DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	9-24-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 060160	[X] Prepare reply for the Director's signature DATE DUE 10-1-07
2. DATE SIGNED BY DIRECTOR Cleared 10/2/07 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.			

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

September 20, 2007

Log: Jacobs
Dir. Sign

Mr. Robert M. Kerr
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

RE: Ms. Kelly Sawyer for her son
Brennan Sawyer DOB: 05-17-2005

Dear Mr. Kerr,

I am writing to you on behalf of the above named constituent who has contacted me regarding a TEFRA application. 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
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

September 14, 2007

Congressman Joe Wilson
The Midlands Office
1700 Sunset Blvd (US378), Suite 1
West Columbia, SC 29169

Dear Congressman Wilson:

I am in need of your assistance is reference to my son, Brennan Sawyer, born May 17, 2005. Last year on or around December 29th I mailed in a TEFRA Application for Brennan. Unfortunately, I didn't receive a determination until May 17, 2007 that my son wasn't eligible. The denial was based on two reasons: (1) I failed to prove Brennan's citizenship and identity. (His birth certificate was enclosed with his original application along with all of the other requested paperwork and was returned to me by their office via the US Postal Service.) (2) It was determined that Brennan does not meet the criteria of being disabled.

On June 6, 2007, an appeal was mailed to the attention of Jennifer Dabbs. (I have enclosed a copy of the letter enclosed for your review.) After a couple months, I called to follow up and was told they didn't show they received it so I would have to start the whole process over again. I was so upset to hear this because I did what I was supposed to and most importantly, I don't understand the denial in the first place. The application process takes several months and my family is suffering financial hardships trying to cover all my son's medical conditions and treatments. My current employer, Carolina Care Plan, Inc, has worked with me and allowed me to make up absences and retain my job despite the fact that I am constantly out of work caring for my son; however, by the end of the year I will not have a job and health care coverage due to the company being acquired by another company. When discussing my frustration with TEFRA a co-worker she suggested that I contact your office for assistance.

In the two years since my son's birth, he has been diagnosed with the following medical conditions:

- Acid Reflux (resulted in extended hospitalization after birth)
- Asthma / Restricted Airway Disease
- Allergies (trigger asthma attacks and sinus/ear infections – he is also allergic to penicillin which causes me to have to buy more expensive drugs to treat the other illnesses)
- Apnea (resulted in extended hospitalization after birth and monitors at home and overnight sleep studies at hospitals)
- Heart Murmur
- Ventricular Septical Defect (has not closed on his own and surgery possible to close it.)
- Constant Ear Infections (surgery to put tubes in ears)
- Allergic Rhinitis
- Pneumonia (required hospitalization and he is more susceptible due to his asthma – has had this each winter)

- Atopic dermatitis
- General Sickness (e.g. stomach virus, sinus infections, ear infections, etc.)

I have included a copy of the letter his pediatrician, Linda Crout Wingard, MD, provided to TEFRA that documents most, if not all, of these conditions. Despite all these conditions, if my son truly is not disabled as his physicians and his family believes, please assist me in getting a clear explanation of why they don't agree with his physicians on their disability determination and belief that he should qualify for assistance through TEFRA.

In addition, I would ask that you please assist us with appealing for supplemental help through TEFRA so that my son can receive all the treatments he needs. Reapplying will delay assistance and my son's medical conditions need to be treated and he really can't afford to wait another several months to receive a determination. Right now, we can't afford to get his heart defect treated due to trying to afford his everyday medical care and constant illnesses. Also, the bill for his hospital stay with pneumonia last December will be turned over to the courts the beginning of October because I owe Richland Hospital an outstanding balance of almost $800, but I am unable to pay that. I did what I was supposed to do initially and did what I was supposed to in appealing within the timeframe and providing proof of my son's citizenship again.

My son and I would like to thank you for your assistance with this issue. If you need any additional information from me or you are unable to help me, please contact me.

Respectfully,

Kelly Sawyer

Kelly Sawyer
615 Windmill Road
Gilbert, SC 29054
Home (803) 892-4595
Work (803) 561-7750

Ridge Pediatric and Adolescent Center
338 East Columbia Ave.
Batesburg Leesville South Carolina 29070
Phone 803-532-2877 Fax 803-532-5430

January 24, 2007

To Whom It May Concern:

Brennan Sawyer is a 20 month old male with a history of significant medical problems. At birth he was hospitalized in the special care nursery with transient tachypnea. During the nursery stay a heart murmur was detected. During the first few months of life Brennan was diagnosed with severe gastroesophageal reflux. He has continued on Prevacid and Reglan until recently when the decision was made to try him on a trail of no reflux medication. Brennan has myringotomy tubes placed by Dr. Frank Hill, due to a history of recurrent otitis media. Brennan also has severe RAD only fairly well controlled on his medication. He would benefit from a referral to a pediatric pulmonologist but this has not yet been done .The pulmonologist can better plan a course of preventative maintenance medications to hopefully decrease the number of exacerbations of Brennan's RAD. Brennan also has atopic dermatitis and allergic rhinitis, and has recently been to a dermatologist. Brennan has a heart murmur due to a ventricular septal defect. His murmur is more pronounced now, and he is being referred to a pediatric cardiologist who will follow the VSD and manage arranging surgery for closure should his defect not close spontaneously.

Medical bills, primary care, specialist and medications for Brennan are significant. He and his family would benefit from supplemental help with their medical expenses.

Sincerely,

Linda Crout Wingard, MD

Linda Crout Wingard MD

State of South Carolina

Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

January 17, 2007

Brennan T Sawyer
615 Windmill Road
Gilbert, SC 29054

Budget Group Number: 39486607

Dear Mr/Ms Sawyer,

In order to determine eligibility for TEFRA, we will need the information listed below:

Name	Information Needed
Brennan	Return ALL copies of signed Authorizations for Release (DHHS 921).
Brennan	Completed In-Home Care Certification (DSS 3291)

A self-addressed envelope is provided for you to return this information. **PLEASE PROVIDE BY 02/19/2007 OR YOUR APPLICATION WILL BE DENIED. Please be aware that the TEFRA application process can be time consuming. TEFRA requires four different approvals before a Medicaid card can be issued. Thank you for your patience.** I may be contacted at our toll free number 1-888-549-0820, if you have any questions.

Sincerely,

Rhonda Tucker
TEFRA Coordinator
Ext. 82934

South Carolina Department of Disabilities and Special Needs

Permission to Evaluate TEFRA Applicant

I, Brennan Sawyer (print name of applicant), have applied for Medicaid eligibility as part of the national Tax Equity and Fiscal Responsibility Act (TEFRA) through the South Carolina Department of Health and Human Services (SCDHHS). As part of this Medicaid eligibility determination process, I understand that the South Carolina Department of Disabilities and Special Needs (SCDDSN) will determine whether I meet the level of care criteria for an Intermediate Care Facility for the Mentally Retarded (ICF/MR). I further understand that this is not a request to determine my eligibility for care, treatment, training, or residential services from SCDDSN. However, I understand that I may make a separate request for eligibility for SCDDSN services.

I give permission for SCDDSN to review any available medical, educational, and/or other records pertaining to me in order to determine whether I meet ICF/MR level of care criteria. I understand that I may be asked to sign one or more separate authorization forms for release of this information to SCDDSN. I also give permission for SCDDSN to conduct a psychological evaluation or other evaluations of me, if such become necessary as part of this Medicaid eligibility application.

I understand that this document will remain in effect until such time as SCDHHS makes a Medicaid eligibility decision under TEFRA. I understand that I may terminate this permission in writing to SCDDSN or its designated representative at any time.

_____ _____

Applicant's Signature Date

Kelly L. Sawyer, mother COPY 8/21/06

Legal Guardian's Signature Date

(For applicant under 18 yrs. or legally incompetent)

3/09/2005

South Carolina Department of Health and Human Services

APPLICATION FOR TEFRA MEDICAID COVERAGE

Date Received by DHHS: _____

1. Name of Child (the Applicant) applying for Medicaid:

Last Name: Sawyer	First Name: Brennan	Middle Initial: T	Telephone: (803) 892-4595
Birth Date: 5/17/2005	SSN:	Sex: M	Race: W

2. Applicant's Address:

Street Address: 615 Windmill Rd	City: Gilbert	State: SC	Zip Code: 29054
Mailing Address, if different:	City:	State:	Zip Code:

3. Parent(s) or Guardian(s) of the Applicant:

Last Name:	First Name:	Middle Initial:	Relationship to the Applicant:
Sawyer	Kelly	L	mother
Sawyer	Byron	M	father

4. (a) Does the Applicant have income from any source listed below? *(Check Yes or No)*

Income Source	Yes	No	Income Source	Yes	No	Income Source	Yes	No
Social Security		X	Money from Friends or Relatives		X	Other (Identify Source)		X
Veteran's Benefits		X	Interest, Dividends		X			
Child Support		X	Income from a Trust		X			

(b) If the Applicant receives income from any of the sources listed in Section 4(a), complete the following:

Name of Person with Income Source	Income Source [as listed in 4(a)]	Amount	How Often Received

5. (a) Does the Applicant have any of the following assets/resources? *(Check Yes or No)*

Item	Yes	No	Item	Yes	No	Item	Yes	No
Cash on Hand		X	Preneed Burial Contract		X	Trust Account		X
U.S. Savings Bonds		X	Trust Fund		X	Annuity		X
Stocks and Bonds		X	Checking or Savings Account		X	Life Insurance		X
Certificate of Deposit		X	Other		X			

(b) **Fill in the following information for any item checked "yes" in Section 5(a).**

Item *[as listed in 5(a)]*	Amount/Value	Owned By	Name and Address of Bank or Location of Account

6. **Is there any asset/resource available to the Applicant that we have not asked about?** ___Yes _X_No

   If yes, please explain: _____

   _____

7. **Does the Applicant have health insurance?** _X_Yes ___No **If yes, please complete the following:**

Insurance Company or Employer	Policy Number	Policyholder's Name	Policyholder's SSN
Carolina Care Plan	E01K5111Z	Kelly Sawyer	248-43-4204

8. **Did the Applicant receive medical services in the last three months?** _X_Yes ___No **If yes, which months?**

   May, June, July, August, September, October, November + December

9. **Was the Applicant's income and resources the same in the last three months as now?** _X_Yes ___No

   If no, explain how they were different: _____

   _____

10. **Does the Applicant for whom you are applying have a plastic South Carolina Partners for Health (Medicaid) card?**

    ___Yes _X_No

Children under the age of 21 who are eligible for Medicaid may have free health checkups under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Ask your primary care physician about these services.

All Medicaid beneficiaries may be eligible for help with medical transportation. Ask your Medicaid eligibility worker about transportation services.

11. **I have read my Rights and Responsibilities on the next page.** _X_Yes ___No

Signature of Applicant, Parent or Legal Guardian: Kelly Sawyer Date: 8/21/06

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.

Citizenship and Identity Application Addendum

Applicant: Brennan T. Sawyer **Phone Number:** (803) 892-4595

You must provide proof of citizenship or nationality and identity of each Medicaid eligible family member claiming to be a US citizen. You must bring an original form of proof listed below and complete the information below.

You must bring at least one item from Table 1 OR one item from each Table 2 and 3:

Table 1 Proof of citizenship **and** identity		Table 2 Proof of citizenship		Table 3 Proof of identity
• US Passport • Certificate of Naturalization • Certificate of US Citizenship	**OR**	• Birth Certificate • Certificate of Birth Abroad • US Citizen ID Card • Final Adoption Decree showing US place of birth • Evidence of US Government employment before June 1, 1976 • Military record of service showing US place of birth	**AND**	• Certificate of Indian Blood w/ picture ID • Driver's License • School ID card with photo • US military card or draft record • Government issued ID card • Native American Tribal document • School or daycare records that in show place of birth.

Important for you to know:

- When you bring original documents to the local Medicaid office, a worker **will** review them, make a copy, and return the originals to you.
- If you have problems locating documents, please let us know so that we can work with you to help get documents you need. There may be other documents that we can use.

Please **carefully** complete this information for **each** Medicaid eligible family member. Please print. Spelling must be correct.

Full Name at birth	Date of Birth	State of Birth	**County** where hospital or home in which you were born is/was located	Mother's Full Maiden Name
Brennan Thomas Sawyer	5/17/2005	SC	Lexington	Kelly Lynn Fulmer

DHHS Form 3296 July 2006

Please use a separate piece of paper to list more than five people.

South Carolina Department of Health and Human Services

DISABILITY REPORT – Child Under Age 19

☑ Initial – back to DOB ☐ Retro Only

Instructions: This form is used to request a disability determination as an eligibility requirement for Medicaid. ***It is the responsibility of the Medicaid Eligibility Worker to ensure that each blank is completed.*** A copy of the completed form must be maintained in the case record.

Applicant Brennan T. Sawyer (Please Print) Social Security No. 656-90-2004

Applicant's Address 615 Windmill Rd

City Gilbert State SC Zip Code 29054 County Lexington

Date of Birth 5/17/2005 Telephone(803) 892-4595 Category of Application TEFRA

If Deceased, Date of Death ____ Month ____ Day ____ Year (Male) or Female (Circle One)

Application Date ____ Retro Month(s) Requested 19 (to birth)

Contact Person Kelly L. Sawyer Telephone(803) 561-7750

Relationship to Applicant mother

Contact Person's Address 615 Windmill Rd - Gilbert, SC 29054 (Give Complete Mailing Address)

Medicaid Eligibility Worker ____ Telephone( ) ____

Worker's Address ____ (Give Complete Mailing Address)

Worker's Supervisor ____ Telephone( ) ____

Date of Disability Onset or Last Continuing Disability Review birth (5-17-05)

I. DISABILITY

a) When did the child become disabled? 5 Month 17 Day 2005 Year

b) What is the child's disability? acid reflux, asthma/allergies, apnea, heart murmar, ventricular septical defect, tubes

c) Explain how the child's disability affects his or her ability to function. difficulty eating & breathing - affects sleep, play, meal time, etc.

d) Have you applied for Social Security Income (SSI) disability benefits? ☐ Yes ☑ No

If yes, date of application: ____

If denied, have you asked the Social Security Administration (SSA) to reconsider your claim? ☐ Yes ☐ No

Did SSA refuse to reconsider your claim? ☐ Yes ☐ No

Did you request an appeal or a hearing? ☐ Yes ☐ No

e) Please give the name of anyone we may contact (other than the child's doctor or teacher), such as a neighbor, grandparent, etc., who knows about the child's condition.

Name of Contact Lynn Fulmer

Street Address 620 Winamill Rd

City Gilbert State SC Zip Code 29054

Telephone (803) 892-1112 Relationship to child grandmother

f) Please give the name of the child's regular pediatrician and his or her complete address and telephone number.

Name Linda Crout-Wingard Telephone (803) 532-2877

Street Address 338 E. Columbia Ave.

City Leesville State SC Zip Code 29070-9285

II. MEDICAL INFORMATION ABOUT THE CHILD'S DISABILITY

NOTE: If you need additional space for medical sources, list their names, addresses and reasons for visits in the "Remarks" section on page five or attach a separate piece of paper.

a) List name, address and telephone number of the doctor who has the child's most recent medical records. *(We need a complete address to request medical records.)*

Name Linda Crout-Wingard Telephone (803) 532-2877

Street Address 338 E. Columbia Ave

City Leesville State SC Zip Code 29070-9285

Date first seen: 6/2/05 Date last seen: 12/19/06 Next appointment:

Reason for visits Acid reflux, heart murmor, asthma, general illnesses (ear infections, etc.), well visits, apnea

b) Has the child been seen by any other doctors since the disability or injury began?
☑ Yes ☐ No If yes, complete the following. *(We need a complete address.)*

Name Dr. Frank Hill / Centa Medical group Telephone (803) 256-2483

Street Address 9 Richland Medical Park, Suite 510

City Columbia State SC Zip Code 29203-6873

Date first seen: 3/27/06 Date last seen: 12/11/06 Next appointment: 6/18/07

Reason for visits Severe ear infections due to reflux, consult to have tubes, tube insertion, follow-up visits for tubes

c) Has the child been hospitalized or received emergency room treatment for the illness or injury? ☑ Yes ☐ No If yes, complete the following. *(We need a complete address.)*

Name of Hospital Lexington Med Ctr. Patient Number

Street Address 2720 Sunset Blvd

City West Columbia State SC Zip Code 29169

Was the child an in-patient (stayed at least overnight)? ☑ Yes ☐ No

Admission Dates: 5-17-05 to 5-25-05

Reason for Hospitalization or Emergency Room Treatment ventricular septical defect, murmor, reflux, stopped breathing multiple times, apnea

d) Has the child received treatment from a hospital outpatient clinic or other type of clinic? ☑ Yes ☐ No If yes, complete the following. *(We need a complete address.)*

Name of Clinic Lexington Med Center Patient Number Lexington / Batesburg-Leesvi

Street Address 811 W. Main St / 338 E. Columbia Ave

City Lexington / Batesburg State SC Zip Code 29072 / 29070

Date(s) of Treatment: 6-15-05, 6-2-05, 6-23-05, 7-29-05, 8-12-05, 10-31-05, 12-5-05, 1-9-06, 2-20-06, 3-28-06, 8-4-06

Reason for Treatment pneumonia / asthma, vomiting / reflux, colitis, high fever

e) Has the child had any special diagnostic outpatient studies (x-rays, blood tests, EKG's, etc.) performed at a hospital or private laboratory/clinic? ☑ Yes ☐ No
If yes, complete the following. *(We need a complete address.)*

Type of Study/Test x-rays, EKG's, Ultrasounds, ECG's

Name of Hospital, Clinic or Laboratory Lexington Medical Ctr

Street Address 2720 Sunset Blvd

City West Columbia State SC Zip Code 29169

When were these studies done? 5-17-05 to 5-25-05 and 8-30-06

Brennan Thomas Sawyer 5-17-05
656-90-2004

Pediatrix Medical Group of SC
Taylor and Marion
Columbia, SC 29220

Date 1st Seen: 5-17-05 Date last Seen: 5-24-05

reason: ears & hearing, murmurs, tachypnea

Children's Respiratory Center
58 Bear Drive
Greenville, SC 29605-4458

Date Seen: 6-3-05

reason: apnea

Palmetto Health Richland
5 Richland Medical Park Drive
Columbia, SC 29203

Date Seen: 9-29-05

reason: Sleep Study, apnea, pneumonia

—OVER—

Palmetto Dermatology
105 Hospital Drive West
West Columbia, SC 29169-3405

Date seen: 9-12-06

reason: sebaceous cyst, exzema

Pediatric Pulmonary Associates
2113 Adams Grove Rd, Suite 210
Columbia, SC 29203-6873

Date seen: 9-29-05

reason: reflux, apnea

f) Is the child seen regularly or has the child ever been tested or evaluated by any of the following agencies? If available, please include copies of any medical, psychological, developmental information/assessments (including service plans) from these agencies.

1.	S.C. Health Department Clinic	☐ Yes	☑ No
	Division of Children's Health	☐ Yes	☑ No
	Children's Rehabilitative Services (CRS)	☐ Yes	☑ No
	Women, Infant and Children's Program (WIC)	☐ Yes	☑ No
	Baby Net	☐ Yes	☑ No
2.	Department of Disabilities and Special Needs (DDSN)	☐ Yes	☑ No
	County DDSN Board/Regional Center	☐ Yes	☑ No
3.	South Carolina Department of Mental Health	☐ Yes	☑ No
	Mental Health Center	☐ Yes	☑ No
4.	Continuum of Care for Emotionally Disturbed Children	☐ Yes	☑ No
5.	Speech and Hearing Center	☐ Yes	☑ No
6.	Other (i.e., physical, occupational therapy, etc.)	☐ Yes	☑ No

If yes, specify: _____

For each of the agencies at which the child has been seen, complete the following. If you have a copy of the child's service plan, please attach.

Name of Facility _____

Street Address _____

City _____ State _____ Zip Code _____

Date first seen: _____ Date last seen: _____ Next appointment: _____

Type of Treatment or Evaluation Received _____

Case Manager _____ Telephone ( ) _____

Name of Facility _____

Street Address _____

City _____ State _____ Zip Code _____

Date first seen: _____ Date last seen: _____ Next appointment: _____

Type of Treatment or Evaluation Received _____

Case Manager _____ Telephone ( ) _____

III. SCHOOL INFORMATION

a) Is the child currently attending school? ☐ Yes ☑ No If yes, complete the following.

Current Grade _____ Teacher _____

Name of School _____

Street Address _____

City _____ State _____ Zip Code _____

b) Is the child in a special education program? ☐ Yes ☑ No
If yes, explain the services provided (i.e., speech, learning disabled, etc.) _____

Do you have a copy of the child's Individual Education Plan (IEP) report? ☐ Yes ☐ No
If yes, please attach a copy.

c) Does the child attend any type of preschool, daycare or after school program?
☑ Yes ☐ No If yes, please complete the following.

Name of School Happy Camper Child Development Center

Street Address 2705 Highway 378 Gilbert

City Gilbert State SC Zip Code 29054

IV. DAILY ACTIVITIES

Describe what the child does in a typical day. Include any participation in school, church or community activities.

Attends day-care, likes to play outside, eats, naps, takes medications/breathing treatments, plays w/his brothers, likes to watch cartoons

V. REMARKS

Use this section to answer any previous questions and to add additional information that you think will be helpful in making a decision in your child's disability claim.

please see attached additional provider info.

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE.

Print Name of Applicant/Representative Kelly L. Sawyer

Applicant/Representative Signature Kelly L. Sawyer **Date** 8/21/06

Relationship mother

South Carolina Department of Health and Human Services

ATTN: Parent Considering Applying for TEFRA

This letter is to provide you with information about the TEFRA (Katie Beckett) program in Medicaid. We hope the following information will do three things:

1. Help you determine whether you should apply for TEFRA coverage for your child.
2. Help you understand the lengthy process that is involved in determining whether a child is eligible for TEFRA coverage.
3. Provide you with information about things you can do so that the application process can be completed in less time.

South Carolina is fortunate to have an organization called Family Connection of South Carolina, Inc., that is devoted to helping parents with children with chronic illnesses, disabilities and developmental delays. This organization provides a support network for families like yours. You may contact Family Connection at 1-800-578-8750. They may also be able to help you with this application process. Most TEFRA applications take up to 90 days to process; however, many take longer. Please submit all required information with your application so that we can begin to process your application immediately.

