.	**If self employed, most recently completed income tax return must be provided including all forms and schedules.**

Other Income	Amount	Which family member gets this income?	How often is this income received?
Child Support	$ —		
Alimony	$ —		
Social Security Payment	$ —		
Social Security Income	$ —		
Unemployment Benefits	$ —		
Veterans Benefits	$ —		
Interest	$ —		
Workers Compensation	$ —		
Cash Contributions	$ 0		
Other (*Please Explain*)	$ —		

4. Does anyone in your family own the following?

Tell us how much money your family has in cash and/or in bank accounts.

$_____ Cash

$_____ Name and address of Bank:_____ Name on Account:_____

$_____ Name and address of Bank:_____ Name on Account:_____

Resources *Please list other resources such as trusts, IRAs, CDs, lump sums, etc. (Please explain.)*	Yes?	No?	Who owns it?	Value/Equity/Value of Personal Property
Home	✓		Title in Adrien & Cynthia's name	$ Approx. 140,000
Property other than your home				$
Cars/Truck	✓		87 Honda - Adrien > joint ownership 99 Infiniti - Cynthia	*List equity value of each vehicle per licensed driver. Tell us which vehicles are used for self employment. Honda - 2,000.00 Infiniti - 5,000.00 $
Stocks/Bonds	✓		Adrien Thrift	$ 1,800.00
Burial Plots		✓		$
Pre-paid Burial Contracts		✓		$
Interest earned from a bank account		✓		$
Boats/Campers/etc.		✓		$
Life Insurance		✓		$
				$
				$

*** The equity value is the Fair Market Value of a resource minus the amounts of debt(s).**

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

6. **Do you pay someone to take care of your child(ren) under 12 and/or a dependent adult in your home while you work or attend school?**
☐ Yes ☑ No _____ Number of children under age 12 and/or dependent adults for whom you pay for care.

Name of child/dependent adult	Age	Do you participate in the ABC (Childcare) Voucher program?	How much do you pay for this care?	How often do you pay this amount?	Who do you pay? *(Please give name and phone number.)*

7. **Do you pay court ordered child support for a child outside your household?** ☑ No ☐ Yes

Name of child	How much do you pay?	How often do you pay this amount?

8. **Tell us about any health or medical insurance covering anyone for whom you are applying. Include Medicaid in another state. Please send us a copy of the card(s) front and back.**

Even if you already have health insurance, you and/or your children can still qualify for Medicaid.

Insurance Company	Policy Number	Policyholder's Name	Policyholder's ID	Persons Covered	What type of coverage is this?
none					

9. ATTACH REQUIRED PROOF. ***Check below to tell us what you attached. If you do not send this proof, processing your application will be delayed.***

- ☑ Copies of pay stubs for the **last 4 weeks** for **any adult person listed**; *or* a letter from employer that shows last 4 weeks of GROSS pay.
- ☐ A copy of the letter telling the gross amount of any benefits received (Social Security, Unemployment, VA, Workers' Compensation, etc.)
- ☐ Proof of all other income for the last 4 weeks, including child support.
- ☑ Proof of income for retroactive coverage.
- ☐ You are self-employed, and have attached a copy of your most recent federal income tax form including all schedules.
- ☐ Your family has no income. If checked, #5 **must** be completed.
- ☑ Proof of due date from doctor, nurse, or Health Department for each pregnant woman.
- ☐ Verification of the childcare/dependent adult expenses (statement from daycare, receipt, etc.)
- ☐ Bureau of Citizenship and Immigration Services (BCIS) documents for each non-citizen applying for full Medicaid.
- ☑ Proof of Citizenship and Identity for each US citizen applying for Medicaid. (If you have provided this information before, you do not have to provide it again.)

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

10. Does anyone listed on this application already have a plastic SC Partners for Health Medicaid card? ☐ Yes ☑ No

If yes, list their name(s) and Medicaid Number(s) here: _____

11. Take this completed, signed application and required proof to a Medicaid eligibility worker or mail to:

South Carolina Medicaid Division of Central Eligibility Processing Post Office Box 100101 1801 Main Street Columbia, South Carolina 29202-3101	***For faster processing include required proof with application. You may take this form and required proof to your local Medicaid office. For local office locations, contact us at www.scdhhs.gov or 1-888-549-0820.***

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

Applicant's Signature: Cynthia L Thrift Date: 8/23/06

Authorized Representative's Signature: _____ Date: _____

Address: _____ Phone Number: _____

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

DHHS Worker Signature:	Date:
Suzanne Roach	8-23-06

Rights and Responsibilities

1. I know that my children under age 19 who are eligible for Partners for Health Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Medicaid Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Medicaid Card(s).

   a. I know that, in accordance with the federal rules governing the Medicaid Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.

   b. I know that, in accordance with the federal rules governing the Medicaid Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about me and my family with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medicaid programs, and the TANF and Food Stamp agency (DSS, in this state). Immigration status will be verified with the Department of Homeland Security (DHS).

   c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.

   d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.

3. I know that my Social Security Number, which I am required to provide, under §1137(a)(1) of the Social Security Act [42 U.S.C. 1320b-7(a)(1)], may be used or released in connection with the exceptions in Item 2, above.

