DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	4-3-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 100557	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ Copy: Forkner Cleared 4/8/09, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 4/15/09 [ ] 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.			

ATTN: BILL PRINCE MEDICAID DIRECTOR

MY NAME IS LEESA WATSON AND I HAVE BEEN TAKEN OFF MEDICAID BECAUSE OF MY CASE WORKER NOT DOING THEIR JOB. I AM IN ACUTE CARE WITH LUNG DISEASE FROM EXPOSURE TO OXIC MOLD AND I AM ON A OXYGEN MACHINE 24 HOURS A DAY. I HAVE FAXED MY INFORMATION TO EVERYONE THAT WAS INVOLVED WITH MY MEDICAID AND LEFT A MR. TORI TOLAND SEVERAL MESSAGES ALONG WITH JUDY MURPHY AND MRS. PEARSON. I SHOULD NOT HAVE HAD MY BENEFITS CANCELLED BECAUSE I HAVE FILLED OUT ALL OF MY PAPER WORK ON TIME AND I AM STILL GOING THROUGH THE SS DISABILITY DETERMINATION PROCESS. I AM SICKER NOW THAN WHEN I FIRST APPLIED. I DONT HAVE ANY INCOME AND I HAVE A 18 YEAR OLD SON THAT LIVES WITH ME, SO ACCORDING TO THE FORM I STILL AM QUALIFIED. PLUS I HAVE DONE EVERYTHING ASKED OF ME AND ON TIME. I AM ON 13 MEDICATIONS WHICH I CANT GET AND HOME OXYGEN WHICH THEY ARE GOING TO COME AND GET IF I DONT GET THIS URGENT MISTAKE AND NOT CARING ON SOCIAL WORKERS PART THAT THEY HAVE MADE A HUGE MISTAKE. MY HEALTH AND LIFE ARE BEING COMPROMISED BECAUSE I CANT GET ANYONE FROM DHS TO CALL ME BACK OR EVEN REPLY. MR TORI TOLAND KNEW ABOUT THIS IN JANUARY AND TOLD ME HE WOULD WORK ON IT, HE HASNT AND NEITHER HAS ANY OF MY CASE WORKERS. I AM UNDER A SPECIAL DOCTORS CARE, A PULMINOLIGIST, DR IFTIKAR AND MY BREATHING SITUATION IS CRITICAL. I NNED YOUR HELP!! I KEEP CALLING AND FAXING BUT WITH NO RESPONSE FROM ANYONE. MY MEDICAID SHOULD NEVER HAVE BEEN CANCELLED IN THE FIRST PLACE BECAUSE I STILL MEET ALL OF THE CRITERIA. I DONT WANT TO HAVE BRAIN DAMAGE OR DIE BECAUSE I AM NOT ON MY MEDICATION AND I AM GETTING READY TO LOSE MY HOME OXYGEN, ALBUTERAL SYSTEM. AGAIN I CANT STRESS ENOUGH HOW URGENT THIS IS. LEESA WATSON 749-3595 THANK YOU.

8 pages including this Cover page.

LONG'S
trust. care. commitment.
50 YEARS of EXCELLENCE

Letter for Special Consideration for the Electric Company For Oxygen Patients

ATTENTION: _____

Leesa Watson is under a physician's care for Respiratory insufficiencies. This patient requires supplemental oxygen to sustain healthy levels of oxygen in their system. Without the supplemental oxygen this patients well being is compromised and if untreated could result in brain damage or death.

Therefore, while this patient lives at home, supplemental oxygen is provided via an oxygen concentrator. This concentrator requires AC current and cannot be operated from a battery source. This concentrator converts room air into concentrated oxygen by filtering out the carbon dioxide, nitrogen and other elements through sieve beds.

In addition, the concentrator is provided with a power failure alarm which will sound when electricity has been discontinued. There is a backup oxygen tank available to all of our oxygen patients. This tank will last anywhere from 12 hours to 48 hours, depending on the oxygen requirements.

Our electric company's support is urgently needed. When there are power failures, we ask that our home be placed on a priority list for restoration of electricity. Also, if there is a forewarning of a power disconnection, please notify us so that we can make arrangements.