We would like to provide you with some information about the TEFRA program so that you will know what is done when we process your application. TEFRA (Katie Beckett) is a special coverage group for children who need institutional care, but whose families can, and want to, provide care in their homes. It is an option that states may choose to provide coverage, not a federal requirement. However, if states decide to provide this coverage, states must follow federal rules for the program.

Federal rules require that a child meet several criteria in order to qualify. A child may have a number of medical problems and still not qualify for TEFRA. If any of these rules are not met, the child cannot qualify. Some of the rules that are not usually a problem or that can quickly be determined include age (a child must be 18 years old or younger), income and resources (the child's income must be below $1,809 per month and his resources must be at or below $2,000), the child must be living at home, it must be possible for the child to receive adequate care in the home setting, and the cost of the child's care to the Medicaid program cannot exceed the cost that Medicaid would incur if the child were institutionalized. Two of the criteria are more difficult to determine and can involve some time to complete. These are the disability determination and the Level of Care determination.

1. The child must be disabled. (This means the child must meet federal criteria for being considered disabled.)
2. The child must need ongoing institutional care. This is called the Level of Care determination. This generally means nursing home care or intermediate care for the mentally retarded. It can also mean long-term care in a hospital. This criteria is NOT met because a child may need to be admitted to a hospital many times a year to address health crises or corrective procedures.

Most states call their program Katie Beckett, rather than TEFRA. Congress enacted this coverage option after media attention about a child named Katie Beckett. Children who were institutionalized could receive Medicaid coverage after they had lived in an institution for more than 30 consecutive days. After this 30-day period and for as long as the child continued to live in an institution, the parents' income was not counted. Katie Beckett's parents didn't want their child to live in an institution and wanted to care for their severely disabled child at home. While Medicaid would cover Katie as long as she stayed in the institution, Medicaid would provide no assistance to her if she were to move back home. President Reagan read about this and had legislation introduced to change this. This legislation gave states the option to provide coverage for children like Katie Beckett.

For a disability determination, DHHS sends the application to the SC Vocational Rehabilitation Department. This is done after medical records are requested and received from the physicians and healthcare providers that you have identified on your application. Please encourage your healthcare providers to provide the requested information quickly. Physicians and other healthcare providers frequently respond more quickly to you, the parent, than to a government agency like DHHS. **Anything you can do to get the medical records more quickly will help us process the application more quickly. If you do obtain medical records, send them along with your application. If you receive medical records after you send in your application, you can mail or FAX them to us.** Please FAX these records to 803-255-8223 or mail them to:

South Carolina Department of Health and Human Services
Division of Central Eligibility Processing – Attn: TEFRA
Post Office Box 100101
Columbia, SC 29202-3101

If the medical records do not clearly indicate disability, a specialist may be requested to review your child's condition to determine if there is more information that might lead to a positive determination of disability. This step lengthens the process of determination, but is done to give your child every chance of meeting disability criteria.

At the same time the disability determination is being done, we review your child's condition to determine whether he or she needs institutional care. This is called Level of Care. To meet the medical necessity criteria for institutional care, a person has to have functional deficits. For an adult, this means that he or she cannot bathe, dress, eat or transfer (move) without ongoing assistance. These are called deficits in daily living skills.

A child must have deficits in this area that are not simply the age appropriate dependences of a child. The determination for a child is difficult. All children are dependent at birth for assistance in these areas. Therefore, the normal dependency of an infant is age appropriate. It does not mean that they need institutional care. We first look at your child's functional level compared to the functional level that would be expected for a child of your child's age. The first review is to see whether your child's functional level is so different from the expected level that he or she would require ongoing care in a nursing home or hospital. If your child does not need to live in a hospital or nursing home, we then send the application to the SC Department of Disabilities and Special Needs (DDSN). DDSN reviews your child's condition to determine if your child has Mental Retardation or a Related Condition and whether your child needs ongoing care in an Intermediate Care Facility for the Mentally Retarded (ICF-MR).

As you can see, this is a lengthy process. It is lengthy because we make every effort to find your child eligible. These efforts may include finding additional specialists to review your child's condition if medical records do not support a disability determination and home visits related to Level of Care determinations.

This letter may provide you with a better understanding of TEFRA and what it means to qualify. **If you would like to provide us with any additional information that could be helpful, or you would like to send us a written statement about your child's condition, please do so with your application.** We will include your statement and/or the additional information in the material used both in the disability determination and the Level of Care determination. Also, please encourage your child's physicians and healthcare providers to respond quickly to requests from us for medical records.

Please understand that your child may have severe medical problems and still not meet TEFRA requirements. It is frequently the lack of need for continuous institutional care that disqualifies a child. If your child is denied, it in no way means that we do not think your child has serious medical problems or is seriously ill.

South Carolina Department of Health and Human Services

TEFRA Application Checklist

By providing as much information as possible when you apply, DHHS may be able to process your application in a shorter time. Be sure to include these items when you apply. If you are not sure what to send, call our toll-free line at 1-888-549-0820 for help.

- **Application Form – DHHS Form 3290 ME**
- **DHHS Form 3291ME, TEFRA In-Home Care Certification.** Your child's physician must complete this form.
- **DHHS 3218D-ME –Disability Report, Child Under Age 19.** It is important that you fill out each blank, even to indicate not applicable (N/A).
- **DHHS Form 921 – Request for Medical Records.** Please complete a copy for each provider you listed on the DHHS 3218D-ME –Disability Report, Child Under Age 19. In addition, please sign five blank copies of this form. Do not date these forms. Please mail back all copies of this form with the application.
- **SC Department of Disabilities and Special Needs Permission to Evaluate TEFRA Applicant Form.** Sign and return this form.
- Proof of ☐ Citizenship ☐ Identity
- Copies of any recent medical records (within one year) you may have regarding your child's health. These are not mandatory but may help speed up the application process.
- Copies of recent IEP and School Psychological Evaluation for school-age children
- Proof of any income that your child receives, such as child support or Social Security
- Proof of any resources available to your child such as bank accounts, savings bonds, trust accounts, life insurance policies, etc.
- Copies of any health insurance card, front and back, showing that your child is covered. This does not affect your child's eligibility for Medicaid. We need a record of other insurance.

Mail the completed, signed application and other required forms and information to:

South Carolina Partners for Health Medicaid
Division of Central Eligibility Processing
Post Office Box 100101
Columbia, South Carolina 29202-3101

SAWYER
615 Windmill Road ~ Gilbert, SC 29054
(803) 892-4595

June 6, 2007

State Office County DHHS
Attn: Jennifer Dabbs
PO Box 100101
Columbia, SC 29202

RE: Brennan T. Sawyer denial for Katie Beckett - TEFRA

Dear Ms. Dabbs:

This letter is in response to your correspondence dated 5/17/07 concerning the denial of Katie Beckett – TEFRA for my son Brennan T. Sawyer. Please pardon the delay in my response. I have been, and continue to be, out of work on disability.

One of the items on your notice states I failed to prove Brennan's citizenship and identity. His birth certificate was enclosed with his original application along with all of the other requested paperwork and was returned to me by your office via the US Postal Service. For your records I am enclosing Brennan's birth certificate again to show that he is a citizen of the United States.

The other item states that it was determined that Brennan does not meet the criteria of being disabled. I would like to request that someone please review all of his information again. TEFRA is a program that I knew nothing about until a friend told me about it. If I had known about it when he was born, I would have filed for it right away because of his health status. I am a bit confused by this determination because the person who alerted me to the program has two children covered by TEFRA and their only illness is asthma.

Along with asthma, my son has several other medical conditions that I feel would qualify him for assistance through this program. As he has gotten older, his symptoms of the more serious of illnesses continue to worsen. He is in need of special treatment for his heart condition, but I am unable to make that move with him because of the cost associated with maintaining his other conditions. Trying to keep him healthy enough to even been seen by a pediatric cardiologist has been impossible for the entire two years of his life. Oddly enough, your denial letter is dated the date of his second birthday.

When I notified his pediatrician that he had been denied, she was shocked. I consulted her after finding out about the program to get her input to see if she thought that Brennan would be a candidate. She absolutely supported my decision for filing because she felt that Brennan's medical conditions were severe enough to qualify him for the assistance. The letter that she supplied with his medical records outlined all of the current reasons he was being treated for in her office as well as by other medical professionals. She has genuine

concern for the well being of my son and wants to see him receive the treatment that he needs so badly. However, she also understands the financial burden that his medical costs puts on my family.

I know that my child is not the sickest child in the world, but I know that he is a very sick little boy that does not deserve to have the problems that he does. He cannot do all of the things that he would like to do because of being hindered by his medical conditions. Also knowing that there are children that have been approved for the assistance that only have one of the conditions my son has makes me question the consistency of the program.

At this time I do not wish to request a hearing, instead I ask that your staff please review Brennan's information again and reconsider him as a candidate for Katie Beckett – TEFRA. I would not ask for assistance if I did not feel that he was qualified, nor if my family did not need the assistance to handle the cost of raising a child with serious medical conditions.

It is my hope that through an open mind and an honest heart you reconsider your decision about my son and allow him the assistance through TEFRA. I want him to grow and be able to do all of the things that he wants to do in his life. This program would assist me in getting him the treatment he needs with less worry about the financial aspect of his medical care.

Sincerely,

Kelly L. Sawyer

Enc (2)

Medicaid Letter of Action

From: STATE OFFICE COUNTY DHHS
P. O. Box 100101
Columbia SC 29202-0000

To: KELLY SAWYER
615 WINDMILL RD
GILBERT SC 29054

Date: 05/17/2007
Worker Name:
JENNIFER DABBS
Telephone: 803 898-3965
BG #: 39486607
HH #: 101168030
47 JLYNC

Recipient Name:
BRENNAN T SAWYER

Recipient ID:
6780689049

Your application has been denied for: KATIE BECKETT CHILDREN - TEFRA

Reason for denial:

You do not meet the disability criteria.

You did not provide proof of citizenship and identity.

Denied for the month(s) of: 12/2006

Manual/policy reference supporting this action: 102.06.02A
102.04.03

X You may ask for a fair hearing before the Department of Health and Human Services if you believe an error was made in processing your application.

To Request A Hearing from the Department of Health and Human Services

- Ask your Medicaid worker in writing within 30 days of this letter. Attach a copy of this letter to your request.

To Get Help with Your Hearing

- You may hire an attorney to help you
- You may have someone you know come to the hearing and speak for you
- Contact your Medicaid worker in person or by phone to get help in asking for a hearing

log 160

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

October 2, 2007

Ms. Kelly Sawyer
615 Windmill Road
Gilbert, South Carolina 29054

Dear Ms. Sawyer:

closed

Congressman Joe Wilson asked our agen tions and concerns regarding the Medicaid application for you x Equity and Fiscal Responsibility Act (TEFRA) program. We

TEFRA is a program that covers some ch ir parents' income. This program is for children who are disabled and need institutional care. The program was designed to help parents who want to care for their child at home, even though the child needs continuous care in an institution such as a nursing home or intermediate care facility for the mentally retarded.

Brennan's application for TEFRA was denied on May 16, 2007, because he did not meet the Social Security Administration's definition of disability. We forwarded a copy of your letter to the Division of Appeals and Hearings. You should receive a certified letter shortly that will advise of the hearing date and location. If you have questions regarding the appeal process, please call Mr. Vastine Crouch, Director of the Division of Appeals and Hearings, at (803) 898-2661, and he will be happy to assist you.

We are enclosing a copy of the documentation medical examiners used in making their determination regarding Brennan's TEFRA application. We hope this information is helpful. If we may be of further assistance, please let us know.

Sincerely,

Alicia Jacobs

Alicia Jacobs
Interim Deputy Director

AJ/code
Enclosure

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

109 160

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

October 2, 2007

The Honorable Joe Wilson
Member, United States House of Representatives
1700 Sunset Boulevard, Suite 1
West Columbia, South Carolina 29169

Dear Congressman Wilson:

Thank you for referring Ms. Kelly Sawyer to our agency regarding questions about Medicaid's Tax Equity and Fiscal Responsibility Act (TEFRA) program and the healthcare needs of her son, Brennan.

TEFRA is a program for children who meet the Social Security Administration's definition of disability, as well as, institutional level of care based on functional criteria as evaluated by a registered nurse. The program was designed to help parents who want to care for their child at home, even though the child needs continuous care in an institution such as a nursing home or intermediate care facility for the mentally retarded.

A member of our staff has been in direct contact with Ms. Sawyer to answer her questions about the disability requirements for the TEFRA program and assist with Brennan's healthcare needs.

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 do not hesitate to contact me.

Sincerely,

Emma Forkner
Director

EF/jcode

Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202-8206
Phone (803) 898-2504 • Fax (803) 255-8235

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Jacobs	9-24-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000160	[X] Prepare reply for the Director's signature DATE DUE 10-1-07
2. DATE SIGNED BY DIRECTOR Oct 2, 07	[ ] Prepare reply for appropriate signature DATE DUE _____
	[ ] FOIA DATE DUE _____
	[ ] Necessary Action

APPROVALS (Only when prepared for director's signature) D. Cima	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.	9/28/07		
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

September 20, 2007

Mr. Robert M. Kerr
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Log: Jacobs
dir. Sign

RE: Ms. Kelly Sawyer for her son
Brennan Sawyer DOB: 05-17-2005

Dear Mr. Kerr,

I am writing to you on behalf of the above named constituent who has contacted me regarding a TEFRA application. 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
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

September 14, 2007

Congressman Joe Wilson
The Midlands Office
1700 Sunset Blvd (US378), Suite 1
West Columbia, SC 29169

Dear Congressman Wilson:

I am in need of your assistance is reference to my son, Brennan Sawyer, born May 17, 2005. Last year on or around December 29th I mailed in a TEFRA Application for Brennan. Unfortunately, I didn't receive a determination until May 17, 2007 that my son wasn't eligible. The denial was based on two reasons: (1) I failed to prove Brennan's citizenship and identity. (His birth certificate was enclosed with his original application along with all of the other requested paperwork and was returned to me by their office via the US Postal Service.) (2) It was determined that Brennan does not meet the criteria of being disabled.

On June 6, 2007, an appeal was mailed to the attention of Jennifer Dabbs. (I have enclosed a copy of the letter enclosed for your review.) After a couple months, I called to follow up and was told they didn't show they received it so I would have to start the whole process over again. I was so upset to hear this because I did what I was supposed to and most importantly, I don't understand the denial in the first place. The application process takes several months and my family is suffering financial hardships trying to cover all my son's medical conditions and treatments. My current employer, Carolina Care Plan, Inc, has worked with me and allowed me to make up absences and retain my job despite the fact that I am constantly out of work caring for my son; however, by the end of the year I will not have a job and health care coverage due to the company being acquired by another company. When discussing my frustration with TEFRA a co-worker she suggested that I contact your office for assistance.

In the two years since my son's birth, he has been diagnosed with the following medical conditions:

- Acid Reflux (resulted in extended hospitalization after birth)
- Asthma / Restricted Airway Disease
- Allergies (trigger asthma attacks and sinus/ear infections – he is also allergic to penicillin which causes me to have to buy more expensive drugs to treat the other illnesses)
- Apnea (resulted in extended hospitalization after birth and monitors at home and overnight sleep studies at hospitals)
- Heart Murmur
- Ventricular Septical Defect (has not closed on his own and surgery possible to close it.)
- Constant Ear Infections (surgery to put tubes in ears)
- Allergic Rhinitis
- Pneumonia (required hospitalization and he is more susceptible due to his asthma – has had this each winter)

- Atopic dermatitis
- General Sickness (e.g. stomach virus, sinus infections, ear infections, etc.)

I have included a copy of the letter his pediatrician, Linda Crout Wingard, MD, provided to TEFRA that documents most, if not all, of these conditions. Despite all these conditions, if my son truly is not disabled as his physicians and his family believes, please assist me in getting a clear explanation of why they don't agree with his physicians on their disability determination and belief that he should qualify for assistance through TEFRA.

In addition, I would ask that you please assist us with appealing for supplemental help through TEFRA so that my son can receive all the treatments he needs. Reapplying will delay assistance and my son's medical conditions need to be treated and he really can't afford to wait another several months to receive a determination. Right now, we can't afford to get his heart defect treated due to trying to afford his everyday medical care and constant illnesses. Also, the bill for his hospital stay with pneumonia last December will be turned over to the courts the beginning of October because I owe Richland Hospital an outstanding balance of almost $800, but I am unable to pay that. I did what I was supposed to do initially and did what I was supposed to in appealing within the timeframe and providing proof of my son's citizenship again.

My son and I would like to thank you for your assistance with this issue. If you need any additional information from me or you are unable to help me, please contact me.

Respectfully,

Kelly Sawyer

Kelly Sawyer
615 Windmill Road
Gilbert, SC 29054
Home (803) 892-4595
Work (803) 561-7750

Ridge Pediatric and Adolescent Center
338 East Columbia Ave.
Batesburg Leesville South Carolina 29070
Phone 803-532-2877 Fax 803-532-5430

January 24, 2007

To Whom It May Concern:

Brennan Sawyer is a 20 month old male with a history of significant medical problems. At birth he was hospitalized in the special care nursery with transient tachypnea. During the nursery stay a heart murmur was detected. During the first few months of life Brennan was diagnosed with severe gastroesophageal reflux. He has continued on Prevacid and Reglan until recently when the decision was made to try him on a trail of no reflux medication. Brennan has myringotomy tubes placed by Dr. Frank Hill, due to a history of recurrent otitis media. Brennan also has severe RAD only fairly well controlled on his medication. He would benefit from a referral to a pediatric pulmonologist but this has not yet been done .The pulmonologist can better plan a course of preventative maintenance medications to hopefully decrease the number of exacerbations of Brennan's RAD. Brennan also has atopic dermatitis and allergic rhinitis, and has recently been to a dermatologist. Brennan has a heart murmur due to a ventricular septal defect. His murmur is more pronounced now, and he is being referred to a pediatric cardiologist who will follow the VSD and manage arranging surgery for closure should his defect not close spontaneously.

Medical bills, primary care, specialist and medications for Brennan are significant. He and his family would benefit from supplemental help with their medical expenses.

Sincerely,

Linda Crout Wingard, MD

Linda Crout Wingard MD

State of South Carolina

Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

January 17, 2007

Brennan T Sawyer
615 Windmill Road
Gilbert, SC 29054

Budget Group Number: 39486607

Dear Mr/Ms Sawyer,

In order to determine eligibility for TEFRA, we will need the information listed below:

Name	Information Needed
Brennan	Return ALL copies of signed Authorizations for Release (DHHS 921).
Brennan	Completed In-Home Care Certification (DSS 3291)

A self-addressed envelope is provided for you to return this information. **PLEASE PROVIDE BY 02/19/2007 OR YOUR APPLICATION WILL BE DENIED. Please be aware that the TEFRA application process can be time consuming. TEFRA requires four different approvals before a Medicaid card can be issued. Thank you for your patience.** I may be contacted at our toll free number 1-888-549-0820, if you have any questions.

Sincerely,

Rhonda Tucker
TEFRA Coordinator
Ext. 82934

South Carolina Department of Disabilities and Special Needs

Permission to Evaluate TEFRA Applicant

I, Brennan Sawyer (print name of applicant), have applied for Medicaid eligibility as part of the national Tax Equity and Fiscal Responsibility Act (TEFRA) through the South Carolina Department of Health and Human Services (SCDHHS). As part of this Medicaid eligibility determination process, I understand that the South Carolina Department of Disabilities and Special Needs (SCDDSN) will determine whether I meet the level of care criteria for an Intermediate Care Facility for the Mentally Retarded (ICF/MR). I further understand that this is not a request to determine my eligibility for care, treatment, training, or residential services from SCDDSN. However, I understand that I may make a separate request for eligibility for SCDDSN services.

I give permission for SCDDSN to review any available medical, educational, and/or other records pertaining to me in order to determine whether I meet ICF/MR level of care criteria. I understand that I may be asked to sign one or more separate authorization forms for release of this information to SCDDSN. I also give permission for SCDDSN to conduct a psychological evaluation or other evaluations of me, if such become necessary as part of this Medicaid eligibility application.

I understand that this document will remain in effect until such time as SCDHHS makes a Medicaid eligibility decision under TEFRA. I understand that I may terminate this permission in writing to SCDDSN or its designated representative at any time.

_____ _____

Applicant's Signature Date

Kelly L Sawyer, mother COPY 8/21/06

Legal Guardian's Signature Date

(For applicant under 18 yrs. or legally incompetent)

3/09/2005

South Carolina Department of Health and Human Services

APPLICATION FOR TEFRA MEDICAID COVERAGE

Date Received by DHHS: _____

1. Name of Child (the Applicant) applying for Medicaid:

Last Name: Sawyer	First Name: Brennan	Middle Initial: T	Telephone: (803)892-4595
Birth Date: 5/17/2005	SSN:	Sex: M	Race: W

2. Applicant's Address:

Street Address: 615 Windmill Rd	City: Gilbert	State: SC	Zip Code: 29054
Mailing Address, if different:	City:	State:	Zip Code:

3. Parent(s) or Guardian(s) of the Applicant:

Last Name:	First Name:	Middle Initial:	Relationship to the Applicant:
Sawyer	Kelly	L	mother
Sawyer	Byron	M	father

4. (a) Does the Applicant have income from any source listed below? *(Check Yes or No)*

Income Source	Yes	No	Income Source	Yes	No	Income Source	Yes	No
Social Security		X	Money from Friends or Relatives		X	Other (Identify Source)		X
Veteran's Benefits		X	Interest, Dividends		X			
Child Support		X	Income from a Trust		X			

(b) If the Applicant receives income from any of the sources listed in Section 4(a), complete the following:

Name of Person with Income Source	Income Source [as listed in 4(a)]	Amount	How Often Received

5. (a) Does the Applicant have any of the following assets/resources? *(Check Yes or No)*

Item	Yes	No	Item	Yes	No	Item	Yes	No
Cash on Hand		X	Preneed Burial Contract		X	Trust Account		X
U.S. Savings Bonds		X	Trust Fund		X	Annuity		X
Stocks and Bonds		X	Checking or Savings Account		X	Life Insurance		X
Certificate of Deposit		X	Other		X			

(b) Fill in the following information for any item checked "yes" in Section 5(a).