4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

5. I know that the Medicaid program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Medicaid has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.

6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Medicaid coverage.

7. I understand that I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.

8. I know that I may request a hearing if I believe an error has been made in processing my application.

July 2006 Budget Workbook

Primary Individual: cynthia thrift HH#: BG#: Application Date:

Budget Group Information

Instructions

	Budget Group Members	Relationship	Income: Wages	Self Employment	SSA	VA	Pension	UCI Benefits	Child Support	Cntribtion	Interest Dividends	Other Unearned	Disregards: Childcare Paid
	1 cynthia	Primary											
	2 adrien		5,706.66										
Children	3 eva												
Children	4 hayden												
Children	5												
Children	6												
Children	7												
Children	8												
			5,706.66	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Aid Group Members (Adults)	Resources: Auto, truck	Life Insurance	Checking	Savings	Pre-need Burial	Real Property	Personal Needs	Other Resource
1 cynthia								
2 adrien								
Totals	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

System Matches

No Hit	Hit	
☑ Bendex	☐	0
☐ ESC	☑	
☑ UCB	☐	
☐ SDX	☐	
☑ SC Retirement	☐	0

Calculator

Period	1	2	3	4	Total	Average per Period	FI Monthly Average	SSI Monthly Average
Weekly					0.00	0.000	0.00	0.00
Bi-Weekly	2,853.33	2,853.33			5,706.66	2,853.330	6,163.19	6,182.21
Semi-Monthly					0.00	0.000	0.00	0.00

Period	1	2	3	4	Total	Average per Period	FI Monthly Average	SSI Monthly Average
Weekly					0.00	0.000	0.00	0.00
Bi-Weekly					0.00	0.000	0.00	0.00
Semi-Monthly					0.00	0.000	0.00	0.00

cynthia thrift

BG#:

Pregnant Woman

Section 1: Computation of Income				
Type of Income	Income of AG Members			
Earned Income	cynthia	adrien	Children	Totals
1 Gross Earned Income	0.00	5,706.66		5,706.66
2 Earned Income Disregard	0.00	100.00		100.00
3 Incapacitated Adult Care Paid				0.00
4 Total Disregards	0.00	100.00		100.00
5 Subtotal	0.00	5,606.66		5,606.66
Unearned Income				
6 Child Support Payments			0.00	0.00
7 SSA Benefits	0.00	0.00	0.00	0.00
8 VA Benefits	0.00	0.00	0.00	0.00
9 Pension	0.00	0.00	0.00	0.00
10 UCI Benefits	0.00	0.00	0.00	0.00
11 Contributions	0.00	0.00	0.00	0.00
12 Other	0.00	0.00	0.00	0.00
13 Gross Unearned Income	0.00	0.00	0.00	0.00
14 Child Care Deduction	0.00	0.00		0.00
	Net Income			5,606.66

Budget Group 5
Income Limit 3,608.00

Income Ineligible
Resource Eligible

BG#:

Baby Under 1 (PB)

Section 1: Computation of Income				
Type of Income	Income of AG Members			
Earned Income	cynthia	adrien	Children	Totals
1 Gross Earned Income	0.00	5,706.66		5,706.66
2 Earned Income Disregard	0.00	100.00		100.00
3 Incapacitated Adult Care Paid				0.00
4 Total Disregards	0.00	100.00		100.00
5 Subtotal	0.00	5,606.66		5,606.66
Unearned Income				
6 Child Support Payments			0.00	0.00
7 SSA Benefits	0.00	0.00	0.00	0.00
8 VA Benefits	0.00	0.00	0.00	0.00
9 Pension	0.00	0.00	0.00	0.00
10 UCI Benefits	0.00	0.00	0.00	0.00
11 Contributions	0.00	0.00	0.00	0.00
12 Other	0.00	0.00	0.00	0.00
13 Gross Unearned Income	0.00	0.00	0.00	0.00
14 Child Care Deduction	0.00	0.00		0.00
	Net Income			5,606.66

Budget Group 4
Income Limit 3,083.00

Income Ineligible
Resource Eligible

Action: App.
Retroactive Medicaid:

EDC: 10-06
Month of Eligibility:

Eligibility Worker's Signature: Suzanne Roach

Decision Date: 8/23/06
Processing Time: Day(s)

July 2006 Budget Workbook

BG#: cynthia thrift

Partners for Healthy Children

Section 1: Computation of Income				
Type of Income	**Income of AG Members**			
Earned Income	**cynthia**	**adrien**	**Children**	**Totals**
1 Gross Earned Income	0.00	5,706.66		5,706.66
2 Earned Income Disregard	0.00	100.00		100.00
3 Incapacitated Adult Care Paid				0.00
4 Total Disregards	0.00	100.00		100.00
5 Subtotal	0.00	5,606.66		5,606.66
Unearned Income				
6 Child Support Payments			0.00	0.00
7 SSA Benefits	0.00	0.00	0.00	0.00
8 VA Benefits	0.00	0.00	0.00	0.00
9 Pension	0.00	0.00	0.00	0.00
10 UCI Benefits	0.00	0.00	0.00	0.00
11 Contributions	0.00	0.00	0.00	0.00
12 Other	0.00	0.00	0.00	0.00
13 Gross Unearned Income	0.00	0.00	0.00	0.00
14 Child Care Deduction	0.00	0.00		0.00
	Net Income			5,606.66

Resource Eligible

Income Ineligible

Aid Group 4
Income Limit 2,500.00

Action: Application
Decision: Denial
Retroactive Medicaid:
Eligibility Month:

Eligibility Worker's Signature: Suzanne Bach

Decision Date: 8/23/2006
Processing Time: Day(s)

D H E C

PROMOTE PROTECT PROSPER

PICKENS COUNTY HEALTH DEPARTMENT
200 McDaniel Avenue
Pickens, SC 29671 Date: 9/22/06.