Sincerely,

Leesa Watson
Name

500 Harbison Blvd Apt-1701
Address

Columbia, S.C. 29212
City State Zip

803-749-3595
Phone Number

Long's HME
454 Berryhill Rd
Columbia, SC 29210
888-882-3691

Form 702 (5/08)

Transitional Medicaid Assistance Quarterly Report

0006 0001863
RICHLAND COUNTY DHHS
3220 Two Notch Road
Columbia SC 29204-2026

Date: 01/20/2009
Worker: JUDY MURPHY
Telephone: 803 714-7621
BG#: 99640986
HH#: 101127426

PRESORTED FIRST-CLASS

LEESA WATSON
500 HARBISON BLVD APT 1701
COLUMBIA SC 29212-1727

ATTN: Judy M.

Answer Questions for the Months of: 11/08, 12/08 AND 01/09

YOUR MEDICAID WILL END IF THIS REPORT IS NOT COMPLETED, SIGNED AND RETURNED WITH PROOF OF INCOME AND CHILDCARE BY: 02/21/2009

Dear Parent/Caretaker Relative:

You and your children are receiving Medicaid benefits under a program called Transitional Medicaid Assistance. It is time for us to see if you are still eligible. We need you to tell us if there have been any changes in your household, income or child care in the last 3 months. Please complete and return this report to your worker within 30 days from the date of this letter.

Has anyone moved in or out of your home in the last 3 months? ☐ Yes ☒ No

If yes, did they ☐ move in, or did they ☐ move out? What is their name and relationship to you?

How much money did your family earn in the last 3 months?

Month	Gross Pay	Tips
November	0	
December	0	
January	0	

Please attach proof of income for the last 3 months.

If no income in one or more of the last 3 months, please explain.

I dont have any income my exhusband pays the rent directly to the apartment complex. I have already provided checks made out to Wellspring Apts copies.

Do you pay child care? ☐ Yes ☒ No

If yes, for how many children under 12 do you pay child care? _____

How much do you pay? _____ ☐ Weekly ☐ Other **Attach proof of amount.**

By signing this form, you are saying that the information you gave us on this form is correct and you have read the enclosed Rights and Responsibilities.

Signed Leesa Watson Date: 2-10-09

If you have questions regarding this report, contact your DHHS worker listed above.

WKR004 October 2008

ATTN:LEA McQUEEN

THIS IS AN EMERGENCY AND NEEDS YOUR IMMEDIATE ATTENTION

I HAVE FAXED THIS INFORMATION TO JUDY MURPHY BUT I AM NOT SURE WHO MY CASE WORKER IS AT THIS POINT. I HAVE SPOKEN TO MR. TORI TOLLAND AND CANT BELIEVE WHAT HAS HAPPENED. I HAVE SENT IN ALL OF MY REQUIRED DOCUMENTATION ON TIME BY FAX AND HAVE SPOKEN TO MR.TOLAND AND I THOUGHT THAT MY CASE WAS TAKEN CARE OF BUT IT WASNT AND NOW MY MEDICAID HAS BEEN CANCELLED. I AM SICKER NOW THEN WHEN I FIRST APPLIED FOR SS DISABILITY. I HAVE BEEN EXPOSED FOR SEVERAL MONTHS TO TOXIC MOLD AND HAVE TO BE ON OXYGEN AND TAKE 13 MEDICATIONS A DAY. I ALMOST DIED ABOUT 10 DAYS AGO AND I AM HAVING TO SEE A PULMINARY SPECIALIST BECAUSE OF DIMINISHED LUNG FUNCTION. MY BOXYGEN LEVEL IS SO LOW THAT I LOST CONCIOUSNESS AND FELL BREAKING MY TAIL BONE AND CAUSING A FRATURE TO THE TIP OF MY SPINE. PLEASE READ THE LETTER FROM LONG'S HOME HEALTH CARE EXPLAINING HOW IMPORTANT IT IS FOR ME TO STAY ON OXYGEN BECAUSE I COULD HAVE BRAIN DAMAGE OR DIE!!! IF YOU CAN HELP ME AT ALL PLEAE CONTACT WHO EVER YOU NEED TO GET THIS FIXED. I DONT WONT TO BE HOSPITALIZED AGAIN, 5 TIMES NOW WITHIN A FEW MONTHS OR HAVE MORE DAMAGE DONE TO MY BODY. I CANT STRESS ENOUGH HOW SICK I AM NOW.. LEESA WATSON 749-3595

7 pages including the Cover page.