Item *[as listed in 5(a)]*	Amount/Value	Owned By	Name and Address of Bank or Location of Account

6. **Is there any asset/resource available to the Applicant that we have not asked about?** ___Yes X No

   If yes, please explain: _____

   _____

7. **Does the Applicant have health insurance?** X Yes ___No **If yes, please complete the following:**

Insurance Company or Employer	Policy Number	Policyholder's Name	Policyholder's SSN
Carolina Care Plan	E01KS1112	Kelly Sawyer	248-43-4204

8. **Did the Applicant receive medical services in the last three months?** X Yes ___No **If yes, which months?**

   May, June, July, August, September, October, November + December

9. **Was the Applicant's income and resources the same in the last three months as now?** X Yes ___No

   If no, explain how they were different: _____

   _____

10. **Does the Applicant for whom you are applying have a plastic South Carolina Partners for Health (Medicaid) card?**

    ___Yes X No

Children under the age of 21 who are eligible for Medicaid may have free health checkups under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Ask your primary care physician about these services.

All Medicaid beneficiaries may be eligible for help with medical transportation. Ask your Medicaid eligibility worker about transportation services.

11. **I have read my Rights and Responsibilities on the next page.** X Yes ___No

Signature of Applicant, Parent or Legal Guardian: Kelly L. Sawyer Date: 8/21/06

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.

Citizenship and Identity Application Addendum

Applicant: Brennan T. Sawyer **Phone Number:** (803) 892-4595

You must provide proof of citizenship or nationality and identity of each Medicaid eligible family member claiming to be a US citizen. You must bring an original form of proof listed below and complete the information below.

You must bring at least one item from Table 1 OR one item from each Table 2 and 3:

Table 1 Proof of citizenship **and** identity		Table 2 Proof of citizenship		Table 3 Proof of identity
• US Passport • Certificate of Naturalization • Certificate of US Citizenship	**OR**	• Birth Certificate • Certificate of Birth Abroad • US Citizen ID Card • Final Adoption Decree showing US place of birth • Evidence of US Government employment before June 1, 1976 • Military record of service showing US place of birth	**AND**	• Certificate of Indian Blood w/ picture ID • Driver's License • School ID card with photo • US military card or draft record • Government issued ID card • Native American Tribal document • School or daycare records that in show place of birth.

Important for you to know:

- When you bring original documents to the local Medicaid office, a worker will review them, make a copy, and return the originals to you.
- If you have problems locating documents, please let us know so that we can work with you to help get documents you need. There may be other documents that we can use.

Please **carefully** complete this information for **each** Medicaid eligible family member. Please print. Spelling must be correct.

Full Name at birth	Date of Birth	State of Birth	**County** where hospital or home in which you were born is/was located	Mother's Full Maiden Name
Brennan Thomas Sawyer	5/17/2005	SC	Lexington	Kelly Lynn Fulmer

DHHS Form 3296 July 2006

Please use a separate piece of paper to list more than five people.

South Carolina Department of Health and Human Services

DISABILITY REPORT – Child Under Age 19

☑ **Initial** – back to DOB ☐ **Retro Only**

Instructions: This form is used to request a disability determination as an eligibility requirement for Medicaid. ***It is the responsibility of the Medicaid Eligibility Worker to ensure that each blank is completed.*** A copy of the completed form must be maintained in the case record.

Applicant Brennan T. Sawyer (Please Print) Social Security No. 656-90-2004

Applicant's Address 615 Windmill Rd

City Gilbert State SC Zip Code 29054 County Lexington

Date of Birth 5/17/2005 Telephone (803) 892-4595 Category of Application TEFRA

If Deceased, Date of Death _____ Month _____ Day _____ Year (Male) or Female (Circle One)

Application Date _____ Retro Month(s) Requested 19 (to birth)

Contact Person Kelly L. Sawyer Telephone (803) 561-7750

Relationship to Applicant mother

Contact Person's Address 615 Windmill Rd - Gilbert, SC 29054 (Give Complete Mailing Address)

Medicaid Eligibility Worker _____ Telephone ( )

Worker's Address _____ (Give Complete Mailing Address)

Worker's Supervisor _____ Telephone ( )

Date of Disability Onset or Last Continuing Disability Review birth (5-17-05)

I. DISABILITY

a) When did the child become disabled? 5 Month 17 Day 2005 Year

b) What is the child's disability? acid reflux, asthma/allergies, apnea, heart murmor, ventricular septical defect, tubes

c) Explain how the child's disability affects his or her ability to function. difficulty eating & breathing - affects sleep, play, meal time, etc.

d) Have you applied for Social Security Income (SSI) disability benefits? ☐ Yes ☑ No

If yes, date of application: _____

If denied, have you asked the Social Security Administration (SSA) to reconsider your claim? ☐ Yes ☐ No

Did SSA refuse to reconsider your claim? ☐ Yes ☐ No

Did you request an appeal or a hearing? ☐ Yes ☐ No

e) Please give the name of anyone we may contact (other than the child's doctor or teacher), such as a neighbor, grandparent, etc., who knows about the child's condition.

Name of Contact Lynn Fulmer

Street Address 620 Windmill Rd

City Gilbert State SC Zip Code 29054

Telephone (803) 892-1112 Relationship to child grandmother

f) Please give the name of the child's regular pediatrician and his or her complete address and telephone number.

Name Linda Crout-Wingard Telephone (803) 532-2877

Street Address 338 E. Columbia Ave.

City Leesville State SC Zip Code 29070-9285

II. MEDICAL INFORMATION ABOUT THE CHILD'S DISABILITY

NOTE: If you need additional space for medical sources, list their names, addresses and reasons for visits in the "Remarks" section on page five or attach a separate piece of paper.

a) List name, address and telephone number of the doctor who has the child's most recent medical records. *(We need a complete address to request medical records.)*

Name Linda Crout-Wingard Telephone (803) 532-2877

Street Address 338 E. Columbia Ave

City Leesville State SC Zip Code 29070-9285

Date first seen: 6/2/05 Date last seen: 12/19/06 Next appointment: _____

Reason for visits Acid reflux, heart murmur, asthma, general illnesses (ear infections, etc.), well visits, apnea

b) Has the child been seen by any other doctors since the disability or injury began?
☑ Yes ☐ No If yes, complete the following. *(We need a complete address.)*

Name Dr. Frank Hill / Centa Medical group Telephone (803) 256-2483

Street Address 9 Richland Medical Park, Suite 510

City Columbia State SC Zip Code 29203-6873

Date first seen: 3/27/06 Date last seen: 12/11/06 Next appointment: 6/18/07

Reason for visits Severe ear infections due to reflux, consult to have tubes, tube insertion, follow-up visits for tubes

c) Has the child been hospitalized or received emergency room treatment for the illness or injury? ☑ Yes ☐ No If yes, complete the following. *(We need a complete address.)*

Name of Hospital Lexington Med Ctr. Patient Number

Street Address 2720 Sunset Blvd

City West Columbia State SC Zip Code 29169

Was the child an in-patient (stayed at least overnight)? ☑ Yes ☐ No

Admission Dates: 5-17-05 to 5-25-05

Reason for Hospitalization or Emergency Room Treatment Ventricular Septical defect, murmor, reflux, stopped breathing multiple times, apnea

d) Has the child received treatment from a hospital outpatient clinic or other type of clinic? ☑ Yes ☐ No If yes, complete the following. *(We need a complete address.)*

Name of Clinic Lexington Med Center Patient Number Lexington / Batesburg-Leesv

Street Address 811 W. Main St / 338 E. Columbia Ave

City Lexington / Batesburg State SC Zip Code 29072 / 29070

Date(s) of Treatment: 6-15-05, 6-2-05, 6-23-05, 7-29-05, 8-12-05, 10-31-05, 12-5-05, 1-9-06, 2-20-06, 3-28-06, 8-4-06

Reason for Treatment pneumonia / asthma, vomiting / reflux, colitis, high fever

e) Has the child had any special diagnostic outpatient studies (x-rays, blood tests, EKG's, etc.) performed at a hospital or private laboratory/clinic? ☑ Yes ☐ No
If yes, complete the following. *(We need a complete address.)*

Type of Study/Test x-rays, EKG's, Ultrasounds, ECG's

Name of Hospital, Clinic or Laboratory Lexington Medical Ctr

Street Address 2720 Sunset Blvd

City West Columbia State SC Zip Code 29169

When were these studies done? 5-17-05 to 5-25-05 and 8-30-06

Brennan Thomas Sawyer 5-17-05
656-90-2004

Pediatrix Medical Group of SC
Taylor and Marion
Columbia, SC 29220

Date 1st Seen: 5-17-05 Date last Seen: 5-24-05

reason: ears & hearing, murmurs, tachypnea

Children's Respiratory Center
58 Bear Drive
Greenville, SC 29605-4458

Date Seen: 6-3-05

reason: apnea

Palmetto Health Richland
5 Richland Medical Park Drive
Columbia, SC 29203

Date Seen: 9-29-05

reason: Sleep Study, apnea, pneumonia

— OVER —

Palmetto Dermatology
105 Hospital Drive West
West Columbia, SC 29169-3405

Date seen: 9-12-06

reason: sebaceous cyst, exzema

Pediatric Pulmonary Associates
2113 Adams Grove Rd, Suite 210
Columbia, SC 29203-6873

Date seen: 9-29-05

reason: reflux, apnea

f) Is the child seen regularly or has the child ever been tested or evaluated by any of the following agencies? If available, please include copies of any medical, psychological, developmental information/assessments (including service plans) from these agencies.

1.	S.C. Health Department Clinic	☐ Yes	☑ No
	Division of Children's Health	☐ Yes	☑ No
	Children's Rehabilitative Services (CRS)	☐ Yes	☑ No
	Women, Infant and Children's Program (WIC)	☐ Yes	☑ No
	Baby Net	☐ Yes	☑ No
2.	Department of Disabilities and Special Needs (DDSN)	☐ Yes	☑ No
	County DDSN Board/Regional Center	☐ Yes	☑ No
3.	South Carolina Department of Mental Health	☐ Yes	☑ No
	Mental Health Center	☐ Yes	☑ No
4.	Continuum of Care for Emotionally Disturbed Children	☐ Yes	☑ No
5.	Speech and Hearing Center	☐ Yes	☑ No
6.	Other (i.e., physical, occupational therapy, etc.)	☐ Yes	☑ No

If yes, specify: _____

For each of the agencies at which the child has been seen, complete the following. If you have a copy of the child's service plan, please attach.

Name of Facility _____

Street Address _____

City _____ State _____ Zip Code _____

Date first seen: _____ Date last seen: _____ Next appointment: _____

Type of Treatment or Evaluation Received _____

Case Manager _____ Telephone ( ) _____

Name of Facility _____

Street Address _____

City _____ State _____ Zip Code _____

Date first seen: _____ Date last seen: _____ Next appointment: _____

Type of Treatment or Evaluation Received _____

Case Manager _____ Telephone ( ) _____

III. SCHOOL INFORMATION

a) Is the child currently attending school? ☐ Yes ☑ No If yes, complete the following.

Current Grade _____ Teacher _____

Name of School _____

Street Address _____

City _____ State _____ Zip Code _____

b) Is the child in a special education program? ☐ Yes ☑ No
If yes, explain the services provided (i.e., speech, learning disabled, etc.) _____

Do you have a copy of the child's Individual Education Plan (IEP) report? ☐ Yes ☐ No
If yes, please attach a copy.

c) Does the child attend any type of preschool, daycare or after school program?
☑ Yes ☐ No If yes, please complete the following.

Name of School Happy Camper Child Development Center

Street Address 2705 Highway 378 Gilbert

City Gilbert State SC Zip Code 29054

IV. DAILY ACTIVITIES

Describe what the child does in a typical day. Include any participation in school, church or community activities.

attends day-care, likes to play outside, eats, naps, takes medications/breathing treatments, plays w/his brothers, likes to watch cartoons

V. REMARKS

Use this section to answer any previous questions and to add additional information that you think will be helpful in making a decision in your child's disability claim.

please see attached additional provider info.

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE.

Print Name of Applicant/Representative Kelly L. Sawyer

Applicant/Representative Signature Kelly L. Sawyer **Date** 8/21/06

Relationship mother

South Carolina Department of Health and Human Services

ATTN: Parent Considering Applying for TEFRA

This letter is to provide you with information about the TEFRA (Katie Beckett) program in Medicaid. We hope the following information will do three things:

1. Help you determine whether you should apply for TEFRA coverage for your child.
2. Help you understand the lengthy process that is involved in determining whether a child is eligible for TEFRA coverage.
3. Provide you with information about things you can do so that the application process can be completed in less time.

South Carolina is fortunate to have an organization called Family Connection of South Carolina, Inc., that is devoted to helping parents with children with chronic illnesses, disabilities and developmental delays. This organization provides a support network for families like yours. You may contact Family Connection at 1-800-578-8750. They may also be able to help you with this application process. Most TEFRA applications take up to 90 days to process; however, many take longer. Please submit all required information with your application so that we can begin to process your application immediately.

We would like to provide you with some information about the TEFRA program so that you will know what is done when we process your application. TEFRA (Katie Beckett) is a special coverage group for children who need institutional care, but whose families can, and want to, provide care in their homes. It is an option that states may choose to provide coverage, not a federal requirement. However, if states decide to provide this coverage, states must follow federal rules for the program.

Federal rules require that a child meet several criteria in order to qualify. A child may have a number of medical problems and still not qualify for TEFRA. If any of these rules are not met, the child cannot qualify. Some of the rules that are not usually a problem or that can quickly be determined include age (a child must be 18 years old or younger), income and resources (the child's income must be below $1,809 per month and his resources must be at or below $2,000), the child must be living at home, it must be possible for the child to receive adequate care in the home setting, and the cost of the child's care to the Medicaid program cannot exceed the cost that Medicaid would incur if the child were institutionalized. Two of the criteria are more difficult to determine and can involve some time to complete. These are the disability determination and the Level of Care determination.

1. The child must be disabled. (This means the child must meet federal criteria for being considered disabled.)
2. The child must need ongoing institutional care. This is called the Level of Care determination. This generally means nursing home care or intermediate care for the mentally retarded. It can also mean long-term care in a hospital. This criteria is NOT met because a child may need to be admitted to a hospital many times a year to address health crises or corrective procedures.

Most states call their program Katie Beckett, rather than TEFRA. Congress enacted this coverage option after media attention about a child named Katie Beckett. Children who were institutionalized could receive Medicaid coverage after they had lived in an institution for more than 30 consecutive days. After this 30-day period and for as long as the child continued to live in an institution, the parents' income was not counted. Katie Beckett's parents didn't want their child to live in an institution and wanted to care for their severely disabled child at home. While Medicaid would cover Katie as long as she stayed in the institution, Medicaid would provide no assistance to her if she were to move back home. President Reagan read about this and had legislation introduced to change this. This legislation gave states the option to provide coverage for children like Katie Beckett.

For a disability determination, DHHS sends the application to the SC Vocational Rehabilitation Department. This is done after medical records are requested and received from the physicians and healthcare providers that you have identified on your application. Please encourage your healthcare providers to provide the requested information quickly. Physicians and other healthcare providers frequently respond more quickly to you, the parent, than to a government agency like DHHS. **Anything you can do to get the medical records more quickly will help us process the application more quickly. If you do obtain medical records, send them along with your application. If you receive medical records after you send in your application, you can mail or FAX them to us.** Please FAX these records to 803-255-8223 or mail them to:

South Carolina Department of Health and Human Services
Division of Central Eligibility Processing – Attn: TEFRA
Post Office Box 100101
Columbia, SC 29202-3101

If the medical records do not clearly indicate disability, a specialist may be requested to review your child's condition to determine if there is more information that might lead to a positive determination of disability. This step lengthens the process of determination, but is done to give your child every chance of meeting disability criteria.

At the same time the disability determination is being done, we review your child's condition to determine whether he or she needs institutional care. This is called Level of Care. To meet the medical necessity criteria for institutional care, a person has to have functional deficits. For an adult, this means that he or she cannot bathe, dress, eat or transfer (move) without ongoing assistance. These are called deficits in daily living skills.

A child must have deficits in this area that are not simply the age appropriate dependences of a child. The determination for a child is difficult. All children are dependent at birth for assistance in these areas. Therefore, the normal dependency of an infant is age appropriate. It does not mean that they need institutional care. We first look at your child's functional level compared to the functional level that would be expected for a child of your child's age. The first review is to see whether your child's functional level is so different from the expected level that he or she would require ongoing care in a nursing home or hospital. If your child does not need to live in a hospital or nursing home, we then send the application to the SC Department of Disabilities and Special Needs (DDSN). DDSN reviews your child's condition to determine if your child has Mental Retardation or a Related Condition and whether your child needs ongoing care in an Intermediate Care Facility for the Mentally Retarded (ICF-MR).

As you can see, this is a lengthy process. It is lengthy because we make every effort to find your child eligible. These efforts may include finding additional specialists to review your child's condition if medical records do not support a disability determination and home visits related to Level of Care determinations.

This letter may provide you with a better understanding of TEFRA and what it means to qualify. **If you would like to provide us with any additional information that could be helpful, or you would like to send us a written statement about your child's condition, please do so with your application.** We will include your statement and/or the additional information in the material used both in the disability determination and the Level of Care determination. Also, please encourage your child's physicians and healthcare providers to respond quickly to requests from us for medical records.

Please understand that your child may have severe medical problems and still not meet TEFRA requirements. It is frequently the lack of need for continuous institutional care that disqualifies a child. If your child is denied, it in no way means that we do not think your child has serious medical problems or is seriously ill.

South Carolina Department of Health and Human Services

TEFRA Application Checklist

By providing as much information as possible when you apply, DHHS may be able to process your application in a shorter time. Be sure to include these items when you apply. If you are not sure what to send, call our toll-free line at 1-888-549-0820 for help.

- **Application Form – DHHS Form 3290 ME**
- **DHHS Form 3291ME, TEFRA In-Home Care Certification.** Your child's physician must complete this form.
- **DHHS 3218D-ME –Disability Report, Child Under Age 19.** It is important that you fill out each blank, even to indicate not applicable (N/A).
- **DHHS Form 921 – Request for Medical Records.** Please complete a copy for each provider you listed on the DHHS 3218D-ME –Disability Report, Child Under Age 19. In addition, please sign five blank copies of this form. Do not date these forms. Please mail back all copies of this form with the application.
- **SC Department of Disabilities and Special Needs Permission to Evaluate TEFRA Applicant Form.** Sign and return this form.
- Proof of ☐ Citizenship ☐ Identity
- Copies of any recent medical records (within one year) you may have regarding your child's health. These are not mandatory but may help speed up the application process.
- Copies of recent IEP and School Psychological Evaluation for school-age children
- Proof of any income that your child receives, such as child support or Social Security
- Proof of any resources available to your child such as bank accounts, savings bonds, trust accounts, life insurance policies, etc.
- Copies of any health insurance card, front and back, showing that your child is covered. This does not affect your child's eligibility for Medicaid. We need a record of other insurance.

Mail the completed, signed application and other required forms and information to:

South Carolina Partners for Health Medicaid
Division of Central Eligibility Processing
Post Office Box 100101
Columbia, South Carolina 29202-3101

SAWYER
615 Windmill Road ~ Gilbert, SC 29054
(803) 892-4595

June 6, 2007

State Office County DHHS
Attn: Jennifer Dabbs
PO Box 100101
Columbia, SC 29202

RE: Brennan T. Sawyer denial for Katie Beckett - TEFRA

Dear Ms. Dabbs:

This letter is in response to your correspondence dated 5/17/07 concerning the denial of Katie Beckett – TEFRA for my son Brennan T. Sawyer. Please pardon the delay in my response. I have been, and continue to be, out of work on disability.

One of the items on your notice states I failed to prove Brennan's citizenship and identity. His birth certificate was enclosed with his original application along with all of the other requested paperwork and was returned to me by your office via the US Postal Service. For your records I am enclosing Brennan's birth certificate again to show that he is a citizen of the United States.

The other item states that it was determined that Brennan does not meet the criteria of being disabled. I would like to request that someone please review all of his information again. TEFRA is a program that I knew nothing about until a friend told me about it. If I had known about it when he was born, I would have filed for it right away because of his health status. I am a bit confused by this determination because the person who alerted me to the program has two children covered by TEFRA and their only illness is asthma.

Along with asthma, my son has several other medical conditions that I feel would qualify him for assistance through this program. As he has gotten older, his symptoms of the more serious of illnesses continue to worsen. He is in need of special treatment for his heart condition, but I am unable to make that move with him because of the cost associated with maintaining his other conditions. Trying to keep him healthy enough to even been seen by a pediatric cardiologist has been impossible for the entire two years of his life. Oddly enough, your denial letter is dated the date of his second birthday.

When I notified his pediatrician that he had been denied, she was shocked. I consulted her after finding out about the program to get her input to see if she thought that Brennan would be a candidate. She absolutely supported my decision for filing because she felt that Brennan's medical conditions were severe enough to qualify him for the assistance. The letter that she supplied with his medical records outlined all of the current reasons he was being treated for in her office as well as by other medical professionals. She has genuine

concern for the well being of my son and wants to see him receive the treatment that he needs so badly. However, she also understands the financial burden that his medical costs puts on my family.

I know that my child is not the sickest child in the world, but I know that he is a very sick little boy that does not deserve to have the problems that he does. He cannot do all of the things that he would like to do because of being hindered by his medical conditions. Also knowing that there are children that have been approved for the assistance that only have one of the conditions my son has makes me question the consistency of the program.

At this time I do not wish to request a hearing, instead I ask that your staff please review Brennan's information again and reconsider him as a candidate for Katie Beckett – TEFRA. I would not ask for assistance if I did not feel that he was qualified, nor if my family did not need the assistance to handle the cost of raising a child with serious medical conditions.

It is my hope that through an open mind and an honest heart you reconsider your decision about my son and allow him the assistance through TEFRA. I want him to grow and be able to do all of the things that he wants to do in his life. This program would assist me in getting him the treatment he needs with less worry about the financial aspect of his medical care.