To: Department of Social Services

From: Pickens County Health Dept.

TO WHOM IT MAY CONCERN:

555-0241811
THRIFT, CYNTHIA
11/28/1980 _____ had a positive pregnancy test and has an

EDC of 11-9-06.

1- 4-07; 4:23PM; ;3 # 17/ 28

paid salary - same each pay period.

TRILLIUM LINKS & VILLAGE, LLC. / PAYROLL ACCOUNT 001313

2853.33 8-01 to 8-15-06

2853.33

FWH 161.33 MED 41.37 SOC 176.90 NCSWH 159.00 DD-Chk 2314.73

538.60

Adrien Thrift GROSS 23076.64 FICA 1765.36
569-99-8217 THRIFTADRI FWH 1328.14 SWH 1292.00 .00

TRILLIUM LINKS & VILLAGE, LLC.
PAYROLL ACCOUNT
ONE TRILLIUM CENTER
CASHIERS, NORTH CAROLINA 28717

UNITED COMMUNITY BANK
P.O. Box 1489
Cashiers, North Carolina 28717
66-1187/531 11

001313

8-15-2006 DD-Chk 0007507116681 2314.73

Adrien Thrift
1137 Fox Squirrel Ridge Rd
Pickens, SC 29671

2314.73
2314.73
.00

01/04/2007 03:23PM

1- 4-07; 4:23PM; ;3 # 18/ 28

TRILLIUM LINKS & VILLAGE, LLC. / PAYROLL ACCOUNT 001179

2853.33 7-01 to 7-14-06

2853.33

FWH 161.33 MED 41.37 SOC 176.91 NCSWH 159.00 DD-Chk 2314.72

538.61

Adrien Thrift GROSS 17369.98 FICA 1328.80
569-99-8217 THRIFTADRI FWH 1005.48 SWH 974.00 .00

TRILLIUM LINKS & VILLAGE, LLC.
PAYROLL ACCOUNT
ONE TRILLIUM CENTER
CASHIERS, NORTH CAROLINA 28717

UNITED COMMUNITY BANK
P.O. Box 1489
Cashiers, North Carolina 28717
56-1167/531 11

001179

7-14-2006 DD-Chk 0007507116681 2314.72

2314.72

Adrien Thrift
1137 Fox Squirrel Ridge Rd
Pickens, SC 29671

2314.72
.00

01/04/2007 03:23PM

1- 4-07; 4:23PM; ;3 # 19/ 28

TRILLIUM LINKS & VILLAGE, LLC. / PAYROLL ACCOUNT 001261

2853.33 7-15 to 7-28-06

2853.33

FWH 161.33 MED 41.38 SOC 176.91 NCSWH 159.00 DD-Chk 2314.71

538.62

Adrien Thrift		GROSS	20223.31	FICA	1547.09
569-99-8217	THRIFTADRI	FWH	1166.81	SWH	1133.00

.00

TRILLIUM LINKS & VILLAGE, LLC.
PAYROLL ACCOUNT
ONE TRILLIUM CENTER
CASHIERS, NORTH CAROLINA 28717

UNITED COMMUNITY BANK
P.O. Box 1489
Cashiers, North Carolina 28717
66-1167/531 11

001261

7-28-2006 DD-Chk 0007507116681 2314.71

2314.71
2314.71
.00

Adrien Thrift
1137 Fox Squirrel Ridge Rd
Pickens, SC 29671

01/04/2007 03:23PM

1- 4-07; 4:23PM; ;3 # 20/ 28

TRILLIUM LINKS & VILLAGE, LLC. / PAYROLL ACCOUNT 001100

2853.33 5-01 to 5-15-06

2853.33

FWH 161.33 MED 41.38 SOC 176.90 NCSWH 159.00 DD-Chk 2314.72

538.61

Adrien Thrift GROSS 5706.66 FICA 436.56
569-99-8217 THRIFTADRI FWH 322.66 SWH 318.00 .00

TRILLIUM LINKS & VILLAGE, LLC.
PAYROLL ACCOUNT
ONE TRILLIUM CENTER
CASHIERS, NORTH CAROLINA 28717

UNITED COMMUNITY BANK
P.O. Box 1489
Cashiers, North Carolina 28717
56-1167/531 11

001100

DIRECT DEPOSIT NOTIFICATION

	DESCRIPTION	ACCOUNT NO.	AMOUNT
5-15-2006	DD-Chk	0007507116681	2314.72

Adrien Thrift
1137 Fox Squirrel Ridge Rd
Pickens, SC 29671

NET PAY	2314.72
TOTAL DEPOSITS	2314.72
CHECK AMOUNT	.00

01/04/2007 03:23PM

Page: 1 Document Name: u itled

MEDESC01 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 08/23/06
MEDSPROD ESC WAGE INQUIRY
THIS IS CONFIDENTIAL INFORMATION PAGE 001 OF 001