SCVRD

DISABILITY DETERMINATION SERVICES
SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT
Providing quality disability determination services to South Carolinians in a responsive, timely and cost-effective manner.
Barbara G. Hollis, Commissioner
Office of State Claims ■ P.O. Box 1868 ■ Lexington, SC 29071 ■ (803) 957-1425
Toll-free: (866) 206-5207 ■ Medical Information Fax: (866) 736-9829

January 08, 2009

Ref. No: H88362

LEESA WATSON
500 HARBISON BLVD
APT 1701
COLUMBIA SC 29212

Dear LEESA WATSON:

This refers to your application for **Medicaid Assistance** Health and Human Services has asked this agency to help determine whether your impairment is severe enough to prevent you from working. Before we can complete processing of your claim, we need additional information about your daily activities.

Please complete the enclosed form. Read the instructions carefully and answer all questions to the best of your ability. Please sign or print the form on the last page and return it to this office in the enclosed envelope immediately.

It is very important that you complete this form and return it to us in the enclosed envelope within 10 days. **Please return this letter with this form.** If you have any questions or need help completing this form, please call this office at the above number. If calling long distance, use the toll free 1-800 number.

Sincerely,

L. McQueen

Lea D. McQueen, Disability Examiner

LD2/800
Claim No: H88362

Enclosure: ADL Questionnaire
Envelope

cc:

M56 (2/07)

0053869510
TDN: 0053869510

ATTN: JUDY MURPHY OR ANYONE WHO HANDLES LEESA WATSON-749-3595

THIS IS AN EMERGENCY AND NEEDS IMMEDIATE ATTENTION

6 PAGES INCLUDING THE COVER PAGE

ATTN: JUDY MURPHY

I HAVE A VERY SERIOUS AND DANGEROUS SITUATION CONCERNING MY HEALTH. I HAVE HAD PNUEMONIA 5 TIMES IN THE LAST COUPLE OF MONTHS AND HAVE DIMINISHED LUNG FUNCTION WHICH REQUIRES ME TO BE ON OXYGEN 24 HOURS A DAY AND ON 2 TYPES OF LUNG MEDICATION ALONG WITH ALBUTERAL TREATMENTS EVERY 4 HOURS. I ALMOST DIED ABOUT 10 DAYS AGO BECAUSE I HAD AN ANAPHALTIC REACTION AND MY THROAT CLOSED UP AND I HAD TO GO TO THE EMERGENCY ROOM AT LEXINGTON MEDICAL. I SENT BY FAX ALL OF THE REQUIRED DOCUMENTATION NEEDED TO STAY ON TRANSITIONAL MEDICAID BECAUSE A DISSCION IN MY CASE FOR DISABILITY HAS NOT BEEN MADE YET.

I HAVE NO INCOME AND I HAVE A 18 YEAR OLD SON , WHICH IT STATES IN ON OF THE LETTERS THAT KEEPS US ON MEDICAID. I HAVE TALKED TO BOTH YOU AND MR.TORI TOLLAND ABOUT THIS SEVERAL TIMES.

NO ONE HAS CONTACTED ME AND MY INSURANCE SHOULD NOT HAVE BEEN CANCELLED AS OF 4-1-09. THIS IS A CRITICAL SITUATION AND MY HEALTH IS BEING COPROMISED BECAUSE OF MESSED UP PAPERWORK.

SOMETHING NEEDS TO BE DONE AND FAST BECAUSE I AM ALSO ON ASTHMA MEDICINE ALONG WITH 12 OTHER MEDICATIONS. WHAT IF I WAS TO DIE BECAUSE OF THE WAY MY CASE IS BEING HANDLED? I WAS TOLD THIS WOULD BE TAKEN CARE OF IN JANUARY! I HAVE TALKED TO YOU AND MR. TOLAND SO MANY TIMES I CANT BELIEVE THAT THIS HAS HAPPENED.

I HAVE ALWAYS SENT MY REQUIRED FORMS FILLED OUT AND SENT BY FAX TO THE ATTENTION OF WHOM EVER ON TIME.