Sincerely,

Kelly L. Sawyer

Enc (2)

Medicaid Letter of Action

From: STATE OFFICE COUNTY DHHS
P. O. Box 100101
Columbia SC 29202-0000

To: KELLY SAWYER
615 WINDMILL RD
GILBERT SC 29054

Date: 05/17/2007
Worker Name:
JENNIFER DABBS
Telephone: 803 898-3965
BG #: 39486607
HH #: 101168030
47 JLYNC

Recipient Name:
BRENNAN T SAWYER

Recipient ID:
6780689049

Your application has been denied for: KATIE BECKETT CHILDREN - TEFRA

Reason for denial:

You do not meet the disability criteria.

You did not provide proof of citizenship and identity.

Denied for the month(s) of: 12/2006

Manual/policy reference supporting this action: 102.06.02A
102.04.03

X You may ask for a fair hearing before the Department of Health and Human Services if you believe an error was made in processing your application.

To Request A Hearing from the Department of Health and Human Services

- Ask your Medicaid worker in writing within 30 days of this letter. Attach a copy of this letter to your request.

To Get Help with Your Hearing

- You may hire an attorney to help you
- You may have someone you know come to the hearing and speak for you
- Contact your Medicaid worker in person or by phone to get help in asking for a hearing

From: Vastine Crouch
To: Denise Epps
Date: 9/28/2007 3:41 PM
Subject: Re: Sawyer, Brennan, 101168030

CC: Mark Orf

No, we're going to treat it like any other timely appeal. she contends she sent the letter around the time it is dated and she's already asked Representative Wilson to intervene, so we're just going to proceed as normal. However, our normal is not to telephonically contact claimants to arrange a hearing. You might want to call her and tell her to expect a certified letter in about a week that will contain all of the pertinent details and information.

>>> Denise Epps 9/28/2007 3:36 PM >>>
i may have misunderstood - mark told me you're not necessarily saying she will get a hearing.

unfortunately, i told ms. sawyer in a phone conversation today to expect a call from a hearing officer to set up a hearing.

do i need to call her back?

>>> Vastine Crouch 9/28/2007 9:59 AM >>>
I decided to just go ahead and set up a case. I've already assigned it and rec'd the packet from CEP

>>> Denise Epps 9/28/2007 9:58 AM >>>
valerie gave me a copy yesterday and i plan to send it to ms. sawyer; however, since the response has to meet the approval of the 11th floor, things could change.

anyway, whether ms. sawyer is granted a hearing or not, she wanted the medical evidence supporting the denial of the disability claim.

thanks, i'll keep you posted.
denise

>>> Vastine Crouch 9/27/2007 4:35 PM >>>
It is standard practice for the hearing officer to send a copy of the VR records to the Petitioner on an appeal based on a disability denial. If you get records from Valerie and send them now, let us know.

>>> Denise Epps 9/27/2007 4:16 PM >>>
thanks, vastine. in my written responses to both ms. sawyer and cong. wilson, i will indicate that our OHA will be in touch with her regarding her request to appeal. also, i will send to ms. sawyer copies of brennan's VR's disability determination medical records since she inquired about those as well. thanks again, denise

>>> Vastine Crouch 9/27/2007 4:07 PM >>>
I'm sure you're correct that she was requesting a review and did not understand that there is no provision in SC Medicaid for a review/reconsideration. However, I'm sure that if her letter had reached CEP asking for a review, much less an appeal, they would have processed it as an appeal.
As i said before, we'll handle the request from here.

>>> Denise Epps 9/27/2007 3:57 PM >>>
yes, i made a notation of that sentence however she does indicate in the letter that she wants us to review the findings again. she may have just been unfamiliar with our legal process and didn't know that she would have to appeal for the determination to be reviewed. thanks, jean.

>>> Jean M Richardson 9/27/2007 3:28 PM >>>
I just looked at the appeal request and letter that was written to Rep. Wilson's office and that is the first and only time we have ever seen that letter. It does clearly state in the second to last paragraph that she does not want a hearing. We will go ahead and do a summary based on the fact that the appeal request was just received today and forward to OHA. Thanks.

Jean M. Richardson
Program Coordinator II
Central Eligibility Processing
SC DHHS
P.O. Box 100101
Columbia, SC 29202
803-898-3008 Office
803-255-8223 Fax

>>> Vastine Crouch 9/27/2007 3:02 PM >>>
So, as you pointed out, she sends a copy of a letter dated 6/6 to Rep. Wilson that says she doesn't want a hearing at this time and complains that she didn't get her appeal!
It is quite possible her letter was rec'd and handled in just the manner she requested.
I wish CEP or their file could shed some light on this. I'm not thrilled about granting an appeal based on a letter dated almost 4 months ago that says she isn't asking for a hearing.
If CEP doesn't have any more info. than Jean referenced in her earlier email, we'll communicate with Ms. Sawyer directly.

From: Vastine Crouch
To: Denise Epps
Date: 9/28/2007 9:59 AM
Subject: Re: Sawyer, Brennan, 101168030

CC: Jean M Richardson; Jennifer Dabbs; Valerie Hollis

I decided to just go ahead and set up a case. I've already assigned it and rec'd the packet from CEP

>>> Denise Epps 9/28/2007 9:58 AM >>>
valerie gave me a copy yesterday and i plan to send it to ms. sawyer; however, since the response has to meet the approval of the 11th floor, things could change.

anyway, whether ms. sawyer is granted a hearing or not, she wanted the medical evidence supporting the denial of the disability claim.

thanks, i'll keep you posted.
denise

>>> Vastine Crouch 9/27/2007 4:35 PM >>>
It is standard practice for the hearing officer to send a copy of the VR records to the Petitioner on an appeal based on a disability denial. If you get records from Valerie and send them now, let us know.

>>> Denise Epps 9/27/2007 4:16 PM >>>
thanks, vastine. in my written responses to both ms. sawyer and cong. wilson, i will indicate that our OHA will be in touch with her regarding her request to appeal. also, i will send to ms. sawyer copies of brennan's VR's disability determination medical records since she inquired about those as well. thanks again, denise

>>> Vastine Crouch 9/27/2007 4:07 PM >>>
I'm sure you're correct that she was requesting a review and did not understand that there is no provision in SC Medicaid for a review/reconsideration. However, I'm sure that if her letter had reached CEP asking for a review, much less an appeal, they would have processed it as an appeal.
As i said before, we'll handle the request from here.

>>> Denise Epps 9/27/2007 3:57 PM >>>
yes, i made a notation of that sentence however she does indicate in the letter that she wants us to review the findings again. she may have just been unfamiliar with our legal process and didn't know that she would have to appeal for the determination to be reviewed. thanks, jean.

>>> Jean M Richardson 9/27/2007 3:28 PM >>>
I just looked at the appeal request and letter that was written to Rep. Wilson's office and that is the first and only time we have ever seen that letter. It does clearly state in the second to last paragraph that she does not want a hearing. We will go ahead and do a summary based on the fact that the appeal request was just received today and forward to OHA. Thanks.

Jean M. Richardson
Program Coordinator II
Central Eligibility Processing
SC DHHS
P.O. Box 100101
Columbia, SC 29202
803-898-3008 Office
803-255-8223 Fax

>>> Vastine Crouch 9/27/2007 3:02 PM >>>
So, as you pointed out, she sends a copy of a letter dated 6/6 to Rep. Wilson that says she doesn't want a hearing at this time and complains that she didn't get her appeal!
It is quite possible her letter was rec'd and handled in just the manner she requested.
I wish CEP or their file could shed some light on this. I'm not thrilled about granting an appeal based on a letter dated almost 4 months ago that says she isn't asking for a hearing.
If CEP doesn't have any more info. than Jean referenced in her earlier email, we'll communicate with Ms. Sawyer directly.

From: Valerie Hollis
To: Denise Epps
Date: 9/27/2007 2:04 PM
Subject: log ltr - cong. wilson inquiry re: brennan sawyer

CC: Jean M Richardson; Jennifer Dabbs; Vastine Crouch

Denise,
As Vastine stated, most doctors really don't know anything about SSA's disability criteria. The patient may be "disabled" based on their physician's criteria, but they still have to meet SSA's disability criteria. You can let her know that all of her questions regarding her son's disability will be discussed at the hearing. Thanks

>>> Vastine Crouch 9/27/2007 12:46 PM >>>
She needs to get a brief, signed letter requesting appeal to Central Eligibility Processing(if they don't already have the letter she says went to Jennifer.) CEP should then prepare a typical appeal summary packet and add additional language explaining what they know about the alleged appeal request from June. When we receive the packet, we'll address the issue of timeliness to see if there's good cause for the request being late(such as her request being lost in-house.)
you can fax the letter to 255-8206 if you wish.
As for the question of explaining VR's decision, I'll let Valerie address that, but "disability" is not a medical diagnosis. Few, if any, doctors who don't work for VR know anything about the SSI disability criteria.

>>> Denise Epps 9/27/2007 12:35 PM >>>
(SS# 656-20-9004) - TEFRA application of 12/06 - denied 5/07 - "not disabled."

ms. sawyer wrote cong. wilson for help in (1) obtaining an explanation why her son is not considered disabled when his doctor's emphatically say he is and (2) getting her request for a hearing approved.

she claims CEP dropped the ball twice -- once when she provided citizenship & identity info and again when she sent an appeal letter on 6/6/07 to jennifer dabbs' attention.

what i want to know is if it's too late for your office to accommodate her request for a fair hearing. i could fax you a copy of her letter to congressman wilson where she gives a history of what happened/when.

(valerie, as far as what VR's medical examiners concluded and why, is this something we can share with her?)

thanks a bunch!
denise

From: Jean M Richardson
To: Denise Epps; Vastine Crouch
Date: 9/27/2007 1:04 PM
Subject: log ltr - cong. wilson inquiry re: brennan sawyer

CC: Jennifer Dabbs; Monica Williams; Tamara Douglas; Valerie Hollis

That should be fine. When you forward the letter it needs to be sent attention to Monica Williams since she is the TEFRA worker assigned to the case. Thanks!

Jean M. Richardson
Program Coordinator II
Central Eligibility Processing
SC DHHS
P.O. Box 100101
Columbia, SC 29202
803-898-3008 Office
803-255-8223 Fax

>>> Denise Epps 9/27/2007 1:01 PM >>>
thanks for being willing to look at it, i'll send it shortly.

(jean, if i provide you a copy of her letter to cong. wilson, as well as her original appeal letter, would that suffice?)

thanks,
denise

>>> Vastine Crouch 9/27/2007 12:46 PM >>>
She needs to get a brief, signed letter requesting appeal to Central Eligibility Processing(if they don't already have the letter she says went to Jennifer.) CEP should then prepare a typical appeal summary packet and add additional language explaining what they know about the alleged appeal request from June. When we receive the packet, we'll address the issue of timeliness to see if there's good cause for the request being late(such as her request being lost in-house.)
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(valerie, as far as what VR's medical examiners concluded and why, is this something we can share with her?)

thanks a bunch!
denise

From: Jean M Richardson
To: Denise Epps; Vastine Crouch
Date: 9/27/2007 12:57 PM
Subject: log ltr - cong. wilson inquiry re: brennan sawyer

CC: Jennifer Dabbs; Monica Williams; Tamara Douglas; Valerie Hollis

After checking the child's case record there appears to be no request for a hearing in the file and I checked all the faxes that have come in for the last year and there is not a fax on file for the Sawyer family. If she would like an appeal then please have her send in a request and we will type up the summary and submit it to OHA as soon as possible. Thank you.

Jean M. Richardson
Program Coordinator II
Central Eligibility Processing
SC DHHS
P.O. Box 100101
Columbia, SC 29202
803-898-3008 Office
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thanks a bunch!
denise

MEDELD01 P S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DATE: 09/28/07
MEDSPROD MEDICAID ELIGIBILITY DECISION ACTION:
DATES-FROM: 12 / 2006 THRU: __ / ____ PAGE: 2 OF 3
HH NAME: BRENNAN T SAWYER HH NUMBER: 101168030
BGN: 39486607 PCAT: TEFRA SPN: ____ _____ ACT TYPE: MAINTENANCE
BG: D BGP: D WKR: JLYNC JENNIFER DABBS ACT DATE: 05/16/07
COUNTABLE BG MEMBERS: 1
COUNTABLE INCOME: 0.00 COUNTABLE RESOURCES: 0.00
INCOME LIMIT: 1869.00 RESOURCE LIMIT: 2000.00
POV-LVL: +.00 % HLTH INS PREM: 0.00
RECURRING INC: 0.00 TOTAL ALLOC: 0.00 OSS AWARD: 0.00
MEETS NON-FINANCIAL? (Y/N): N ACT ON DECISION COMPLETE? (Y/N): Y
MEETS INCOME? (Y/N): Y DECISION ACCEPTED DATE: 05/16/07
MEETS RESOURCES? (Y/N): Y NEXT REVIEW DATE: 05/16/08
MEETS OTHER CONDITIONS? (Y/N): N ANTICIPATED CLOSURE DATE: _____
REASON(S) FOR DENIAL/CLOSURE/CHANGE:
020 You do not meet the disability criteria.
012 You did not provide proof of citizenship and identity.
ELIGIBILITY DECISION APPEALED? (Y/N) _ CONTINUE BENEFITS? (Y/N): _
APPEAL REQUEST DATE: _____ COUNTY DECISION UPHELD? (Y/N): _
UPDATED: USER ID: MONIW DATE: 05/16/07 SYSTEM ID: ELD3000 DATE: 05/16/07
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

South Carolina Department of Health and Human Services
Medicaid Disability Tracking System
Disability Applicant Event Listing

Applicant Name: Sawyer, Brennan T
Social Security #: 656209004

Applicant ID	OrdList	Event ID	Event Description	Date
31953	6	12	File sent to imaging	08/31/2007
31953	5	11	Letter to eligibility worker re:disability decision	05/15/2007
31953	4	23	Decision Received from VR	05/10/2007
31953	3	31	Additional Information to VR	04/05/2007
31953	2	21	Package forwarded to VR	03/13/2007
31953	1	1	Initial package received from eligibility worker	03/07/2007

615 Windmill Road
Gilbert, SC 29054

Appl. date: 12/29/06 decision date: 5/9/07

worker: Tucker "not disabled"

Acid reflux / Asthma + Allergies / Apena /
Heart Murmur / Ventricular Septical Defect / Tube Fed

Claind T
IN A06

Name/re aim
KELL YE
BREN AW
615 W R
GILB
29054

Clai sab

Claim t Ned
DENIE

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gnosis

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trointestina
RD

B. Disabi ed

Ba

Med List N

N35

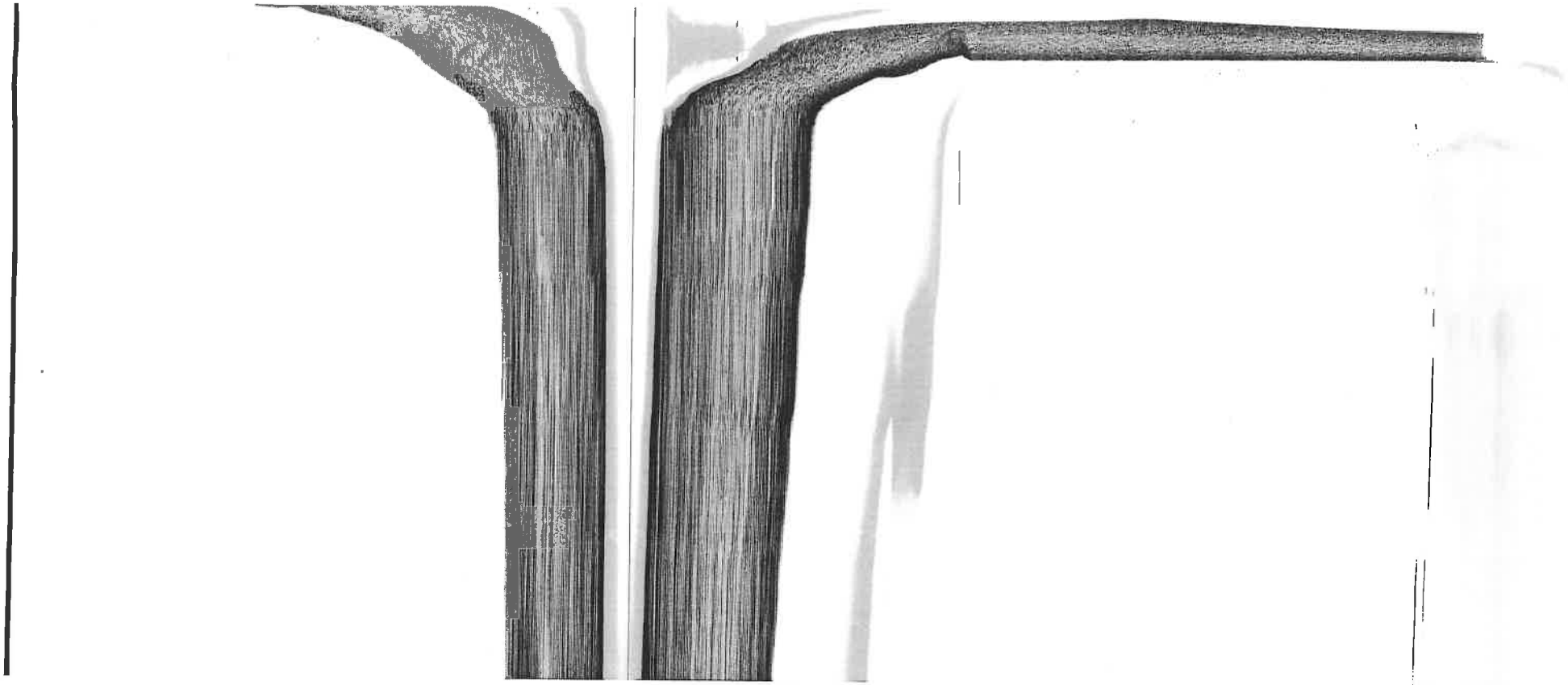
VR

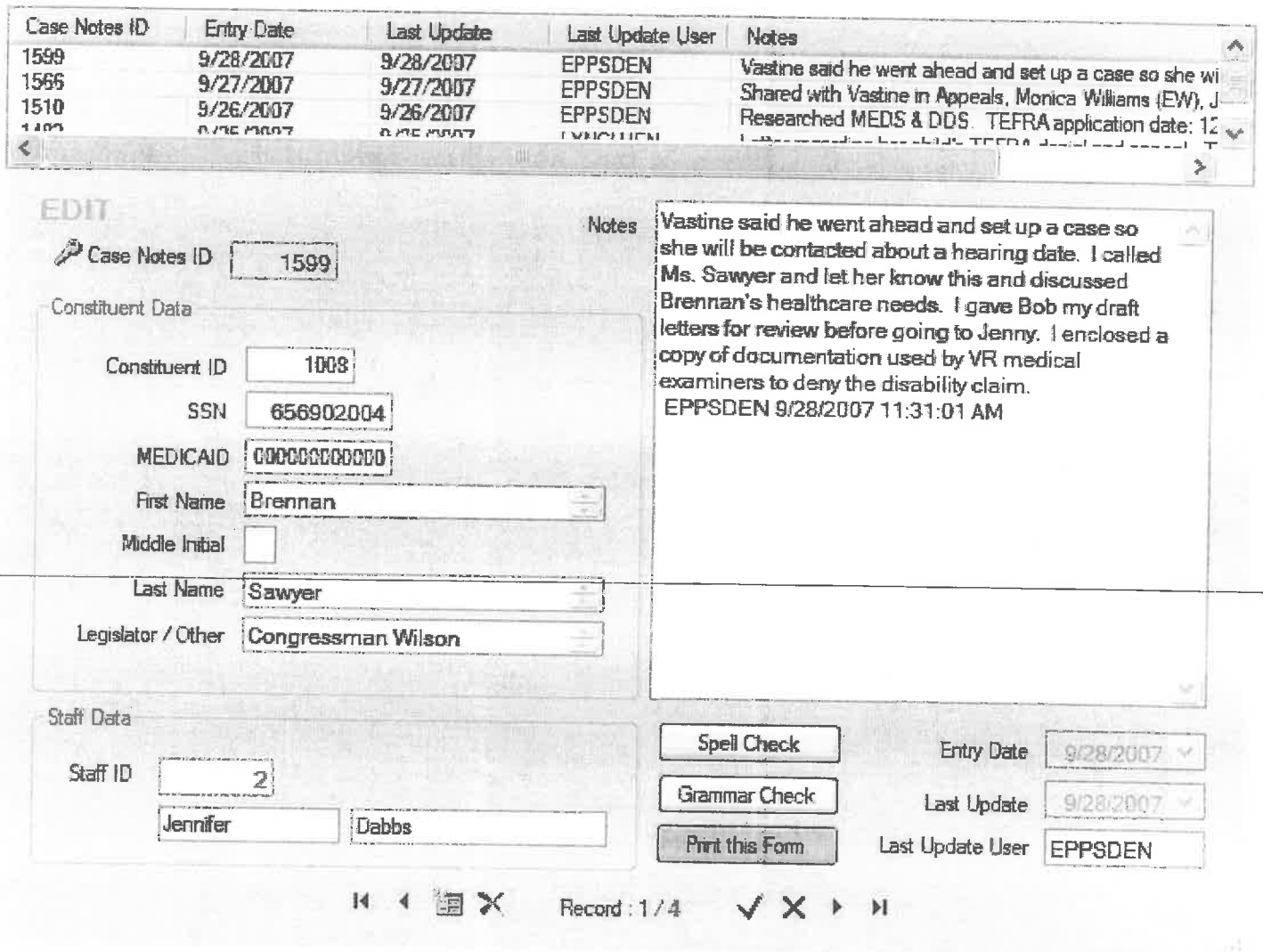
Remarks
GERD AND MEDIA NOT EXPECTED TC
AD SEVERE DO NOT MEET OR EQUAL LI

Disability Examiner

Yvonne M. Wilson

YMW/804
Claim No: G13546
MAO 99 (7/04)





Case Notes ID	Entry Date	Last Update	Last Update User	Notes
1599	9/28/2007	9/28/2007	EPPSDEN	Vastine said he went ahead and set up a case so she wi
1566	9/27/2007	9/27/2007	EPPSDEN	Shared with Vastine in Appeals, Monica Williams (EW), J
1510	9/26/2007	9/26/2007	EPPSDEN	Researched MEDS & DDS. TEFRA application date: 12