ESC SSN : 249-67-9417 NAME: C BEH
MEDS SSN: 249679417 NAME: CYNTHIA L THRIFT
RCP NUM : 3780258805 HH NUM: 100910417 COUNTY: 39

EMP#	NAME & ADDRESS	TRADE NAME
0136055	MRS R HUNTER PARK	R HUNTER PARK MRS

41 STONE HAVEN DRIVE
GREENVILLE SC 29607

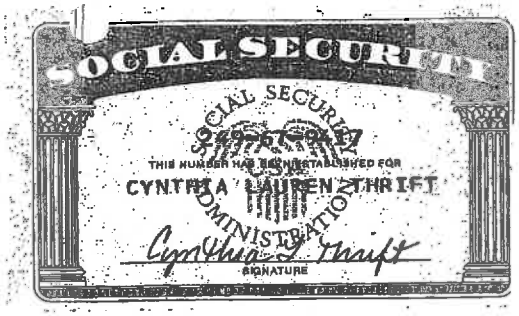
QTR	AMT	QTR	AMT
06/1	.00	05/4	.00
05/3	.00	05/2	.00
05/1	.00	04/4	242.55

UPDATED: SYSTEM ID: ESC2100 DATE: 08/12/06
ME912002 WAGE RECORD FOUND
PF1->HELP PF5->RCP INFO PF6->PREV PF7->BACK PF8->FORWARD
PF10->PREV MENU PF11->IEV PF12->EARNED INC PF14->SDX

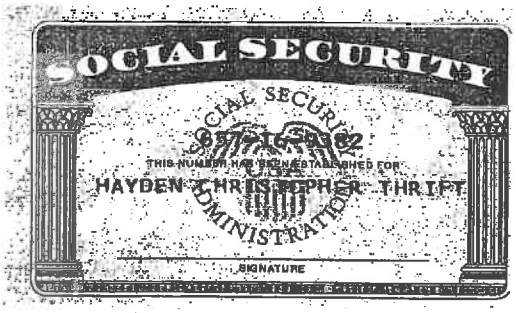
Date: 8/23/2006 Time: 9:31:18 AM

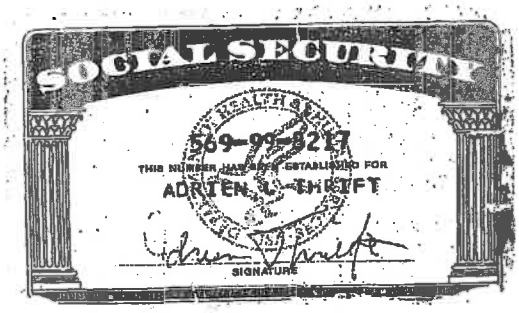
PERMANENT

SECTION

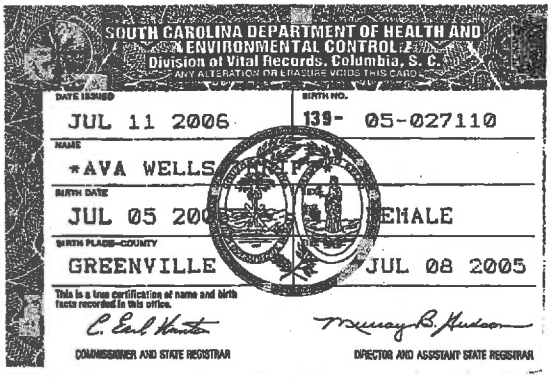


Viewed orig.
8-23-06
SR

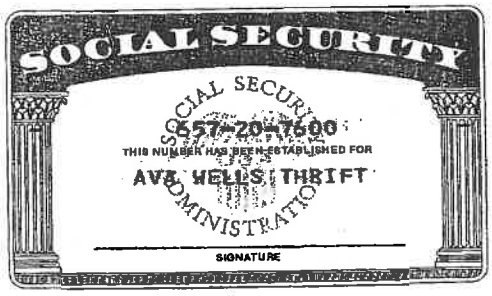


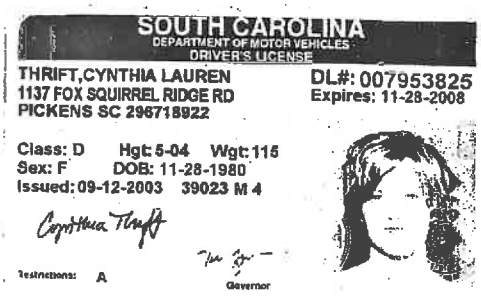


TO REMOVE CARD—CAREFULLY SEPARATE FORM



DO NOT LAMINATE CARD





D H E C
PROMOTE PROTECT PROSPER

VERIFICATION OF CITIZENSHIP FOR MEDICAID ELIGIBILITY (VCME)

The "Verification of Citizenship For Medicaid Eligibility (VCME)" system was able to verify the following individual:

Medicaid ID#: 3780258806

First Name: hayden

Last Name: bennett

Date of Birth: 12/15/2003

NOTE: This form is issued to a government agency for official use only pursuant to S.C. Code Ann. R. 61-19, Section 39(d).