I HAVE CALLED MY PULMINARY DOCTOR AND HE TOLD ME TO PLEASE EXPLAIN TO WHO- EVER IS OVER MY CASE HOW CRITICAL MY SITUATION IS. I HAVE TO BE REINSTATED IN MY MEDICAID AND ISURANCE ASAP, OR I COULD DIE, AND I AM NOT BEING DRAMATIC ABOUT THIS, PLEASE READ THE LETTER FROM LONGS HOME HEALTH CARE. I DONT WANT BRAIN DAMAGE DO TO LACK OF OXYGEN. AGAIN I STATE THIS SHOULD NEVER HAVE HAPPENED BECAUSE I STILL QUALIFY FOR MEDICAID AND CANCELLING MY MEDICAID COULD COST ME MY LIFE!!!

PLEASE FOWARD THIS TO ANYONE THAT HAS CONTROL OVER MY CASE OR MR.TOLAND, LEESA WATSON 749-3595 SSN# 248-41-1562

UseMyWallet

RICHLAND COUNTY DHHS
3220 Two Notch Road
Columbia SC 29204-2826

LEESA WATSON
500 HARBISON BLVD
APT 1701
COLUMBIA SC 29212

Date: 12/22/2008
Worker:
JUDY MURPHY
Telephone: 803 714-7621
BG# 99640986
HH# 101127426
40 JMURP

You and your family are currently receiving Transitional Medicaid benefits. Due to a change in the State Medicaid Program, the amount of time you receive Transitional Medicaid Assistance may be shortened. Based on the number of months of service you have already received, you have up to 4 months left in Transitional Medicaid.

Beneficiary Name:	Beneficiary ID#	Beneficiary Name:	Beneficiary ID#
LEESA WATSON	1780606189		
KADEN WATSON 18 year old	1780606188		

Tori Folland wrong #

I have done all of these things on time! ↓

Your family will continue to receive these benefits as long as:

The parent/caretaker relative continues to receive earned income that is less than 185% of poverty, the family continues to include a dependent child in the home under the age of 19, the family continues to reside in the state of South Carolina and the family completes and returns all quarterly reports.

The quarterly reports will be mailed to your address once every three (3) months and will ask for verification of the family's gross monthly earnings and the cost of childcare. It is very important that you complete each report showing your earnings and childcare expenses for the months indicated on the form. The report must be received in the Medicaid office by the date on the form. Please notify us right away if your address changes.

Fair Hearing

If you feel that we have made an error, you may ask for a fair hearing before the South Carolina Department of Health and Human Services.

- To ask for a fair hearing, send a request in writing, along with a copy of this letter within 30 days to your worker.
- You can hire an attorney to help you or you can have someone come to the hearing and speak for you.

Please call your worker listed above if you have questions about this letter.

EDELD02 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 04/06/09
MEDSPROD MEDICAID ELIGIBILITY DECISION ACTION:
DATES-FROM: 02 / 2009 THRU: __ / ____ PAGE: 3 OF 3
HH NAME: LEESA WATSON HH NUMBER: 101127426
BGN: 99640986 PCAT: TMA SPN: 4000 RICH Cty Elig ACT TYPE: MAINTENANCE
BG: C BGP: C WKR: JMURP JUDY MURPHY ACT DATE: 02/22/09
RCP NAME: KADEN WATSON RCP NUMBER: 1780606188
PREVIOUS BG: _____ NEW BG: _____ CORRECT RCP NUMBER: _____
IT: _ PING-PONG: _ RETRO: N EXPARTE: _ QMB: N PROT PER DATE: _____

ACTUAL ELIGIBILITY DATES

MEDICAID ---BENEFIT DATES--- BEGIN	END	--MEDICAID+QMB DATES-- BEGIN	END	SERVICE TYPE	REASON CODE 1	REASON CODE 2
04/01/2007	12/01/2008				018	

UPDATED: USER ID: _____ DATE: _____ SYSTEM ID: ELD4000 DATE: 02/22/09
ME900115 BUDGET GROUP PERIOD INFORMATION FOUND
PF1-HELP PF2-PREV MBR PF3-NEXT MBR PF5-HH MBR DTL PF6-RETURN PF10-MENU
PF11-HH MBRS PF15-MD PF16-BG DET PF18-RCP INFO PF21-HIST- PF22-HIST+ PF24-AOD