EDIT

Case Notes ID: 1599

Constituent Data

Constituent ID: 1003
SSN: 656902004
MEDICAID: 000000000000
First Name: Brennan
Middle Initial:
Last Name: Sawyer
Legislator / Other: Congressman Wilson

Notes: Vastine said he went ahead and set up a case so she will be contacted about a hearing date. I called Ms. Sawyer and let her know this and discussed Brennan's healthcare needs. I gave Bob my draft letters for review before going to Jenny. I enclosed a copy of documentation used by VR medical examiners to deny the disability claim.
EPPSDEN 9/28/2007 11:31:01 AM

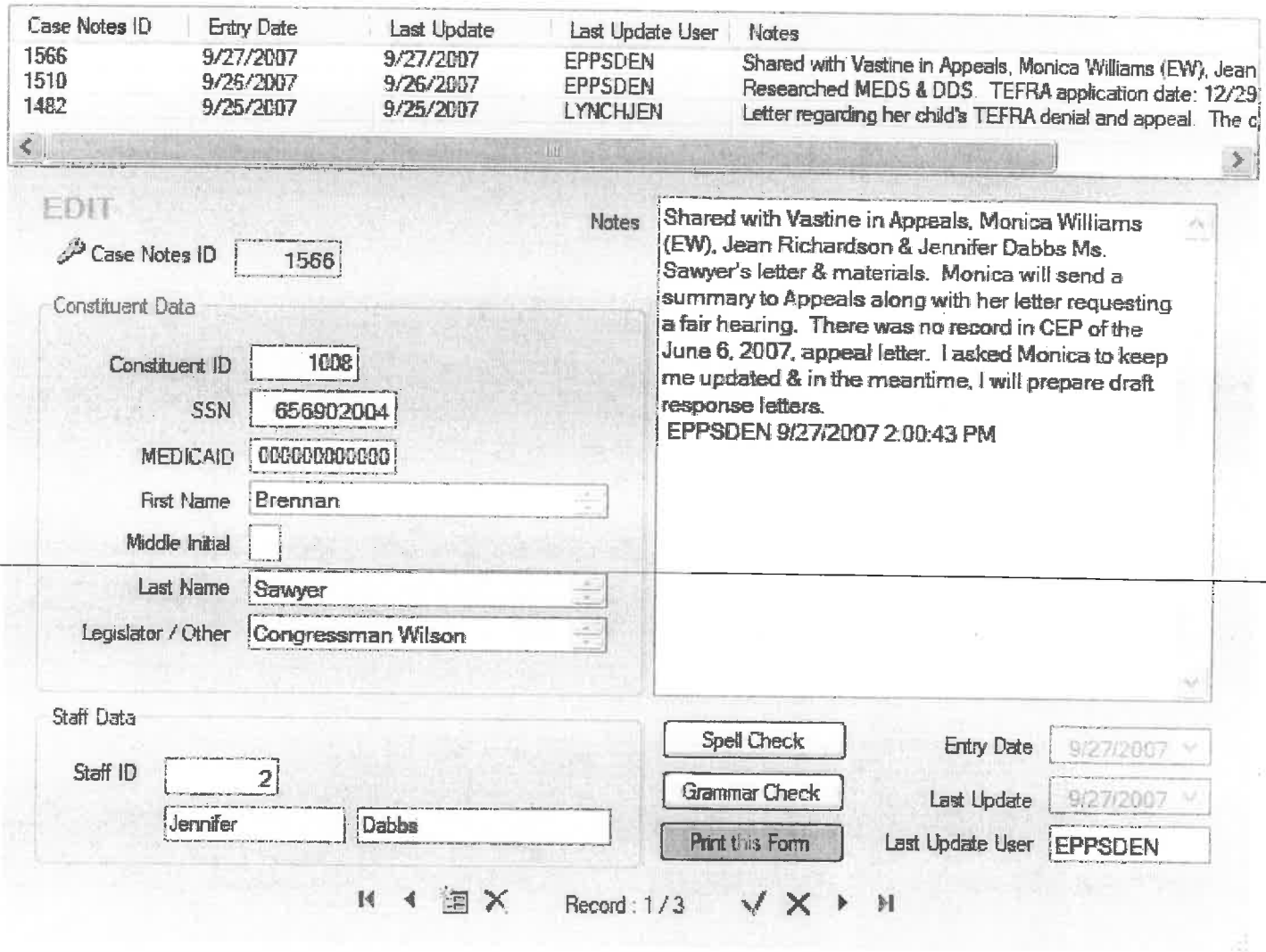
Staff Data

Staff ID: 2
Jennifer Dabbs

Spell Check
Grammar Check
Print this Form

Entry Date: 9/28/2007
Last Update: 9/28/2007
Last Update User: EPPSDEN

Record : 1 / 4



Case Notes ID	Entry Date	Last Update	Last Update User	Notes
1566	9/27/2007	9/27/2007	EPPSDEN	Shared with Vastine in Appeals, Monica Williams (EW), Jean
1510	9/26/2007	9/26/2007	EPPSDEN	Researched MEDS & DDS. TEFRA application date: 12/29
1482	9/25/2007	9/25/2007	LYNCHJEN	Letter regarding her child's TEFRA denial and appeal. The c

EDIT

Case Notes ID: 1566

Constituent Data

Constituent ID: 1008
SSN: 656902004
MEDICAID: 00000000000
First Name: Brennan
Middle Initial:
Last Name: Sawyer
Legislator / Other: Congressman Wilson

Notes:

Shared with Vastine in Appeals, Monica Williams (EW), Jean Richardson & Jennifer Dabbs Ms. Sawyer's letter & materials. Monica will send a summary to Appeals along with her letter requesting a fair hearing. There was no record in CEP of the June 6, 2007, appeal letter. I asked Monica to keep me updated & in the meantime, I will prepare draft response letters.
EPPSDEN 9/27/2007 2:00:43 PM

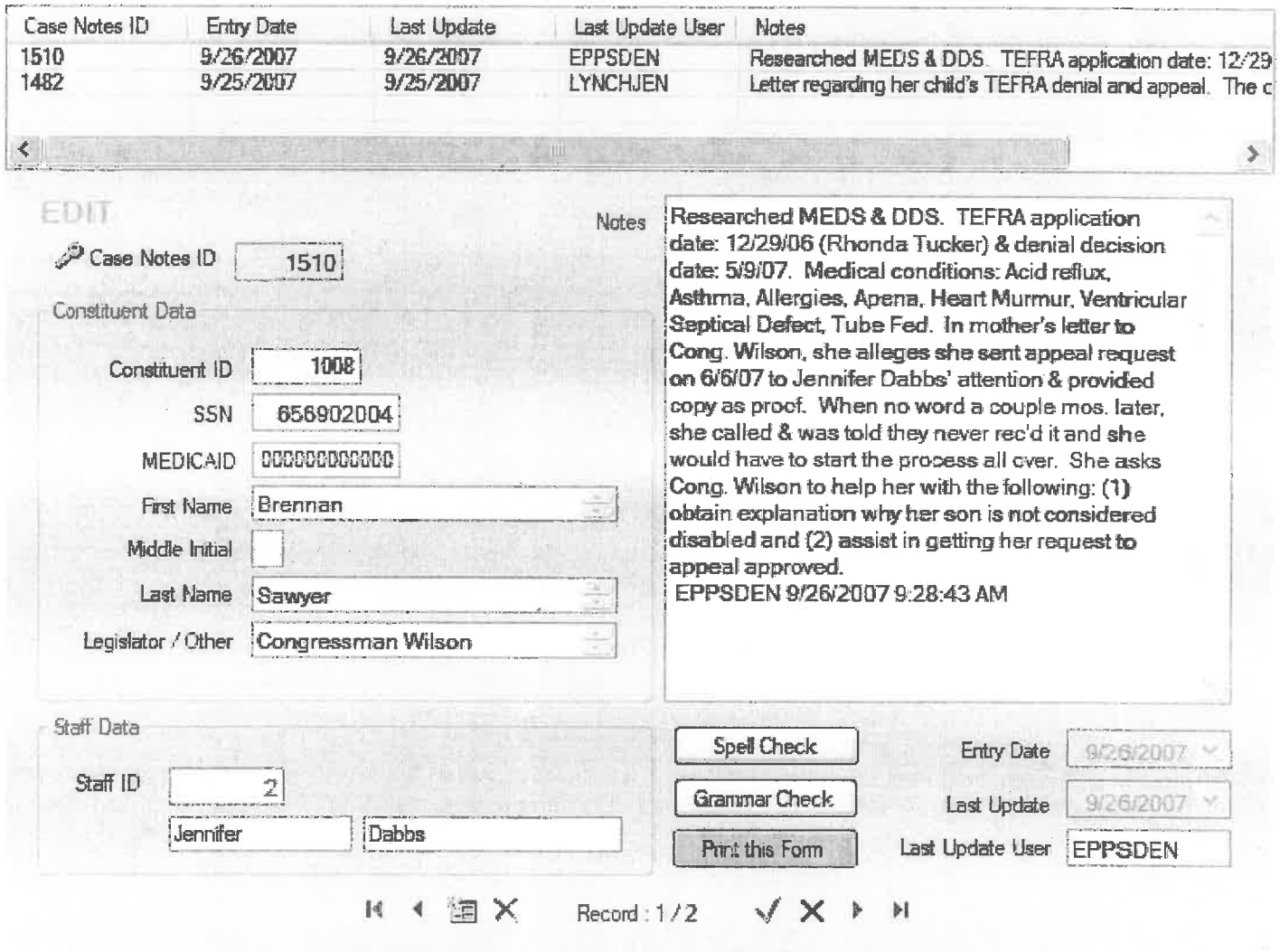
Staff Data

Staff ID: 2
Jennifer Dabbs

Spell Check
Grammar Check
Print this Form

Entry Date: 9/27/2007
Last Update: 9/27/2007
Last Update User: EPPSDEN

Record : 1 / 3



Case Notes ID	Entry Date	Last Update	Last Update User	Notes
1510	9/26/2007	9/26/2007	EPPSDEN	Researched MEDS & DDS. TEFRA application date: 12/29
1482	9/25/2007	9/25/2007	LYNCHJEN	Letter regarding her child's TEFRA denial and appeal. The c

EDIT

Case Notes ID: 1510

Constituent Data

Constituent ID: 1008
SSN: 656902004
MEDICAID: 000000000000
First Name: Brennan
Middle Initial:
Last Name: Sawyer
Legislator / Other: Congressman Wilson

Notes:

Researched MEDS & DDS. TEFRA application date: 12/29/06 (Rhonda Tucker) & denial decision date: 5/9/07. Medical conditions: Acid reflux, Asthma, Allergies, Apena, Heart Murmur, Ventricular Septical Defect, Tube Fed. In mother's letter to Cong. Wilson, she alleges she sent appeal request on 6/6/07 to Jennifer Dabbs' attention & provided copy as proof. When no word a couple mos. later, she called & was told they never rec'd it and she would have to start the process all over. She asks Cong. Wilson to help her with the following: (1) obtain explanation why her son is not considered disabled and (2) assist in getting her request to appeal approved.
EPPSDEN 9/26/2007 9:28:43 AM

Staff Data

Staff ID: 2
Jennifer Dabbs

Spell Check
Grammar Check
Print this Form

Entry Date: 9/26/2007
Last Update: 9/26/2007
Last Update User: EPPSDEN

Record : 1 / 2

EDIT

Constituent ID 1008

Closed? ☐

Date Closed

Source Blue Log

Log No. 0160 Due Date 10/ 1/2007

Print this Form

Constituent Notes

SSN 656-90-2004

MEDICAID ID 0000000000

First Name Brennan MI Last Name Sawyer

Constituent Phone(s) (803) 892-4595 (803) 561-7750

Constituent Phone Extension

HIPAA Authorization

Reason for Referral Medicaid Denial

Staff ID 2 Staff First Name Jennifer Staff Last Name Dabbs

Point of Contact

Authorized Rep Kelly Sawyer

Rep Phone ( ) -

Relationship Mother

Legislator/ Other Congressman Wilson

Entry Date 9/25/2007

Last Update 9/25/2007

Last Update User LYNCHJEN

Apply Cancel Close

Constituent# 1008

Notes ID	Entry Date	Last Update	Notes
1482	9/25/2007	9/25/2007	Letter regarding her child's TEFRA denial and appeal. The original appeal request was not recieved. To Denise to handle LYNCHJEN 9/25/2007 8:22:01 AM

MEDICAID DISABILITY DETERMINATION

Claim Level and Type		Filing Date	SSN
IN MAO6		12/29/06	656-20-9004
Name and Address of Claimant KELLY L SAWYER for BRENNAN T SAWYER 615 WINDMILL RD GILBERT SC 29054		S/A Receipt Date 03/13/07	Date of Birth 05/17/05

Claimant Disabled	B. Onset	C. Diary		
		Type	Mo/Yr	Reason

Claimant Not Disabled DENIED	Primary Diagnosis	Body Sys	Code	Secondary Diagnosis	Body Sys	Code
		05	5690		20	2480
	Other Disorders of (GI) Gastrointestinal System GERD			Otitis Media		

B. Disability Ceased	Basis Code	Reason
	N35-909	NOT EXPECTED TO LAST 12 MONTHS

Med List No.	VR Action A.	B. Screen Out	C. Prev Ref
	☐	[X]	☐

Remarks
GERD AND OTITIS MEDIA NOT EXPECTED TO LAST 12 MOS; VSD AND R
AD SEVERE BUT DO NOT MEET OR EQUAL LISTING

Disability Examiner

Yvonne M. Wilson

Date:
05/09/07

YMW/804
Claim No: G13546
MAO 99 (7/04)

DEVELOPMENT SUMMARY WORKSHEET (INITIAL/RECON)

CLAIM#: G13546
RCPT DATE: 03/13/07
TYPE: MAO6 LEV: IN
CLMNT: 656-20-9004 SAWYER, BRENNAN
W/E:
BIC: DB: 05/17/2005 AGE: 1 SEX: M EDUC:00
STOP WORK DATE: _____ CDB ATTAIN DATE: _____
3PTY: SAWYER, KELLY L PD:
DLI: _____ AOD: 12/29/06 SLC:
BODY SYS: 05 DIGESTIVE DO: BCCP SCDHHS
CTRL DT: _____ PP END DT: _____
MED HOLD:
RECON------ PREV REVIEW PHYSICIAN PREV CE CONSULTANT
IN DENIAL

ADJ: 804 UNIT: 08
Wilson, Yvonne M
PROC TIME: 51

---CLAIMANT ADDRESS---
615 WINDMILL RD
GILBERT SC
29054 (803)892-4595

ALLEGATIONS: acid reflux, asthma/allergies, apnea, heart murmur, ventricular septical defect, diff. eating and breathing, tubes for ears

REMARKS: retro requested 9/06

DEVELOPMENT PROFILE SOURCE	Date & Method of Request (T-Telephone;F-Field;M-Mail) REQ	LTR#	FU	FU	RECVD	
RIDGE PEDIATRIC & AD NOT RCVD	032207	M1	040507 (M)	041907 (M)		
CENTA MEDICAL GROUP	032207	M1			040507	
LEXINGTON MEDICAL CE	032207	M3	040507 (M)		040607	Batesville Hosp
LEXINGTON MEDICAL CE	032207	M3	040507 (M)		041707	
PALMETTO DERMATOLOGY	032207	M1	040507 (M)		041107	

CE TYP	SRCE TEL# & NAME	REQ	EXAM	REMINDER	KEPT	FU	FU	RECVD

DEVELOPMENT SUMMARY
WORKSHEET
(INITIAL/RECON)

CLAIM#: G13546
RCPT DATE: 03/13/07
TYPE: MAO6 LEV: IN
CLMNT: 656-20-9004 SAWYER, BRENNAN
W/E:

ADJ: 804 UNIT: 08
Wilson, Yvonne M

NARRATIVE

Date: 03/22/07 Submitted by: EMG
several additional treating sources listed with dates from 2005

Date: 04/06/07 Submitted by: YMW
LEXINGTON MED CTR
ECHO 8/30/06- SMALL APICAL MUSCULAR VENT SEPTAL DEFECT

Date: 04/06/07 Submitted by: YMW
MER FWD FROM DHHS
RIDGE PEDS & ADOL CTR- 1/24/07- 20 MOS OLD W/ H/O SIGNIF MED PROBS, HOSP AT BIRTH W/TRANSIENT TACHYPNEA, HEART MURMUR DETECTED, DX W/SEVERE GERD, HAS MYRINGOTOMY TUBES DUE TO RECURRENT OTITIS MEDIA, SEVERE RAD ONLY FAIRLY WELL CTRLD ON MEDS, ATOPIC DERMATITIS AND ALLERGIC RHINITIS
INCL GROWTH CHART
ECHO FROM LEX MED CTR-ALREADY REC'VD IN FILE; INCL 2005 ABDOM US, CHEST XRAY, UPPER GI SERIES, ABDOM/KUB; LABS (2006)
PALMETTO RICH MEM HOSP- 9/05- POLYSOMNOGRAM REPORT
INCL WELL CHECKS 5/05-8/06

Date: 04/06/07 Submitted by: YMW
CENTA MED GROUP 3/06-12/06
12/11/06- CHR OM-RESOLVED W/TUBES

Date: 04/11/07 Submitted by: YMW
PALMETTO DERMATOLOGY 8/28/06
KERATOSIS PILARIS W/ MILIA

Date: 04/17/07 Submitted by: YMW
LEXINGTON MED CTR 10/05-1/06
10/31/05- GASTROENTERITIS
1/9/06- RT LOWER LOBE PNEUMONIA, REACTIVE AIRWAY DISEASE

Date: 04/20/07 Submitted by: YMW
P RATING

Date: 04/30/07 Submitted by: YMW
CALLED RIDGE PEDS & ADOL RE: STATUS (DR WALSH NEEDS THESE RECS); ALSO CALLED CL'S MOTHER RE: CARDIOLOGIST REFERRAL, LM 9:35AM 803-892-4595

Date: 05/01/07 Submitted by: YMW
SPOKE W/MOTHER RE: RECS, HE HAS NOT BEEN TO SEE CARDIOLOGIST YET B/C DR HAS WANTED TO GET RESPIRATORY ISSUES RESOLVED FIRST, PEDS HAS BEEN MONITORING HIS HEART CONDITION

Date: 05/02/07 Submitted by: YMW
CALLED RIDGE PEDS & ADOL AGAIN RE: STATUS OF RECS, LM FOR MED RECS B/C THE LADY WHO DOES IT WAS IN WITH THE DOCTOR, 2:37PM

Date: 05/03/07 Submitted by: YMW
CALLED RIDGE PEDS & ADOL AGAIN RE: STATUS, LM FOR MED RECS AGAIN 11:30AM
ALSO CALLED MOTHER AGAIN TO FIND OUT IF SHE WAS ABLE TO GET IN TOUCH W/RIDGE PEDS, LM FOR HER 11:32AM

CLAIM#: G13546
RCPT DATE: 03/13/07
TYPE: MAO6 LEV: IN
CLMNT: 656-20-9004 SAWYER, BRENNAN
W/E:

DEVELOPMENT SUMMARY
WORKSHEET
(INITIAL/RECON)

ADJ: 804 UNIT: 08
Wilson, Yvonne M

NARRATIVE

Date: 05/04/07 Submitted by: YMW

CALLED RIDGE PEDS AGAIN TODAY AND GOT VOICEMAIL AGAIN; MOTHER ALSO HAS NOT CALLED BACK TO LET ME KNOW IF SHE WAS ABLE TO TALK TO RIDGE PEDS RE: STATUS OF RECS; WILL SEE WHAT DR WALSH WANTS TO DO W/FILE NOW SINCE SHE WANTED THOSE RECS

Date: 05/09/07 Submitted by: YMW

STILL NO RESPONSE RE: RECS FROM RIDGE PEDS OR MOTHER

NAME: Brennan Sawyer
SSN: 052-20-9004

MEDICAL EVALUATION REFERRAL

☐ Physical ☒ Pediatric ☐ Onset Only ☐ Re-Eval by _____
☐ Mental ☒ Current ☐ XF40

Allegation(s) acid reflux, asthma/allergies, apnea, heart murmur/ventricular septical defect, difficulty eating + breathing tubes for ears

DE Input/Questions

Examiner: [signature] Date: 4/20/07

Mental Impairments	Current	Projected

Comments

Consultant: _____ Date: _____

Physical Impairments	Current	Projected
Otitis Media	Same	NS
GERD	Same	NS
Reactive Airway Disease	Same	
Congenital Heart Defect (VSD)	Same	

Comments

Consultant: [signature] Date: _____

NELSON WESTON, MD Final Disp Date _____

MXF35 (9/04)

SAWYER KELLY L
SAWYER BRENNAN T
615 WINDMILL RD
GILBERT SC 29054
C/N 656-20-9004
A/N
(803) 892-4595
001 DOB 05/17/2005

08 800
IN MA06
N

BCCP

G13546
G13546

Level of determination:
☒ Initial ☐ CDR ☐ Other _____
☐ Reconsideration ☐ CDR Reconsideration

Is the child engaging in SGA? ☐ Yes ☐ No
Filing Date: _____

I. SUMMARY

A. IMPAIRMENTS:

240 week hx of GERD; RAD, [illegible] USD, chronic [illegible]

B. DISPOSITION: Check one entry that best describes your findings in this case. **Complete this section last.**

1. ☐ **NOT SEVERE** - No medically determinable impairment OR impairment or combination of impairments is a slight abnormality or a combination of slight abnormalities that results in no more than minimal functional limitations. (Explain below.)

Explanation:

☐ Continued in Section III

2. ☐ **MEETS LISTING** _____ . (Cite complete Listing and subsection(s), including any applicable B criteria for 112.00.)

3. ☐ **MEDICALLY EQUALS LISTING** _____ . (Cite complete Listing and subsection(s), including any applicable B criteria for 112.00 and explain below.)

Explanation:

☐ Continued in Section III

4. ☐ **FUNCTIONALLY EQUALS THE LISTINGS** - The child's medically determinable impairment or combination of impairments results in marked limitations in two domains or an extreme limitation in one domain (Explained in Section II A&B), OR the impairment or combination of impairments is one of the examples cited in POMS DI 25225.060 (20 CFR 416.926a(m)), example # _____ (Explained in Section III.)