*The VCME System may not identify all deceased individuals.

Requestor: SUZANNE ROACH Date: 8-23-06

Requestor's Signature: Suzanne Roach

8/23/2006 9:38:22 AM

South Carolina Department of Health and Human and Services

STATEMENT OF CHILD'S IDENTITY

Under penalty of perjury, I, Cynthia Thrift (Name of Parent or Guardian),

affirm that Ava Thrift (Name of Child)

is my child (Relationship of Child to Parent or Guardian). Ava (Name of Child)

was born on 7-5-05 (Birth Date of Child) in Greenville (City of Birth),

Greenville (County of Birth), SC (State of Birth).

Cynthia Thrift
Signature of Person Giving Statement

Print Name of Person Giving Statement

Street or PO Box of Person Giving Statement

City, State, and Zip Code of Person Giving Statement

DHHS Form 3293 July 2006

South Carolina Department of Health and Human and Services

STATEMENT OF CHILD'S IDENTITY

Under penalty of perjury, I, Cynthia Thrift (Name of Parent or Guardian),

affirm that Hayden Thrift (Name of Child)

is my child (Relationship of Child to Parent or Guardian). Hayden (Name of Child)

was born on 12-15-03 (Birth Date of Child) in Greenville (City of Birth),

Greenville (County of Birth), SC (State of Birth).

Cynthia Thrift
Signature of Person Giving Statement

Print Name of Person Giving Statement

Street or PO Box of Person Giving Statement

City, State, and Zip Code of Person Giving Statement

DHHS Form 3298 July 2006

From: Sam waldrep
To: Alicia Jacobs
Date: 1/4/2007 1:46 PM
Subject: Fwd: Re: Qualified State Long Term Care Insurance Partnership
Attachments: Re: Qualified State Long Term Care Insurance Partnership

CC: Susan Bowling

Alicia- Am keeping you in the loop. I've asked George Burnett to look at what DoI is saying. I'm not sure how this impacts our proceeding with the SPA until the DoI can certify their statute meets this federal standard.

>>> Sam waldrep 01/04/07 1:37 PM >>>
George- Can you please review this response from the DoI and let me know your opinion about it. It's been several months since I looked at this but I was thinking that we had to have an MoA with the DoI re: their certification of policies.

>>> "Ann Roberson" <ARoberson@doi.sc.gov> 01/04/07 12:13 PM >>>
Dear Sam,

Based upon our review of the July 27, 2006 memorandum from the Centers for Medicare & Medicaid Services, it is our opinion that the South Carolina Department of Health and Human Services (Medicaid Agency) is the appropriate agency that should form the Qualified State LTC Insurance Partnership under the Deficit Reduction Act of 2005.

As a follow-up to my earlier e-mail, we have reviewed the information sent to us as well as Chapter 72 of Title 38 of the South Carolina Insurance Code and Regulation 69-44. It appears that these statutes need to be revised to reflect the most recent changes found in the latest National Association Insurance Commissioner's (NAIC) Model Act and Regulation prior to the South Carolina Department of Insurance (SC DOI) providing you with a certification that our statutes meet the specified requirements of the NAIC Model Act and Regulation. Even though SC has not adopted the latest NAIC Model Act and Regulation, the forms and rates area is aware of the federal requirements of insurance companies for Qualified Long Term Care policies and approve only policies that meet these requirements.
We are proposing that the SCDOI adopt the latest NAIC Model Act and Regulation which was approved by the NAIC at its September 2006 meeting.

Please let us know if we can provide any further information regarding this issue.

Sincerely,

Ann Roberson
Executive Assistant to the Director/PIO

From: "Ann Roberson" <ARoberson@doi.sc.gov>
To: "Sam waldrep" <Waldrep@scdhhs.gov>
Date: 1/2/2007 10:13 AM
Subject: Re: Qualified State Long Term Care Insurance Partnership

Good morning Sam,

I met with two of our folks, Ann Bishop and Tina Amaker, before the holidays and shared the materials that you sent me. They were going to check on some of the specifics- I will touch base with them and get back with you shortly.

Ann
>>> "Sam waldrep" <Waldrep@scdhhs.gov> 01/02/2007 10:03 AM >>>

Hi Ann-

Have you had a chance to look at the materials I sent you in November? We would like to see if we are ready to schedule a meeting to discuss this with you and the appropriate staff at DoI. Thanks.

Sam Waldrep

>>> "Ann Roberson" <ARoberson@doi.sc.gov> 11/17/06 10:18 AM >>>
Sam,

I 'll keep a look out for the packet and we will review it and get back with you. Thanks so much and we'll talk with you soon.
Sincerely,

Ann Roberson
Executive Assistant to the Director/PIO
SC Department of Insurance
Columbia, SC 29202
803-737-6207 (phone)
803-737-6229 (fax)
aroberson@doi.state.sc.us

>>> "Sam waldrep" <Waldrep@scdhhs.gov> 11/17/2006 9:48 AM >>>

Ann- Thank you for taking time to talk with me about the Qualified State Long Term Care Insurance Partnership. I could not locate any of the information electronically, but have compiled a packet of information for you that I will drop in the mail today. After you review it, call or email me (898-2725) or Brenda Hyleman (898-2687) and let's discuss how we will might proceed.