* You can no longer get Medicaid because your child is 18

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EDHMS54 P        S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES    DATE: 04/06/09
MEDSPROD                      RECIPIENT INFORMATION                ACTION:
                    MEMBER PERIOD START: 02/22/09  END:            PAGE: 0001
NAME: WATSON LEESA                                 HH NAME: WATSON LEESA
RCP NUMBER: 1780606189      HH NUMBER: 101127426   ACTION TYPE: MAINTENANCE
SSN: 248-41-1562  VC: V    APL STATUS:            ACTION DATE: 11/06/08
PRIMARY INDIVIDUAL:        APL CO: 40     WORKER ID: TLEWI    LOCATION: 444
500 HARBISON BLVD                         SSCN:               RRN:
APT 1701                                  RACE: 01   SEX: F   MARITAL STATUS: X
                                          TPL: N     RSP: 1   RELATION: SELF
COLUMBIA                    SC 29212-     DOB: 06/30/1962     DOD:
CORRECT RCP NUMBER: __________            LIV ARRANGEMENT: HOME INCOME TRUST:
                                          PROVIDER:

     BG       BEG         END                  BENEFITS QMB RETRO  % OF POV
S  NUMBER     ELIG        ELIG     PCAT QCAT   TYPE     IND  IND    LEVEL    SPONSOR
_ 99640986 04/01/2007 04/01/2009 11   30     FULL       N    N        .00     4000
_ 79250388 06/01/2006 04/01/2007 59   30     FULL       N    Y        .84

 UPDATED: USER ID: TLEWI      DATE: 11/06/08  SYSTEM ID: IEV7115  DATE: 07/23/06
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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EDHMS54 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 04/06/09
MEDSPROD RECIPIENT INFORMATION ACTION:
MEMBER PERIOD START: 02/22/09 END: PAGE: 0001

NAME: WATSON KADEN HH NAME: WATSON LEESA
RCP NUMBER: 1780606188 HH NUMBER: 101127426 ACTION TYPE: MAINTENANCE
SSN: 585-87-1615 VC: V APL STATUS: ACTION DATE: 11/06/08
PRIMARY INDIVIDUAL: APL CO: 40 WORKER ID: TLEWI LOCATION: 444
500 HARBISON BLVD SSCN: RRN:
APT 1701 RACE: 01 SEX: M MARITAL STATUS: S
TPL: N RSP: 1 RELATION: CHILD
COLUMBIA SC 29212- DOB: 07/16/1990 DOD:
CORRECT RCP NUMBER: _____ LIV ARRANGEMENT: HOME INCOME TRUST:
PROVIDER:

S	BG NUMBER	BEG ELIG	END ELIG	PCAT	QCAT	BENEFITS TYPE	QMB IND	RETRO IND	% OF POV LEVEL	SPONSOR
_	50349131	12/01/2008		88	30	FULL	N	N	.00	4000
_	99640986	04/01/2007	12/01/2008	11	30	FULL	N	N	.00	4000
_	79250388	06/01/2006	04/01/2007	59	30	FULL	N	Y	.84	

UPDATED: USER ID: NADEH DATE: 06/14/06 SYSTEM ID: TTR1001 DATE: 06/16/06
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

4 son

Log#0557

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

April 8, 2009

Ms. Leesa Watson
500 Harbison Blvd.
Apartment 1701
Columbia, South Carolina 29212

Dear Ms. Watson:

Thank you for contacting our agency about the problems you faced when trying to reach a Medicaid eligibility worker. Good customer service is very important to us, and I regret your unpleasant experience during our eligibility re-determination process. We are reviewing the issues you have encountered, and we are working to correct them.

I am pleased to inform you that your Medicaid services under the *Aged, Blind or Disabled* (ABD) program will continue with no break in coverage. Your may use the same Medicaid card.

Medicaid uses the same disability criteria as the Social Security Administration (SSA) for our ABD program. Once SSA reaches a disability decision for your case, Medicaid must adopt that decision. If you have any questions, please contact Ms. Jessie Alford in our Richland County Office at (803) 714-7361.

Your son, Kaden, will continue to have Medicaid coverage under our *Partners for Healthy Children* program until he reaches age 19. We have enclosed some resources on healthcare and daily living needs that we hope may be of assistance to and your son.

Again, please accept my apology for the difficulties you have encountered during our eligibility re-determination process. If you have any questions about the Medicaid program, please call Ms. Denise Epps in Constituent Services at (803) 898-2505.

Sincerely,

Alicia Jacobs

Alicia Jacobs
Deputy Director

AJ/cle
Enclosures

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