5. ☒ **IMPAIRMENT OR COMBINATION OF IMPAIRMENTS IS SEVERE, BUT DOES NOT MEET, MEDICALLY EQUAL, OR FUNCTIONALLY EQUAL THE LISTINGS.** (Explained in Section(s) II A&B and, if applicable, III.)

6. ☐ **DOES NOT MEET THE DURATION REQUIREMENT** -The child's medically determinable impairment(s) is or was of listing-level severity, but is not expected to be, or was not, of listing-level severity for 12 continuous months, and is not expected to result in death. (Expained in Section(s) IIA&B and, if applicable, III.)

7. ☐ Other (Specify) _____ (Explained in Section III.)

ASSESSMENT OF FUNCTIONING THROUGHOUT SEQUENTIAL EVALUATION

I affirm, by signing below, that when I evaluated the child's functioning in deciding:

- If there is a *severe impairment(s)*;
- If the impairment(s) *meets or medically equals a listing* (if the listing includes functioning in its criteria); and
- If the impairment(s) *functionally equals the listings*;

I considered the following factors and evidence.

FACTORS:

1. How the child's functioning compares to that of children the same age who do not have impairments; i.e., what the child is able to do, not able to do, or is limited or restricted in doing.

2. Combined effects of multiple impairments and the interactive and cumulative effects of an impairment(s) on the child's activities, considering that any activity may involve the integrated use of many abilities. So,
   - A single limitation may be the result of one or more impairments, and
   - A single impairment may have effects in more than one domain.

3. How well the child performs activities with respect to:
   - Initiating, sustaining, and completing activities independently (range of activities, prompting needed, pace of performance, effort needed, and how long the child is able to sustain activities);
   - Extra help needed (e.g., personal, equipment, medications);
   - Adaptations (e.g., assistive devices, appliances);
   - Structured or supportive settings (e.g., home, regular or special classroom), including comparison of functioning in and outsde of setting, ongoing signs or symptoms despite setting, amount of support needed to function within regular setting.

4. Child's functioning in unusual settings, (e.g., one-to-one, a CE) vs. routine settings (e.g., home, childcare, school).

5. Early intervention and school programs (e.g., school records, comprehensive testing, IEPs, class placement, special education services, accommodations, attendance, participation).

6. Impact of chronic illness, characterized by episodes of exacerbation and remission, and how it interferes with the child's activities over time.

7. Effects of treatment, including adverse and beneficial effects of medications and other treatments, and if they interfere with the child's day-to-day functioning.

EVIDENCE:

For all dispositions, wherever appropriate, I have explained how I considered the medical, early intervention, school/pre-school, parent/caregiver, and other relevant evidence that supports my findings, how I weighed medical opinion evidence, evaluated physical and mental symptoms, resolved any material inconsistencies, and weighed evidence when material inconsistencies in the file could not be resolved. I have considered and explained test results in the context of all the other evidence.

A consultant with overall responsibility for the findings in this MF-538 must complete the first signature line (See 20 CFR 523O.OOIB4). If any additional consultants provided input to these findings, they must also sign in the boxes below.

THESE FINDINGS COMPLETE THE MEDICAL PORTION OF THE DISABILITY DETERMINATION.

Consultant with overall responsibility (Sign, print name and specialty)	Date
S. Wilson Lestourneau Ph.D.	5/7/07
Additional consultant signature (Sign, print name and specialty)	**Date**
Additional consultant signature (Sign, print name and specialty)	**Date**

UNCTIONAL EQUIVALENCE

ider functional equivalence when the child's medically determinable impairment(s) is "severe" but does not meet or cally equal a listing. An impairment(s) functionally equals the listings if it results in "marked and severe functional tions," i.e., the impairment(s) causes "marked" limitations in two domains or an "extreme" limitation in one domain. FOR INITIONS OF "MARKED" AND "EXTREME" see page 5.

Describe and evaluate the child's functioning in all domains; see POMS DI 25225.025-.055 (20 CFR 416.926a(f)-(l)). Then discuss the factors that apply in the child's case and how you evaluated the evidence as described in Section IC above and in POMS DI 25210.001ff. (20 CFR 416.924a). Rate the limitations that result from the child's medically determinable impairment(s).

Check **one** box for **each** domain to indicate the degree of limitation assessed.

A. DOMAIN EVALUATIONS

1. Acquiring and Using Information ☐ No Limitation ☒ Less Than Marked ☐ Marked ☐ Extreme

☐ Continued in Section III

2. Attending and Completing Tasks ☐ No Limitation ☒ Less Than Marked ☐ Marked ☐ Extreme

☐ Continued in Section III

3. Interacting and Relating With Others ☐ No Limitation ☒ Less Than Marked ☐ Marked ☐ Extreme

☐ Continued in Section III

DOMAIN EVALUATIONS (continued)

Moving About and Manipulating Objects ☐ No Limitation ☒ Less Than Marked ☐ Marked ☐ Extreme

☐ Continued in Section III

Caring For Yourself ☐ No Limitation ☒ Less Than Marked ☐ Marked ☐ Extreme

☐ Continued in Section III

Health and Physical Well-Being ☐ No Limitation ☐ Less Than Marked ☒ Marked ☐ Extreme
(Reminder - see additional definitions of marked and extreme for this domain on page 5)

Problems with diverticulitis, GERD, RAD
all seem to be improving but COPD
does not seem to be responding as
severely is monitored

☐ Continued in Section III

CONCLUSION

Does the impairment or combination of impairments functionally equal the listings?

Yes -- Marked limitation in two domains; findings explained in Section IIA.

Marked limitation See POMS DI 25225.020B (20 CFR 416.926a(e)(2)).

The impairment(s) **interferes seriously** with the child's ability to independently initiate, sustain, or complete domain-related activities. Day-to-day functioning may be seriously limited when the child's impairment(s) limits only one activity or when the interactive and cumulative effects of the child's impairment(s) limit several activities.

- "More than moderate" but "less than extreme" limitation (i.e., the equivalent of functioning we would expect to find on standardized testing with scores that are at least two, but less than three, standard deviations below the mean), or
- Up to attainment of age 3, functioning at a level that is more than one-half but not more than two-thirds of the child's chronological age when there are no standard scores from standardized tests in the case record, or
- At any age, a valid score that is two standard deviations or more below the mean, but less than three standard deviations, on a comprehensive standardized test designed to measure ability or functioning in that domain, and the child's day-to-day functioning in domain-related activities is consistent with that score.

For the **"Health and Physical Well-Being"** domain, we may also find a "marked" limitation if the child is frequently ill or has frequent exacerbations that result in significant, documented symptoms or signs. For purposes of this domain, "frequent" means episodes of illness or exacerbations that occur on an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more. We may also find a "marked" limitation if the child has episodes that:

- occur more often than 3 times in a year or once every 4 months but do not last for 2 weeks, or
- occur less often than an average of 3 times a year or once every 4 months but last longer than 2 weeks,

if the overall effect (based on the length of the episode(s) or its frequency) is equivalent in severity.

☐ **Yes -- Extreme limitation in one domain; findings explained in Section IIA.**

Extreme limitation See POMS DI 25225.020C (20 CFR 416.926a(e)(3)).

The impairment(s) **interferes very seriously** with the child's ability to independently initiate, sustain, or complete domain-related activities. Day-to-day functioning may be very seriously limited when the child's impairment(s) limits only one activity or when the interactive and cumulative effects of the child's impairment(s) limit several activities. "Extreme" describes the worst limitations, but does not necessarily mean a total lack or loss of ability to function.

- "More than marked" limitation (i.e., the equivalent of the functioning we would expect to find on standardized testing with scores that are at least three standard deviations below the mean), or
  Up to attainment of age 3, functioning at a level that is one-half of the child's chronological age or less when there are no standard scores from standardized tests in the case record, or
- At any age, a valid score that is three standard deviations or more below the mean on a comprehensive standardized test designed to measure ability or functioning in that domain, and the child's day-to-day functioning in domain-related activities is consistent with that score.

For the **"Health and Physical Well-Being"** domain we may also find an "extreme" limitation if the child is ill or has frequent exacerbations that result in significant, documented symptoms or signs substantially in excess of the requirements for showing a "marked" limitation. However, if the child has episodes of illness or exacerbations of the impairment(s) that we would rate as "extreme" under this definition, the impairment(s) should meet or medically equal the requirements of a listing in most cases.

☐ **No -- Findings explained in Section IIA.**

EXPLANATION OF FINDINGS

: this section:
To explain any functional equivalence "example" cited in disposition 4;
To explain disposition 7;
For any continued explanation of dispositions 1, 3, 5, and 6, or functional equivalence findings that do not fit into Section II;
To discuss any relevant factors and evidence not explained elsewhere; e.g., how you weighed evidence when material inconsistencies in the file could not be resolved;
At the discretion of the adjudicative team, to explain disposition 2; to make clear other issues particular to individual cases; to record all of the required elements of a rationale rather than on an SSA-4268-U4/C4 per POMS DI 25235.001.

DISABILITY DETERMINATION SERVICES
SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT

Providing quality disability determination services to South Carolinians in a responsive, timely and cost-effective manner.

Larry C. Bryant, Commissioner

SCVRD

Office of State Claims ▪ P.O. Box 1868 ▪ Lexington, SC 29071 ▪ (803) 957-1425
Toll-free: (866) 206-5207 ▪ Administrative Fax: (803) 808-8134 ▪ Medical Information Fax: (866) 736-9829

March 22, 2007

218629

LEXINGTON MEDICAL CENTER
ATTN: MEDICAL RECORDS
811 WEST MAIN ST
LEXINGTON SC 29072

RE: BRENNAN T SAWYER

AKA:
ADD: 615 WINDMILL RD
GILBERT SC 29054
Ref. No: G13546
DOB: 05/17/05

This patient has applied for Medicaid benefits under the South Carolina Department of Health and Human Services. We need the following information:

Treatment Records: 010106 TO PRESENT

In-patient records.

Admission/discharge summaries.

X-rays.

Laboratory studies: all.

Operative note.

Pathology report.

Emergency room records.

Out-patient treatment records.

STATE CLAIMS
RECEIVED
MAR 27 2007
LEXINGTON, S.C.

Please submit your response within 10 days. See attached page for instructions on returning your report to the DDS. We pay $25.00 for a copy of treatment records. Out of State requests will be compensated according to that state's established fee schedule. **If payment is required, please sign on the line for "Provider's Signature" and include that page as the TOP document with your report, with this letter underneath.** Thank you.

Sincerely,

9 pgs HJ
3-29-07

Yvonne M. Wilson

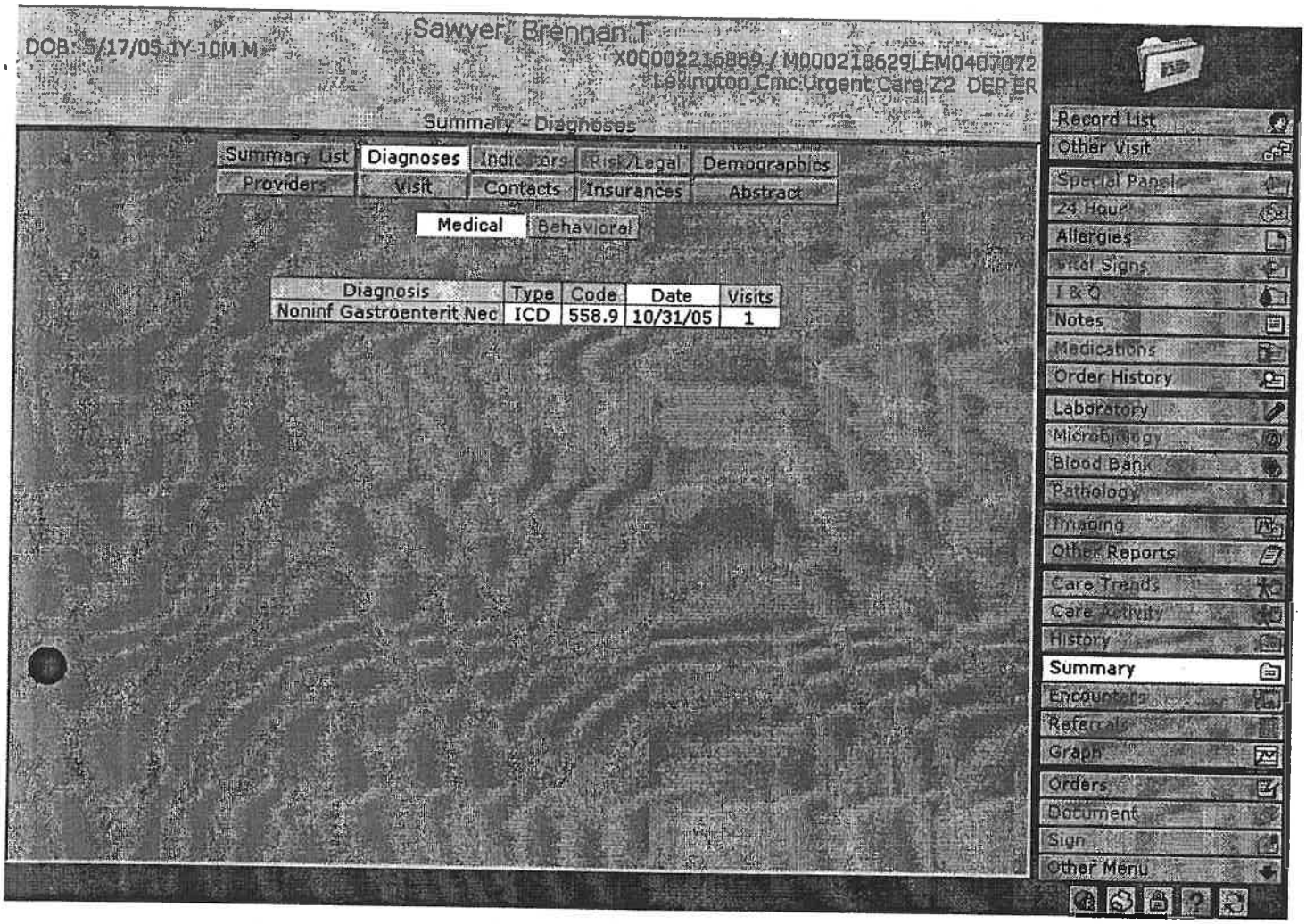
Yvonne M. Wilson, Disability Examiner

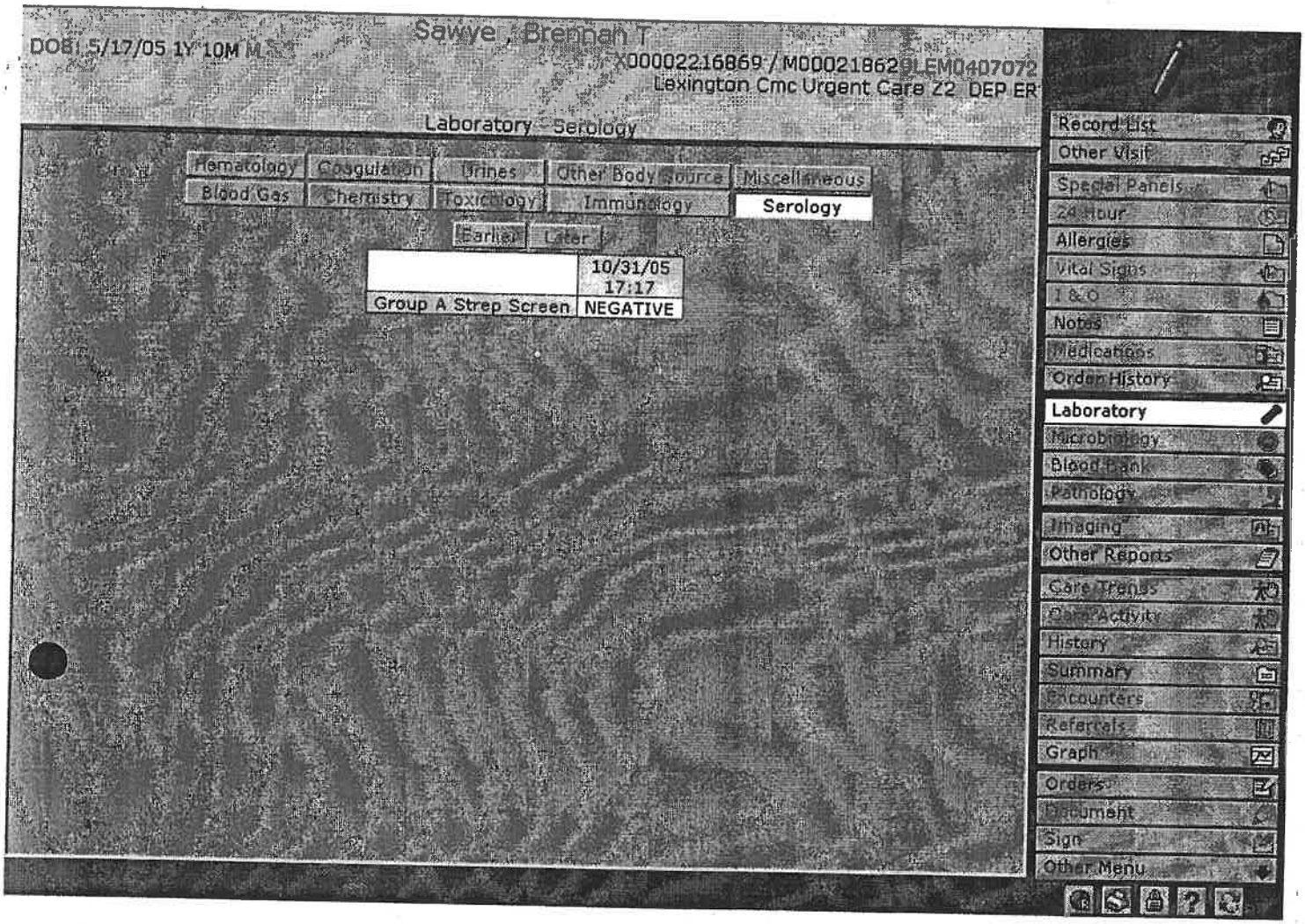
PLEASE INCLUDE THIS LETTER WITH YOUR REPORT.

ENCLOSURE: Release, Envelope
804/EMG

Claim No: G13546
M3 (2/07)

0044695.159
TDN: 0044695159




DOB 5/17/05 1Y 10M M
Sawye , Brennan T
X00002216869 / M000218629LEM0407072
Lexington Cmc Urgent Care Z2 DEP ER
Laboratory - Serology
Hematology
Coagulation
Urines
Other Body Source
Miscellaneous
Blood Gas
Chemistry
Toxicology
Immunology
Serology
Earlier
Later
10/31/05
17:17
Group A Strep Screen
NEGATIVE
Record List
Other Visit
Special Panels
24 Hour
Allergies
Vital Signs
I & O
Notes
Medications
Order History
Laboratory
Microbiology
Blood Bank
Pathology
Imaging
Other Reports
Care Trends
Care Activity
History
Summary
Encounters
Referrals
Graph
Orders
Document
Sign
Other Menu

LEXINGTON
MEDICAL CENTER
811 West Main
Lexington, South Carolina 29072
803-358-6100

PATIENT: SAWYER, BRENNAN T
VISIT DATE: 10/31/2005
ADM. #: X00002216869
M.R. #: M000218629
PHYSICIAN: JAN L. MCBRIDE, MD
D: 10/31/2005 5:04 PM

T: 11/02/2005 9:15 AM / tym

URGENT CARE

CC: Vomiting and fever.

S: Mother noticed that patient vomited yesterday after eating in the evening and then today at day care, she was told that he either refused to eat or he vomited everything he ate throughout the day. They also noted a low grade temperature. He has had no diarrhea. No URI symptoms. he is cutting teeth. PMH: He has had only 1 previous infection that was a mild ear infection, and he had a reaction to penicillin given at that time. He has reflux basically since birth and refluxes liquids that are not thickened with yogurt or something similar. ALLERGIES: PENICILLIN. CURRENT MEDICATIONS: Reglan, Prevacid, and Bromhist. SH: Does attend day care. FH: Noncontributory. ROS: Negative or noncontributory, other than that noted above.

O: VITAL SIGNS: Pulse 158, respirations 14, temperature 98.7, O2 sat 100%. GENERAL: Well-developed, well-nourished, healthy appearing 5-month-old white male, active, alert, and in no acute distress. Appears well hydrated. Fussy. HEENT: Normocephalic. Sclerae and conjunctivae clear. TMs noninflamed. Nose with no rhinorrhea or congestion. LUNGS: Clear to auscultation. HEART: Regular rate and rhythm. ABDOMEN: Soft and nontender. Bowel sounds normoactive.

A: Gastroenteritis.

P: Mother advised to give Pedialyte this evening and tomorrow morning, and if he has continued vomiting tomorrow or a higher fever, to have him rechecked.

ADDENDUM

S: After patient was discharged, mother noted he had a rash on his legs and I reexamined him.

O: SKIN: A scattered macular rash on the legs and also on the arms and slightly on the abdomen. None on the back. It does blanch with pressure. The area on the arms is slightly raised. DIAGNOSTIC STUDIES: Rapid strep screen came up negative.

A: Viral exanthem.

P: Proceed as planned on the previous note.