Thanks.

Sam Waldrep, MA, LMSW
Bureau Chief
Bureau of Long Term Care Services
SC Department of Health and Human Services
P.O.Bx 8206
Columbia, SC 29202-8206
803-898-2725

waldrep@scdhss.gov

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.

LEGISLATIVE LOG #	0420
LEGISLATOR/INQUIRER	Jim DeMint
CONSTITUENT	Cynthia Thrift
SSN	
BC ASSIGNED LOG	Jacobs
DATE REC'D BY AGENCY	12/21/2006
DATE DRAFT DUE GR	1/4/2007
LOG LETTER DUE DATE	1/5/2007
DATE REFERRED TO BC	12/21/2006

Brief Description of Issue/Problem	Date	Staff Person	Phone #	Action Taken
Wants Medicaid coverage for her pregnancy and delivery of their 3rd child. She has already been assisted on 3 other occasions and does not qualify for OCWI, PHC or LIF as her husband makes too much money. Unfortunately, her husband only works 8 mos out of the year but their income cannot be annualized because he is not self-employed. So, their income is over the limit.	12/21/2006	Jill	8-3936	Gave to Mark to distribute (3pm)
	12/27/2006	Denise	8-2505	Mark gave to me to research, then give to Jenny tomorrow.
	12/27/2006	Denise		Since this is the 4th inquiry from Ms. Thrift and we last assisted her in Sept 06, I asked Jan if we could verbally let Sen. DeMint's ofc know that we have done all we can to assist Ms. Thrift. (This inquiry to Sen. DeMint's ofc was sent 1st of Sept & we did not receive it til 3 mos. later.)
	1/3/2006	Denise	8-2505	Returned log to Jan so she can see if Gary wants to close w/o responding to Ms. Thrift again as DeMint's inquiry from Ms. Thrift was dated Sept & we've assisted her since then.

CHECKLIST

Family Size	
Income/Resources	

Other Resources:

Communicare	
FQHCs	
Free Medical Clinics	
Medicare	
MIAP	
Prescription Drug Programs	
Social Security	
Together Rx	

Programs:

ABD (32)	
Foster Children (31,60)	
General Hospital (14)	
HCBWS (15)	
LIF (59)	
MBCCP (71)	
Nursing Home (10)	
OSS (85,86)	
PHC (88)	
Pregnant Women & Infants (12,87)	
QMB (90)	
SILVERxCARD (92)	
SLMB (48,52)	
SSI (80)	
TEFRA (57)	
Transitional (11)	
Working Disabled (40)	

Instructions:

Jan creates new worksheet for each log by copying template into workbook & changing name of worksheet to proper log #.
Each user finds log # on bottom tab & enters "date/action taken" in shaded cells. (Once entered, user must exit document.)
If question about current status of a log letter, contact previous user.
Jan & Linda will update upon each log's return and, as a log is closed, they will cut and paste each worksheet into the archive file.
Path: GROUPS/Constituent Services/Log Letters & Transmittals/Aides for Creating-Tracking/Trackers-Tools/Excel Log Tracker

From: Denise Epps
To: Jan Polatty
Date: 12/27/2006 12:27 PM
Subject: log # 0420 - cynthia thrift

CC: Jennifer Dabbs; Mark Orf; Robert G Liming

as you are aware, this is her 4th plea for medicaid -- twice in sept (i handled the request she made thru the "Insure Kids Now Hotline" and bob handled the request to sen. martin's ofc.) bob also handled her 3rd request to the gov's ofc that was in oct of this year.

ms. thrift sent her email to senator demint in sept. so we have assisted her since then. she asked for medicaid coverage for her pregnancy & delivery of their 3rd baby due in oct.

when we assisted her in sept., we doublechecked policy and they do not qualify for OCWI, PHC and LIF. ms. thrift was not happy that we had to use her husband's gross income and not an annualized amount since he is not self-employed. we shared all available healthcare resources with her at that time.

i would suggest we not open pandora's box again with ms. thrift and verbally communicate with senator demint's ofc letting them know we have assisted ms. thrift as much as we could.

does this suit?

thanks,
denise

From: Bryan Kost
To: Robert G Liming
Date: 9/11/2006 2:18 PM
Subject: Fwd: Re: Sen. Larry Martin request re Mr. and Mrs. Adrien Thrift RCP # 3780258805

Hi:
I talked to Martha Casto later Friday - thanks for helping her!

Bryan Kost
DHHS Public Information
803.898.2865
cell- 429.3201
kostbr@scdhhs.gov

>>> Robert G Liming 9/8/2006 3:34 PM >>>
FYI: This is one from Brenda I was given on Friday afternoon that we can show as logged and now completed. The call came from Ms. Martha Castor (sp?) in Sen. Larry Martin's Office.

The issue is for Mrs. Thrift who is pregnant and expecting her third child in October. The family has been turned down for LIF, PHC and now Pregnant Women due to excess income. The latest denial was 8/23.

Bottom line is Mr. Thrift works in Cashiers, NC, and draws some $5,600 a month, but he only works April through October. Mrs. Thrift doesn't feel it is fair for it to be based on gross, and also wants the income based on an annualized amount. However, I got with Alicia and then had Betty Moses review policy and it is clear that since he is not self-employed and is on a salary the income must be based on his last four weeks of salary payments, this would put them some $2,500 over the limit.

I explained this in great detail to Mrs. Thrft and advised her about CHCs and Free Clinic, but she wasn't interested. She was very emotional, but said she appreciated the effort. I also informed the Senator's Office about the income issue and the fact that there was no way they could qualify for any Medicaid program. We can call this closed. Thanks

>>> Valerie Hollis 9/8/2006 12:32 PM >>>
Thanks for the heads up. If you can't reach her today, I'll see what I can do on Monday. Thanks

>>> Robert G Liming 9/8/2006 12:29 PM >>>
A Martha Cato (Sp?) was transferred to me by Brenda because she didn't know where else to send it. Apparently both Bryan and Jan are out (think Byran's wife is expecting).

Any way Martha seemed extremely miffed that she had been passed to me, she was also not pleased when I told her that due to HIPAA I couldn't discuss details without approval of the client. I told her I would call the client, but she had no number and no SS #, I told her I would try and locate one and still contact the client. She made very clear that she worked for the senator and wanted information as soon as possible. I will do my best, but the phone has been ringing off the wall and I am apparently the only Indian still on duty. Will keep you posted.....but since I am gone next week wanted you to be aware of the situation.

Robert G. Liming
Special Project Manager, Office of Constituent Services
South Carolina Department of Health and Human Services
Room 310
1801 Main Street
P.O. Box 8206
Columbia, South Carolina 29202-8206

803-898-2621
E-Mail: limingr@scdhhs.gov

Website: www.scdhhs.gov

From: Robert G Liming
To: Dabbs, Jennifer; Polatty, Jan
Date: 10/18/2006 8:47 AM
Subject: Re: Fwd: Gov Office/constituent inquiries: 1) Cynthia Thrift

CC: Epps, Denise; Hollis, Valerie; Marchese, Jill Ann

FYI: This is second request we have received on this lady. I handled the original request back in September as a contact from Senator Larry Martin's Office. We have had the supervisor check this twice for income verification and to look at all program options. I did not call Ms. Thrift again this time because she certainly is not pleased with what I have already told her three times, she is ineligible due to income.

As background, Mrs. Thrift has two other children, one age one and another age two. She was supposed to have her third child about now.

She had applied for pregnant women, but was denied in late August, their combined income was $5,606.66 and allowable is $3,608. We also tried them for PHC, but even more over because PHC limit is $2,500. As background she was also denied LIF back in 2004 after first child because of income, even when we tried to keep the family size at two. She is not unfamiliar with the rules and regulations and we have exhausted all avenues to try and get her qualified. Their income is simply far over the allowable limits.

The issue is for Mrs. Thrift who was pregnant and expecting her third child in mid-October. The family has been turned down for LIF, PHC and now Pregnant Women due to excess income. The latest denial was 8/23/06.

Bottom line is Mr. Thrift works in Cashiers, NC, and draws some $5,600 a month, but he only works April through October. Mrs. Thrift doesn't feel it is fair for it to be based on gross, and also wants the income based on an annualized amount. However, I got with Alicia and then had Betty Moses review policy and it is clear that since he is not self-employed and is on a salary the income must be based on his last four weeks of salary payments, this would put them some $2,000 over the limit.

I explained this in great detail to Mrs. Thrift in September and advised her about CHCs and Free Clinic, but she wasn't interested. She was very emotional, but said she appreciated the effort. At that time I also informed Senator's Martin's Office about the income issue and the fact that there was no way they could qualify for any Medicaid program. We can call this closed.

>>> Constituent Services 10/13/2006 3:37 PM >>>
Per Jan, only handle Cynthia Thrift. Do not worry about Ms. Brown. Thanks!

From: Jan Polatty
To: Denise Epps
Date: 1/3/2007 2:11 PM
Subject: Re: ok to close? (plz see explanation below.) log # 0420 - cynthia thrift

Denise, please send the log up and I'll include this information and ask Gary to approve the close. Thanks, Jan

>>> Denise Epps 01/03/07 12:20 PM >>>
as you are aware, this is her 4th plea for medicaid - twice in sept (i handled the request she made thru the "Insure Kids Now Hotline" and bob handled the request to sen. martin's ofc.) bob also handled her 3rd request to the gov's ofc that was in oct of this year.

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does this suit?

thanks,
denise

From: Denise Epps
To: 877kidsnow@prodigy.net
Date: 9/18/2006 10:24 AM
Subject: Ms. Thrift

Shari, we have communicated with Ms. Thrift, so you may clear this inquiry off your mail log system. Thanks for all you do. Sincerely, Denise Epps

Denise M. Epps
Constituent Services
Bureau of Eligibility Policy & Oversight
(803) 898-2505 direct; (803) 255-8350 fax
eppsden@scdhhs.gov

>>> "Insure Kids Now Hotline" <877kidsnow@prodigy.net> 9/13/2006 4:46 PM >>>

Dear Mark,
I am your Insure Kids Now Coordinator who also sends you your statistics each month for your state. I have received the following email through the Health Resources and Services Administration (HRSA) email center which controls all incoming email inquiries through the Insure Kids Now Website (www.insurekidsnow.gov <http://www.insurekidsnow.gov/>).