JAN L. MCBRIDE, MD

cc:

LEXINGTON
MEDICAL CENTER
811 West Main
Lexington, South Carolina 29072
803-358-6100

PATIENT: SAWYER, BRENNAN T
VISIT DATE: 10/31/2005
ADM. #: X00002216869
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D: 10/31/2005 5:04 PM

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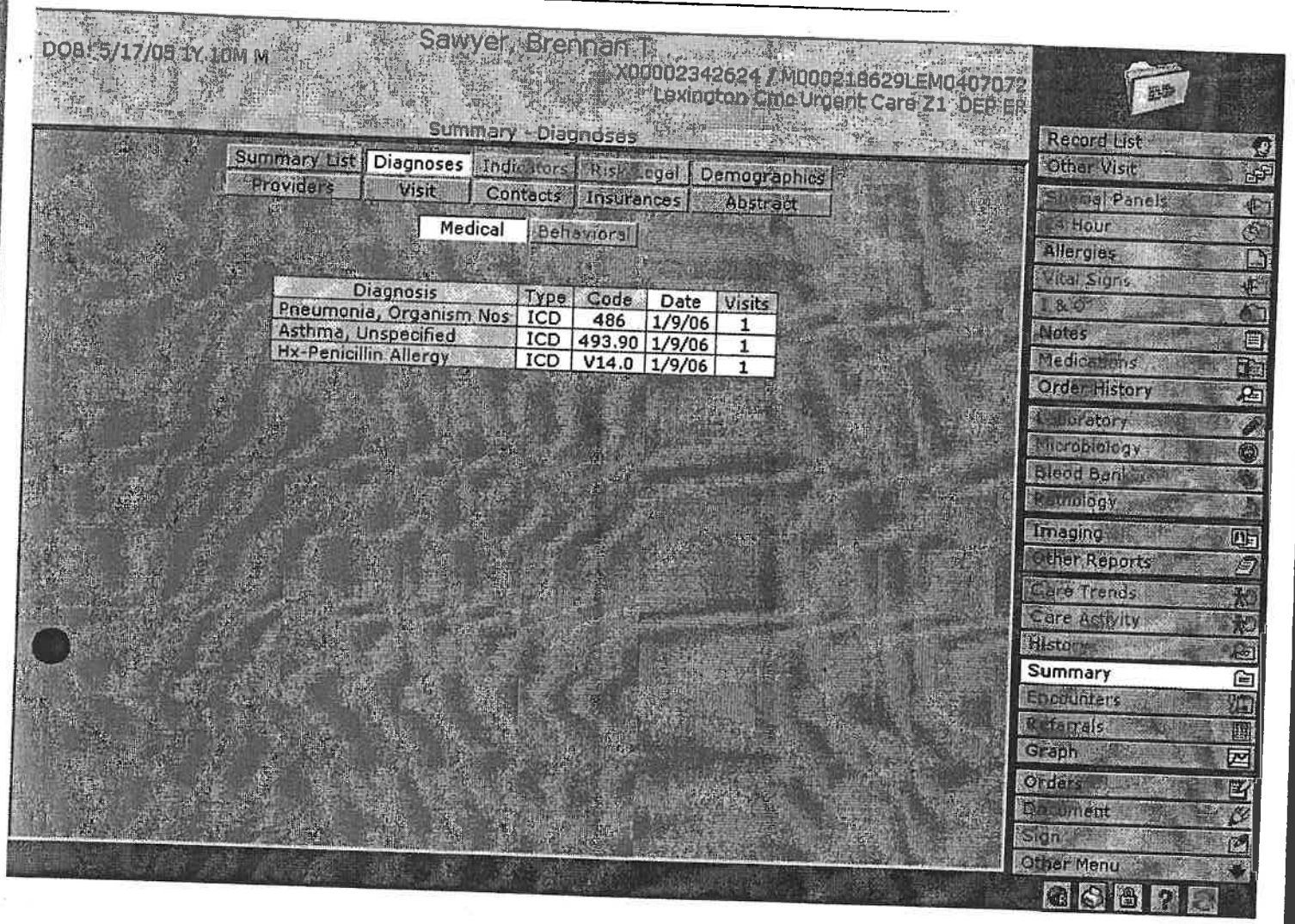
A: Gastroenteritis.

P: Mother advised to give Pedialyte this evening and tomorrow morning, and if he has continued vomiting tomorrow or a higher fever, to have him rechecked.

JAN L. MCBRIDE, MD

cc:


DOB: 5/17/05 1Y 10M M
Sawyer, Brennan T
X0000234262 / M000218629LEM0407072
Lexington Clinic Urgent Care Z1 DEP ER
Summary - Diagnoses
Summary List
Diagnoses
Indicators
Risk/Legal
Demographics
Providers
Visit
Contacts
Insurances
Abstract
Medical
Behavioral
Diagnosis | Type | Code | Date | Visits
Pneumonia, Organism Nos | ICD | 486 | 1/9/06 | 1
Asthma, Unspecified | ICD | 493.90 | 1/9/06 | 1
Hx-Penicillin Allergy | ICD | V14.0 | 1/9/06 | 1
Record List
Other Visit
Allergies
Vital Signs
I & O
Notes
Medications
Order History
Laboratory
Microbiology
Imaging
Other Reports
Care Trends
Care Activity
History
Summary
Encounters
Graph
Orders
Sign
Other Menu

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER – LEXINGTON
811 WEST MAIN STREET
LEXINGTON, SC 29073
PHONE: (803) 358-6120

PATIENT: **SAWYER,BRENNAN T**

AGE: 7M 24D
DOB: 05/17/2005
SEX: M

UNIT/MR NO: M000218629
ACCT NO: X00002342624
SSN: 000-00-0000
REQ NO: 06-0000639
REPORT NO: 0110-0033

ORDERING DR: **WESLEY H SHULER MD**

PT LOCATION: LEXURG
SHUWES EM

COPY TO: WESLEY H SHULER MD
STUDY TYPE: 0109-0067 LRAD/CHEST 2 VIEWS

DATE OF EXAM: **01/09/06**

CLINICAL DATA: COUGH AND CONGESTION.

DEP ER LEXURG
7M 23DM

CHEST (TWO VIEWS):

Two views of the chest show bilateral pulmonary haziness. Lung volumes are somewhat diminished. I suspect that the haziness is due to low lung volumes rather than to pneumonitis. However, I am not entirely certain.

>>> IMPRESSION: Expiratory infant chest results in bilateral pulmonary haziness. It would be difficult to exclude acute pneumonitis.

HER

CHARLES G HOOD MD

REPORT STATUS: Signed

ORDER#/PROCEDURE: **0109-0067 LRAD/CX2 (71020TC)**
EXAM TECH: **ECLIN**
LEXURG/
REP RELEASED BY: **HOOCHA RAD 01/10/06 1340**
ADD RELEASED BY:
DISC DATE: **01/09/06**
ED DISC DIAG:

PT LOC/ROOM:

SAWYER,BRENNAN T

LEXINGTON MEDICAL CENTER
811 West Main
Lexington, South Carolina 29072
803-358-6100

PATIENT: SAWYER, BRENNAN T
VISIT DATE: 01/09/2006
ADM. #: X00002342624
M.R. #: M000218629
PHYSICIAN: WESLEY H SHULER, MD
D: 01/09/2006 9:52 PM

T: 01/10/2006 11:35 AM / ksb

URGENT CARE

CC: Cough and congestion.

S: This is a 7-month-old male with the recent onset of nasal congestion, cough, and wheezing. He has not had any fevers at home. PMH: Unremarkable. CURRENT MEDICATION: Donatussin, Dimetapp, Prevacid. ALLERGIES: PENICILLIN. ROS: Patient has been in a normal state of health other than above. All other systems reviewed negative.

O: VITAL SIGNS: TEMP 97.5, pulse 137, respirations 26, O2 SAT 99%. GENERAL: Alert. No nasal flaring or intercostal retractions. HEENT: Ear canals and drums clear. Nose congested. Throat clear. CHEST: Wheezes. CARDIOVASCULAR: Regular sinus rhythm. DIAGNOSTIC STUDIES: Chest x-ray shows infiltrate in right lower lobe. RSV done, report will be called to mother.

A: Right lower lobe pneumonia, reactive airway disease.

P: Rx Albuterol syrup 1/2 tsp. every 8 hours, Septra suspension 1 tsp. every 12 hours. See regular doctor in follow-up. Tylenol or Ibuprofen p.r.n. Recheck p.r.n.

_____
WESLEY H SHULER, MD

cc:
LINDA WINGARD, MD

DISABILITY DETERMINATION SERVICES

SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT

Providing quality disability determination services to South Carolinians in a responsive, timely and cost-effective manner.

Larry C. Bryant, Commissioner

SCVRD

Office of State Claims ▪ P.O. Box 1868 ▪ Lexington, SC 29071 ▪ (803) 957-1425
Toll-free: (866) 206-5207 ▪ Administrative Fax: (803) 808-8134 ▪ Medical Information Fax: (866) 736-9829

106335

March 22, 2007

DDS - STATE CLAIMS RECEIVED APR 11 2007 S.C.

PALMETTO DERMATOLOGY PA
105 WEST HOSPITAL DRIVE
W COLUMBIA SC 29169

RE: BRENNAN T SAWYER
AKA:
ADD: 615 WINDMILL RD
GILBERT SC 29054

Ref. No: G13546
DOB: 05/17/05

ATTN: MEDICAL RECORDS

Your patient has applied for Medicaid benefits under the South Carolina Department of Health and Human Services. We need the following information:

Treatment records: 01/01/06 TO PRESENT

PLEASE SEND US COPIES OF YOUR RECORDS OR A NARRATIVE prepared in your office or dictated using the SC Dictation System. In a narrative please describe the HISTORY, OBJECTIVE FINDINGS, SEVERITY, ONSET, AND DURATION of impairment. Note the individual's ability to perform work-related physical and mental activities.

Is your patient capable of handling monthly benefits in his/her own best interest? _____Yes ___✓___No

Physician's Signature Keith Yoe PA

If a consultative examination is necessary, are you willing to perform the examination (including history, examination, and written report)? Yes _____ No ___✓___

We pay South Carolina physicians $15.00 for a copy of treatment records, for a narrative submitted through our teledictation system prepared in a physician's office. Out of state physicians are paid according to the fee schedule effective in that state. **Do not complete payment instructions unless records/reports are sent with this request.**

See attached page for instructions on returning your report to the DDS. **If payment is required, please sign on the line for "Provider's Signature" and include that page as the TOP document with your report, with this letter underneath. Thank you.**

Sincerely,

Yvonne M. Wilson

Yvonne M. Wilson, Disability Examiner

0044695197
TDN: 0044695197

PLEASE INCLUDE THIS LETTER WITH YOUR RESPONSE.

Enclosure: Release, Envelope
EMG/804
Claim No: G13546
M1 (2/07)

Allergies
Per

Patient: Brennan Ferguson New/Estab. (L.O.V.:) Date 8-28-06

Nurse Assessment: 15 month old baby

Medications: listed Hx sheet Jody

Chief Complaint(s):

History of Present Illness:
1. Location
2. Duration
3. Signs/Symptoms
4. Modifying factors
5. Past Treatments (OTC/Rx)

Places that itch forehead, Rt Cheek, for 4-5 months

Going & Coming

DDS - STATE CLAIMS RECEIVED APR 11 2007 LEXINGTON, S.C.

Past Medical hx: Dysplastic nevus, MM, BCC, SCC, PMK, None.
yes, specifiy:

Past Family / Social / ROS History (see sheet dated ___/___/___)
significant changes

Areas Examined:

- ☐ Declines Full Skin Exam
- ☐ Scalp/Hair
- ☑ Head/Face
- ☐ Conj/Eyelids
- ☐ Neck
- ☐ Lips/Teeth/Gums
- ☐ Chest/Breast/Axilla
- ☐ back
- ☐ Abdomen
- ☐ Genitalia/Groin/Buttocks
- ☐ R/L ↑Extremity
- ☑ R/L ↓Extremity
- ☐ Digits/Nails
- ☐ _____

Ow hite papule to (LT) knee, skin very dry to face arms legs & back

Diagnosis/Plan: 1) Keratosis Pilaris & Milia

Lactic acid lotion daily to AA.

n by: McElveen/Thompson/Roberts/Fox Nurse: _____ RTO PRN

DISABILITY DETERMINATION SERVICES
SOUTH CAROLINA VOCATIONAL REHABILITATION DEPARTMENT

Providing quality disability determination services to South Carolinians in a responsive, timely and cost-effective manner.
Larry C. Bryant, Commissioner

Office of State Claims ▪ P.O. Box 1868 ▪ Lexington, SC 29071 ▪ (803) 957-1425
Toll-free: (866) 206-5207 ▪ Administrative Fax: (803) 808-8134 ▪ Medical Information Fax: (866) 736-9829
SCVRD

March 22, 2007

M00021860?
8-30-06 Echo
1400085d 71735

LEXINGTON MEDICAL CENTER
ATTN: MEDICAL RECORDS
2720 SUNSET BOULEVARD
W COLUMBIA SC 29169

MAR 26 2007

RE: BRENNAN T SAWYER
AKA:
ADD: 615 WINDMILL RD
GILBERT SC 29054
Ref. No: G13546
DOB: 05/17/05

This patient has applied for Medicaid benefits under the South Carolina Department of Health and Human Services. We need the following information:

DDS - STATE CLAIMS RECEIVED APR 06 2007 LEXINGTON, S.C.

Treatment Records: 010106 TO PRESENT

In-patient records.

Admission/discharge summaries.

X-rays.

Laboratory studies: all.

Operative note.

Pathology report.

Emergency room records.

Out-patient treatment records.

PROCESSED BY QCS
ENTIRE ABSTRACT X OUT-PATIENT EMERGENCY
DO/S: 5/8/07
PAGES:
COMMENTS:
COPIED BY: DATE: 4-3-07

Please submit your response within 10 days. See attached page for instructions on returning your report to the DDS. We pay $25.00 for a copy of treatment records. Out of State requests will be compensated according to that state's established fee schedule. **If payment is required, please sign on the line for "Provider's Signature" and include that page as the TOP document with your report, with this letter underneath.** Thank you.

Sincerely,

Yvonne M. Wilson

Yvonne M. Wilson, Disability Examiner

PLEASE INCLUDE THIS LETTER WITH YOUR REPORT.

ENCLOSURE: Release, Envelope
804/EMG

Claim No: G13546
M3 (2/07)

0044695113
TDN: 0044695113

iod incorporated has been retained by the Health Information Services Department of

LEXINGTON MEDICAL CENTER

to fulfill requests for copies of medical records. Enclosed are the reproduced medical documents specifically authorized by the patient or his/her legal representative. We wish to emphasize that the increasing demands for patient data pose a rising threat to the confidentiality of the patient's medical information. **iod incorporated** strives to take every opportunity to safeguard the patients' right to privacy as outlined in the AHA's Patient Bill of Rights. Specifically, all patients have the right "to expect that all communications and records pertaining to their care will be treated as confidential by the hospital and any other party entitled to review certain information in such records." As one such party, we ask that all information transmitted herewith be treated with utmost respect and the dignity such personal medical information warrants. Please be advised of the following state and federal disclosure statements governing medical records.

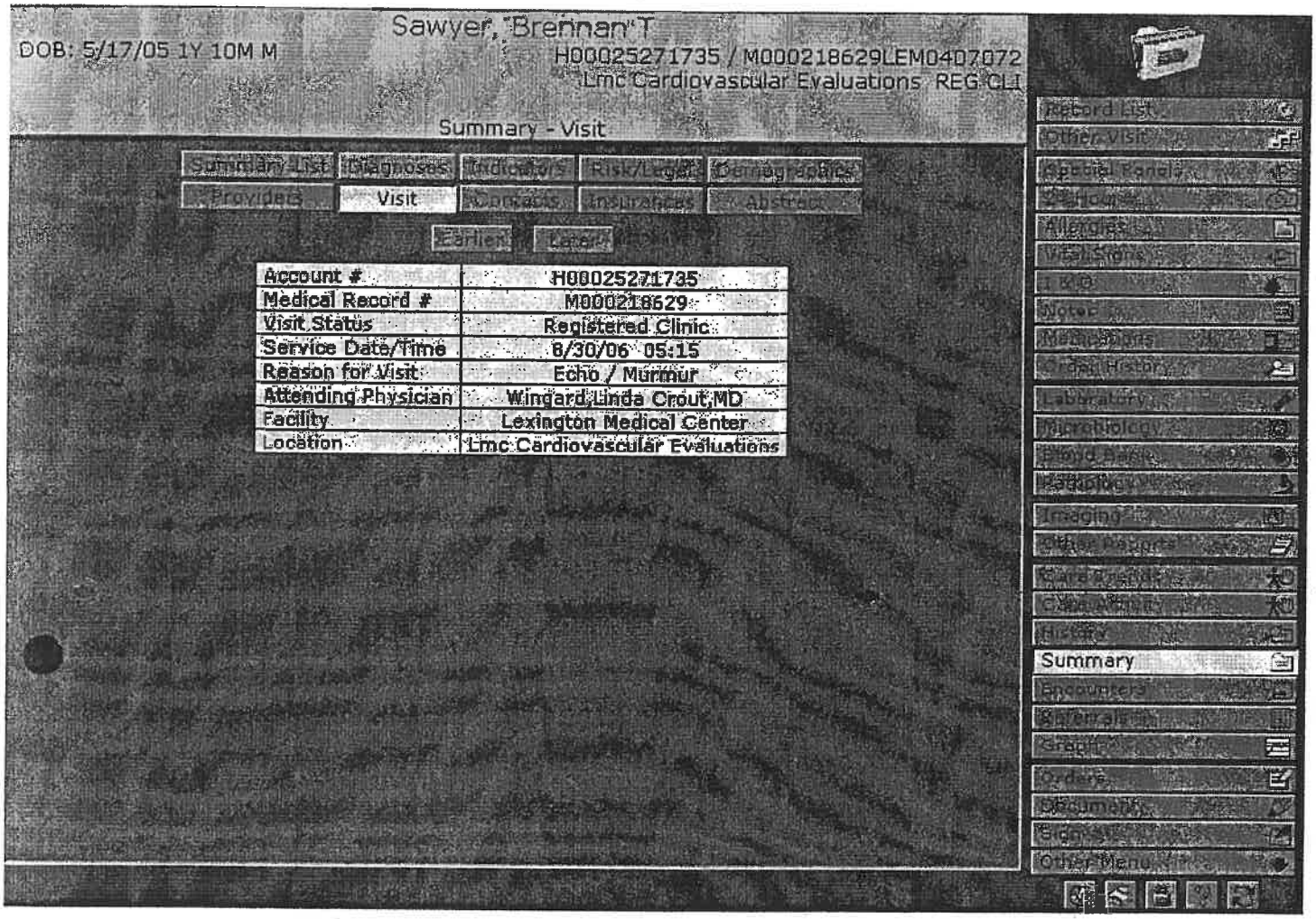
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

This information has been disclosed to you from state records whose confidentiality is protected by SC state statute. State regulations limit your right to make any further disclosure of this information without prior consent of the person to whom it pertains.

This information has been disclosed to you from records protected by SC State law. SC State law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the HIV related statute provided for in state law. A general authorization for the release of medical or other information is not sufficient for this purpose.

Based upon guidelines provided by the American Health Information Management Association, the records should be destroyed after the stated need has been fulfilled.

We thank you for your cooperation in maintaining the patient's right to privacy. Each medical record has been carefully reviewed to assure that proper disclosure goes only to the authorized Requestor. If you have any questions, please do not hesitate to contact us at 1-800-236-3355 and one of our Customer Service Representatives will be happy to assist you.



LEXINGTON
MEDICAL CENTER
2720 Sunset Boulevard
West Columbia, South Carolina 29169
803-791-2000

ECHOCARDIOGRAM

PATIENT: SAWYER, BRENNAN T
LOCATION: HCVE
ADM. #: H00025271735
M.R. #: M000218629
ADMITTED: 08/30/2006
D: 08/30/2006 3:49 PM
DISCHARGED:
T: 08/30/2006 3:55 PM / dnm
PHYSICIAN: LUTHER C WILLIAMS, III, MD

PROCEDURE PERFORMED: Transthoracic echocardiogram was performed with M-mode, 2-D, spectral Doppler, and color flow Doppler analysis.

DATE OF PROCEDURE: 08/30/2006.

CLINICAL INDICATIONS: M-mode, 2-D, spectral, and color flow Doppler study was performed on this patient with a cardiac murmur.

TECHNICAL FINDINGS: The study shows normal cardiac chamber and great vessel segmental relationships. Left ventricular systolic function is satisfactory. A small apical muscular ventricular septal defect is identified. The left-to-right shunt is quite small. Examination of the great arteries discloses no evidence of ductal patency or aortic arch obstruction. Pulmonary venous connections are to the left atrium. The atrial septum appears to be intact. The aortic valve and coronary arteries are normal. No intracardiac masses or vegetations are seen. No pericardial effusion is present.

IMPRESSION: Small apical muscular ventricular septal defect.

SIGNED REPORT IN THE DEPARTMENT.

LUTHER C WILLIAMS, III, MD

MEDICAID REPORT OF CONTACT

VR CONTACT	APPLICANT/BENEFICIARY
NAME: Vocational Rehabilitation	NAME: **Brennan T. Sawyer**
	SOCIAL SECURITY NUMBER: xxx-xx-9004
FROM: Deron Gray	COUNTY:
DHHS DEPARTMENT OF DISABILITY DETERMINATIONS	CATEGORY:

☒ PLEASE ASSOCIATE ATTACHED MATERIAL WITH FILE FORWARDED TO YOU ON 03/13/07

☐ PRIOR CDR RECORDS ATTACHED PER YOUR REQUEST.

☐ PLEASE ADD DATE OF REVIEW TO YOUR DETERMINATION.