This email center is monitored and controlled by HRSA to see what types of inquiries are received by the government on different issues. It is my responsibility to forward any Insure Kids Now inquiries to the appropriate state contact for a response. I have copied the email inquiry below.

If you could, please respond to the inquirer at their indicated email address and copy me at 877kidsnow@prodigy.net so that I may clear the email inquiry on the system.

We understand that sometimes you will not be able to help the person because they do not qualify for the program. If you could just restate that in your email to them and possibly offer an alternative, that would be great. Please let me know if you have any questions, I may be reached at 877kidsnow@prodigy.net or at 301.834.4681.

Thank you so much!
Shari :-)

Shari Nakamoto
Insure Kids Now Hotline
Health Resources and Services Administration (HRSA)
State Children's Health Insurance Program (SCHIP) Consultant
<http://www.insurekidsnow.gov> www.insurekidsnow.gov
877-KIDS-NOW - Toll Free
(1-877-543-7669)
301.834.4681 - Phone
301.834.3298 - Fax
<mailto:877kidsnow@prodigy.net> 877kidsnow@prodigy.net - Email

The Customer's Name is: Cynthia Thrift
Their Email address is: cynthiathrift@bellsouth.net

Customer (Cynthia Thrift) - 09/07/2006 03:31 PM I am searching for a way to show that our family qualifies for SCHIP and also medicaid for my pregnancy.

I applied and was denied with the reason stating our income level was too high. I am seven months pregnant with our third baby and my husband is employed seasonally. The season pays out 12 months salary in 8 months time so when we submitted our paychecks with medicaid applications we were denied based on gross income. What other programs are there for us to receive assistance for labor and delivery and well baby care? We have tried everything we know and keep getting denied. I waited to receive prenatal care because we did not have health insurance and now the delivery is approaching. We will not be able to afford a hospital birth without health insurance and we desperately need assistance. We will be operating a family of 5 on $43,000 which after taxes leaves us with approx. $3,000 a month. We need help and would like any information as his employer does not offer health care and cannot as it is seasonal work. Is

there any way to get my pregnancy approved with medicaid?

Cynthia Thrift
1137 Fox Squirrel Ridge Road
Pickens, SC 29671
(864) 878-7322

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MEDHMS54 P          S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 01/04/07
 MEDSPROD                        RECIPIENT INFORMATION                ACTION:
                  MEMBER PERIOD START: 08/23/06  END:                 PAGE: 0001
 NAME: THRIFT CYNTHIA L                              HH NAME: THRIFT CYNTHIA L
 RCP NUMBER: 3780258805     HH NUMBER: 100910417     ACTION TYPE: MAINTENANCE
 SSN: 249-67-9417  VC: V    APL STATUS:              ACTION DATE: 08/23/06
 PRIMARY INDIVIDUAL:        APL CO: 39    WORKER ID: SROAC    LOCATION: 001
 1137 FOX SQUIRREL RIDGE ROAD             SSCN:               RRN:
                                          RACE: 01   SEX: F   MARITAL STATUS: S
                                          TPL INSURANCE: Y    RELATION: SELF
 PICKENS                    SC 29671-     DOB: 11/28/1980     DOD:
 CORRECT RCP NUMBER: _____                LIV ARRANGEMENT: HOME INCOME TRUST:
                                          PROVIDER:

     BG       BEG        END                  BENEFITS QMB RETRO  % OF POV   CHIP
S  NUMBER     ELIG       ELIG     PCAT QCAT   TYPE     IND  IND    LEVEL     NUMBER

 UPDATED: USER ID: SROAC     DATE: 08/23/06  SYSTEM ID: SVE3000  DATE: 08/25/06
ME900063 RECIPIENT RECORD FOUND
 PF2->HH BG  PF3->HH MBR DTL  PF4->REFH  PF5->ELD02  PF6->RETURN  PF7->PREV
 PF8->NEXT  PF9->HH NOTES  PF15->RCP SEARCH  PF17->ELD00  PF18->HH MBR BGS
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Look like a golf - Course
job -
regular check stubs in case
salary $2853.00 - all checkstubs
check stubs from 8/1/06 - (4 check stubs)
1st - July thru middle of August.

From: Robert G Liming
To: Hollis, Valerie
Date: 9/8/2006 12:29 PM
Subject: Sen. Larry Martin request re Mr. and Mrs. Adrien Thrift RCP # 3780258805

CC: Epps, Denise; Marchese, Jill Ann; Orf, Mark

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Any way Martha seemed extremely miffed that she had been passed to me, she was also not pleased when I told her that due to HIPAA I couldn't discuss details without approval of the client. I told her I would call the client, but she had no number and no SS #, I told her I would try and locate one and still contact the client. She made very clear that she worked for the senator and wanted information as soon as possible. I will do my best, but the phone has been ringing off the wall and I am apparently the only Indian still on duty. Will keep you posted.....but since I am gone next week wanted you to be aware of the situation.

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