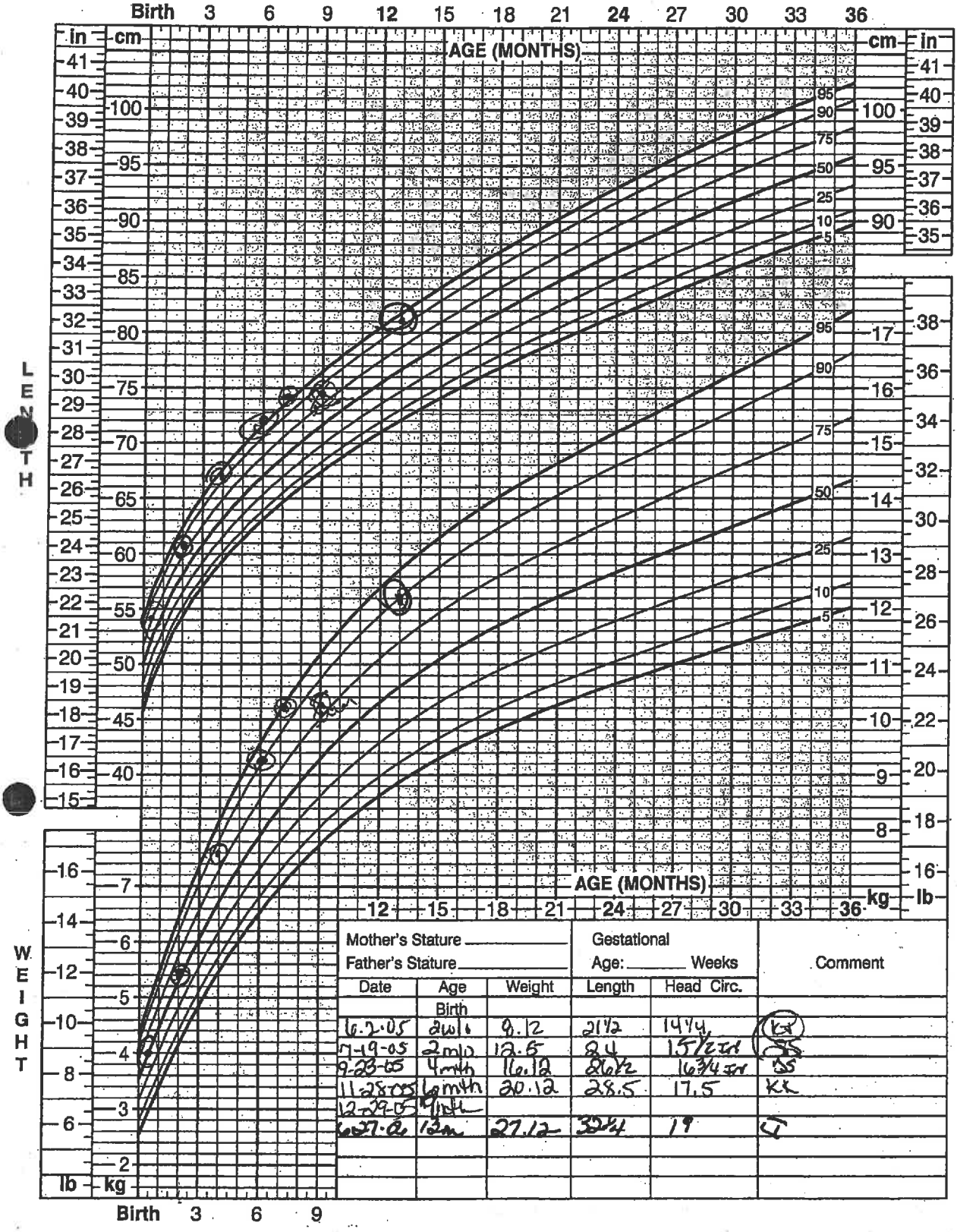
Deron Gray	Program Assistant	04/03/2007
SIGNATURE	TITLE	DATE

Boys, birth to 36 months

Name BRENNAN SAWYER
5-17-05

LENGTH FOR AGE AND WEIGHT FOR AGE PERCENTILES

Record # _____



Mother's Stature _____ Father's Stature _____			Gestational Age: _____ Weeks		Comment
Date	Age	Weight	Length	Head Circ.	
	Birth				
6.2.05	2w/6	8.12	21½	14¼	(KK)
7-19-05	2m/0	12.5	24	15½	(SS)
9-23-05	4mth	16.12	26½	16¾	SS
11-28-05	6mth	20.12	28.5	17.5	KK
12-29-05	7mth				
4.27.06	12m	27.12	32¼	19	KK

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

CDC

Source: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). http://www.cdc.gov/growthcharts

Reprinted by the American Academy of Pediatrics

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Additional copies are available for purchase in quantities of 100.

To order, contact:
American Academy of Pediatrics
141 Northwest Point Blvd
Elk Grove Village, IL 60007-1098
Web site — http://www.aap.org. Minimum order 100.

D H E C

PROMOTE PROTECT PROSPER

Immunization Information

Vaccine Information Statements (VIS) must be given to the patient/guardian prior to administering immunizations. Give patient/guardian opportunity to ask questions.

Vaccine Circle Type Given	Dose	Date Given	Injection Site	Injection Route Circle, if applicable	Vaccine Manufacturer	Vaccine Lot or Control Number	VIS Date	Provider ID See ID Below	VAFAC Eligibility Status See Code Table Below
HBIG				IM					
Hep B	1	5/25/05	JCN	IM					
Hep B	2	7-19-05	Rt	IM	merck	D854H 4/06		JS	#6
Hep B	3	12-29-05	Rt	IM	GSK	AC21B047AA 4/08		RL	
IPV	1	7-19-05	Rt	IM or SQ	Aventis	U2165 3/07		JS	#6
IPV	2	9-23-05	Rt	IM or SQ	Aventis	U0325 4/07		JS	
IPV	3	12-29-05	Rt	IM or SQ	GSK	AC21B047AA 4/08		RL	
IPV	4			IM or SQ					
DTaP•DT	1	7-19-05	Lt	IM	GSK	AC14A011AA 4/06		JS	#6
DTaP•DT	2	9-23-05	Lt	IM	GSK	AC14B009AA 3/07		JS	
DTaP•DT	3	12-29-05	Rt	IM	GSK	AC21B047AA 4/08		RL	
DTaP•DT	4	7-25-06	Rt Lt	IM	GSK	AC14B018AA 4/08		CW DS	not given
DTaP•DT #5	5	8-21-06	Lt	IM	GSK	AC14B018AA 04/08		CW	
DTaP	#5								
Td	1			IM					
Td	2			IM					
Td	3			IM					
Hib	1	7-19-05	Rt	IM	merck	D854H 4/06		JS	#6
Hib	2	9-23-05	Lt	IM	merck	1082P 3/07		JS	
Hib	3	12-29-05	Lt	IM	Merck	0621R 4/08		RL	
Hib	4	7-25-06	Rt	IM	merck	0005F 6/06		JS	not given
Hib #5	5	8-21-06	Rt		merck	0005F 6/08		CW	
PCV	1	9-23-05	Rt	IM or SQ	Wyeth	A4445H 3/07		JS	
PCV	2	12-29-05	Rt	IM or SQ	Wyeth	B0864H 7/07		RL	
PCV	3	7-25-06	Rt	IM or SQ	Wyeth	B0865C 7/07		JS	
PCV	4	8-21-06	Rt	IM or SQ	Wyeth	B0865C 12/07		CW	
MMR	1	7-25-06	Rt Lt	SQ	merck	0465F 5/07		D	
MMR	2			SQ					
VAR	1	7-25-06		SQ					
VAR	2			SQ					

Varicella Disease: Yes ☐ Date Box Checked ___/___/___ Check box if child has a reliable history of Chickenpox**

Other Immunizations

Fluzone Aventis U1770AA 6/06 LT KKuehnhgen 12-22-05

ALLERGIES/COMMENTS:

PRACTICE NAME & ADDRESS:

VAFAC Eligibility Status Code Table
1 = Medicaid
2 = Uninsured
3 = Underinsured
4 = American Indian
5 = Alaskan Native
6 = Insurance pays 100%

Provider ID: Each person administering vaccines to this patient should sign below, and place their initials next to their signature. When immunizations are administered, the provider only needs to record his/her initials in the Provider ID column.

Domecka Shepherd

Patient's Name Brennan Sawyer

Patient's Date of Birth 5-17-05

Patient's ID Number

**A reliable history of Chickenpox is defined as: 1). Physician interpretation of parent/guardian description of Chickenpox: 2). Physician diagnosis of Chickenpox; or 3). Serologic proof of immunity.

LEXINGTON MEDICAL CENTER
2720 Sunset Boulevard
West Columbia, South Carolina 29169
803-791-2000

ECHOCARDIOGRAM

PATIENT: SAWYER, BRENNAN T
LOCATION: HCVE
ADM. #: H00025271735
M.R. #: M000218629
ADMITTED: 08/30/2006
D: 08/30/2006 3:49 PM
DISCHARGED:
T: 08/30/2006 3:55 PM / dnm
PHYSICIAN: LUTHER C WILLIAMS, III, MD

PROCEDURE PERFORMED: Transthoracic echocardiogram was performed with M-mode, 2-D, spectral Doppler, and color flow Doppler analysis.

DATE OF PROCEDURE: 08/30/2006.

CLINICAL INDICATIONS: M-mode, 2-D, spectral, and color flow Doppler study was performed on this patient with a cardiac murmur.

TECHNICAL FINDINGS: The study shows normal cardiac chamber and great vessel segmental relationships. Left ventricular systolic function is satisfactory. A small apical muscular ventricular septal defect is identified. The left-to-right shunt is quite small. Examination of the great arteries discloses no evidence of ductal patency or aortic arch obstruction. Pulmonary venous connections are to the left atrium. The atrial septum appears to be intact. The aortic valve and coronary arteries are normal. No intracardiac masses or vegetations are seen. No pericardial effusion is present.

IMPRESSION: Small apical muscular ventricular septal defect.

SIGNED REPORT IN THE DEPARTMENT.

LUTHER C WILLIAMS, III, MD

LEXINGTON MEDICAL CENTER

cc:

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER -- LEXINGTON
811 WEST MAIN STREET
LEXINGTON, SC 29073
PHONE: (803) 358-6120

PATIENT: **SAWYER,BRENNAN**

AGE: 2M 26D
DOB: 05/17/2005
SEX: M

UNIT/MR NO: M000218629
ACCT NO: X00002063618
SSN:
REQ NO: 05-0015831
REPORT NO: 0812-0057

ORDERING DR: **LINDA WINGARD MD**

PT LOCATION: LEXULT
WINLIN PED

COPY TO: LINDA WINGARD MD
STUDY TYPE: 0812-0007 LULT/US ABDOMEN LIMITED

DATE OF EXAM: **08/12/05**

REG CLI LEXULT
2M 26DM

CLINICAL DATA: PROJECTILE VOMITING

LIMITED ABDOMINAL ULTRASOUND:

FINDINGS: Sonogram of the pyloric channel demonstrates the pyloric channel to not be abnormally lengthened or thickened. Sonographer technologist notes the channel to open during the exam allowing flow of ingested material into the duodenum. The length of the channel is approximately 1.4 cm with the greatest muscle thickness only 0.25 cm.

>>> IMPRESSION: No evidence for hypertrophic pyloric stenosis. Normal pyloric channel imaged.

NOTE: Permanent recorded images were taken.

ASF

EDWIN P PIA MD

REPORT STATUS: Signed

8/15/05

DR. WINGARD; WINGARD,LINDA CROUT,MD
ORDER#/PROCEDURE: 0812-0007 LULT/ABDLTD (76705TC)
EXAM TECH:□ECLIN
REP RELEASED BY: PIAEDW RAD 08/12/05 1448
ADD RELEASED BY:
DISC DATE:□
ED DISC DIAG:□□

PT LOC/ROOM:□LEXULT/

SAWYER,BRENNAN

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER -- LEXINGTON
811 WEST MAIN STREET
LEXINGTON, SC 29073
PHONE: (803) 358-6120

PATIENT NAME: **SAWYER,BRENNAN T** REPORT NO: 0606-0225

FACILITY:	LEXINGTON MEDICAL CENTER - BATESBURG-LEESVILLE
DATE OF EXAM:	06/02/05
FILE NO:	222-22-2222
DATE OF BIRTH/AGE:	05/17/05, 16 DAYS
ORDERING PHYSICIAN:	DR. WINGARD
CLINICAL DATA:	PECTUS EXCAVATUM

PA AND LATERAL CHEST:

The lungs appeared clear. The cardiothymic silhouette and bony structures are within normal limits. A pectus excavatum is difficult to identify. The other skeletal structures were unremarkable.

IMPRESSION: Negative views of the chest.

A draft copy of this report was routed to fax to Dr. Wingard on 6/06/05 at 12:08 PM.

HER

LON P HAMBY MD

REPORT STATUS: Draft

6/28/05

REP RELEASED BY:
ADD RELEASED BY:

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER -- LEXINGTON
811 WEST MAIN STREET
LEXINGTON, SC 29073
PHONE: (803) 358-6120

PATIENT: SAWYER,BRENNAN
AGE: 1M 6D
DOB: 05/17/2005
SEX: M

UNIT/MR NO: M000218629
ACCT NO: X00001970425
SSN:
REQ NO: 05-0012428
REPORT NO: 0623-0034

PT LOCATION: LEXRAD
WINLIN PED

ORDERING DR: LINDA WINGARD MD

COPY TO: LINDA WINGARD MD
STUDY TYPE: 0623-0002 LFLU/UPPER GI SERIES

DATE OF EXAM: 06/23/05

REG CLI LEXRAD
1M 6DM

CLINICAL DATA: REFLUX AND ONE EPISODE OF PROJECTILE VOMITING.

UPPER GI SERIES:

FINDINGS: Single column UGI series was performed. There is no nasopharyngeal reflux during swallowing. The esophagus is unremarkable without extrinsic defect. The patient did exhibit spontaneous reflux during the exam. The stomach is unremarkable. Attention made to the pylorus demonstrates no evidence for pyloric stenosis. The pylorus is minimally prominent, however, but again there is no evidence to suggest stenosis. The ligament of Treitz is within the normal location. There is no outlet obstruction for the stomach.

IMPRESSION: Spontaneous gastroesophageal reflux. No evidence for hypertrophic pyloric stenosis. Of note, however the pylorus is slightly prominent but felt to be within normal limits and without evidence for any stenosis.

SHM

EDWIN P PIA MD

REPORT STATUS: Signed

6/27/05

WINGARD,LINDA CROUT,MD
ORDER#/PROCEDURE: 0623-0002 LFLU/UGI (74240TC)
EXAM TECH:□DFELL
REP RELEASED BY: PIAEDW RAD 06/23/05 1222
ADD RELEASED BY:
DISC DATE:□
ED DISC DIAG:□□

PT LOC/ROOM:□LEXRAD/

SAWYER,BRENNAN

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER -- LEXINGTON
811 WEST MAIN STREET
LEXINGTON, SC 29073
PHONE: (803) 358-6120

PATIENT NAME: **SAWYER,BRENNAN T** REPORT NO: 0617-0196

FACILITY: LEXINGTON MEDICAL CENTER - BATESBURG-LEESVILLE

DATE OF EXAM: 06/15/05
FILE NO: 222-22-2222
DATE OF BIRTH/AGE: 05/17/05, 4 WEEKS
ORDERING PHYSICIAN: DR. WINGARD
CLINICAL DATA: CONSTIPATION

ABDOMEN/KUB (1 VIEW):

One supine projection of the abdomen shows an unremarkable bowel gas pattern. There are no masses or organ abnormality. No pathologic calcifications. The bony structures are intact.

IMPRESSION: Negative abdomen.

A draft copy of this report was routed to fax to Dr. Wingard on 6/17/05 at 11:38 AM.

HER

LAYNE R CLEMENZ MD

REPORT STATUS: Draft

6/17/05

REP RELEASED BY:
ADD RELEASED BY:

LEXINGTON M[illegible] R
BATESBURG-I [illegible]SVILLE
338 E. COLUMIA AVE
BATESBURG-LEESVILLE, SC. 29070

ID: 051705
WB

Coll. Date 08-04-06
Completed 16:51

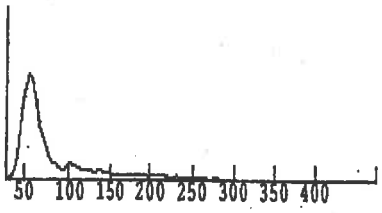
Brennan Sawyer

Coll. Time 1636 **Coll. By** TS
Completed By [illegible]

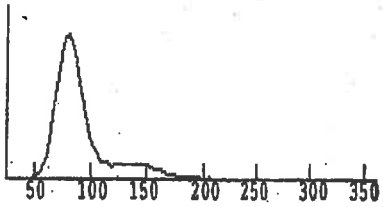
D Wignall

				Patient Limits 2	
WBC	5.1		x10^3/uL	4.0	11.0
LY	67.9	H	%	17.0	44.0
MO	12.8	H	%	0.0	10.0
GR	19.3	L	%	43.0	62.0
LY#	3.5		x10^3/uL	0.7	5.0
MO#	0.7		x10^3/uL	0.0	1.1
GR#	1.0	L	x10^3/uL	1.7	8.0
RBC	4.17	L	x10^6/uL	4.60	6.10
Hgb	11.1	L	g/dL	13.5	18.0
Hct	33.8	L	%	41.0	53.0
MCV	80.9		fL	80.0	98.0
MCH	26.6	L	pg	27.0	31.0
MCHC	32.9		g/dL	32.0	36.0
RDW	14.8	H	%	11.5	14.5
Plt	125.	L	x10^3/uL	130.	400.
MPV	7.1	L	fL	7.8	11.0

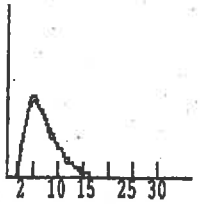
lcw 8-4-06



WBC HISTOGRAM



RBC HISTOGRAM



PLT HISTOGRAM

Manual Differential

Segs	14	Baso	___	Tox. Gran	___
Bands	6	Atp. Lym	1	NRBC	___
Lymphs	68	Meta	___	Vacuole	___
Mono	11	Myelo	___	Other	___
Eos	0	Blast	___		

RBC Morphology

Normal	✓	Polychrom	___	Sickle Cell	___
Microcyte	___	Baso Stippling	___	Other	___
Macrocyte	___	Hypochromia	___	___	
Spherocyte	___	Target Cells	___		
Elliptocyte	___	Stomatocyte	___		

Platelet Estimation/Morphology

Adequate ___
Decreased ✓
Increased ___
Clumps ___
Large ___

Completed By [illegible] **Date** 8/4 **Time** 1656

FAXED TO ___ **DATE** ___ **TIME** ___ **BY** ___
CALLED TO AND READ BACK BY ___ **DATE** ___ **TIME** ___ **BY** ___

AWYER, BRENNAN T
03/28/2006 M
1410868
05/17/2005 10m UC
CCP/CCP 5533908

EXINGTON MEDICAL CENTER BATESBURG ESVILLE
UMBIA AVE. LEESVILLE SC 29070 PHONE (803) 604-0066 FAX (803) 604-0731

Brennan

COMMENTS

Physician Wingard

Hematology

	TEST	RESULT	NORMAL RANGE		TEST	RESULT	NORMAL RANGE
☐	SEDRATE		AGE MALE FEMALE 0-50 0-15 0-20 mm/hr >50 0-20 0-30 mm/hr	☐	PROTIME	SEC=	10.9-13.0 SECS
				☐		INR=	THERAPUTIC 1.9-3.0

Coll time_____ Date_____ By_____ Completed time_____ Date_____ By_____

Immunology

☐	STREP A		NEGATIVE	☐	MONO		NEGATIVE
☐	HCG (SERUM)				HCG (URINE)		

Coll time_____ Date_____ By_____ Completed time_____ Date_____ By_____

Urinalysis

☐ Urinalysis ☐ Random ☐ Clean Catch ☐ Cath ☐ <12 mLs microscopic may be inaccurate
☐ Chemical analysis negative microscopic available upon request ☐ Patient on Pyridium/Azo

CHEMICAL ANALYSIS	RESULT	NORMAL RANGE
COLOR		YELLOW/STRAW
CLARITY		CLEAR
GLUCOSE		NEGATIVE
BILIRUBIN		NEGATIVE
KETONES		NEGATIVE
SP. GRAVITY		1.003-1.030
PH		4.6-8.0
PROTEIN		NEGATIVE
UROBILINOGEN		0.1-1.0
NITRITE		NEGATIVE
BLOOD		NEGATIVE
LEUKOCYTE		NEGATIVE

	MICROSCOPIC	RESULT	NORMAL RANGE
	RBC		0-3/HPF
	WBC		0-5/HPF
	EPITH CELL		
	BACTERIA		
	CAST		
	CRYSTALS		0-3/HPF NONPATH
	AMORPHOUS		
	MUCOUS		
	OTHER		

	CONFIRMATION TEST	RESULT	NORMAL RANGE
•	CLINITEST		
•	ICTOTEST		

☐	MICROALBUMIN		≤20 mg/dL

Coll time_____ Date_____ By_____ Completed time_____ Date_____ By_____

☐ WET PREP	NORMAL VALUES
	NO YEAST, TRICHOMONAS OR CLUE CELLS, WBC'S < ONE PER EPITHELIAL CELL, CONSIDERED TO BE WITHIN NORMAL LIMITS. (WBC'S > ONE PER EPITHELIAL CELL, MAY BE SUGGESTIVE OF CERVICAL OR VAGINAL INFLAMMATION.)

Coll time_____ Date_____ By_____ Completed time_____ Date_____ By_____

TEST	RESULT	NORMAL RANGE
INFLUENZA A & B	Presumptive Neg for Flu A+B	PRESUMPTIVE NEGATIVE FOR INFLUENZA A AND B

time 425 Date 3-28 By DAS Completed time 450 Date 3-28 By RN

TEST	RESULT	NORMAL RANGE		TEST	RESULT	NORMAL RANGE
ULT BLOOD		NEGATIVE	☐	GLYCO HGB		< 6.0% NORMAL <7.0% OPTIMAL >8.0% POOR CONTROL
LUCOSE		70-110 mg/dL				

_____ Date_____ By_____ Completed time_____ Date_____ By_____

DATE TIME BY:

VD READ BACK BY DATE TIME BY:

LEXINGTON MEDICAL CENTER
BATESBURG-LEESVILLE
338 E. COLUMIA AVE
BATESBURG-LEESVILLE, SC. 29070

ID: 051705
WB

☐ CBC/AUTO DIFF ☐ CBC/MANUAL DIFF ☐ HGB ☐ HCT ☐ PLT ☐ WBC

12-05-05
16:58

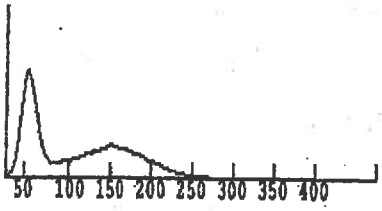
Coll. DATE Completed Coll. TIME 1650 Coll. By TS

Patient Limits 1 By

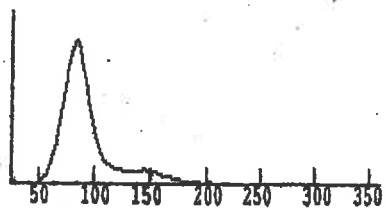
WBC	18.5	H	x10^3/uL	4.5	10.5
LY	46.4		%	20.5	51.1
MO	14.5	*H	%	1.7	9.3
GR	39.1	ML	%	42.2	75.2
LY#	8.6	H	x10^3/uL	1.2	3.4
MO#	2.7	*H	x10^3/uL	0.1	0.6
GR#	7.2	MH	x10^3/uL	1.4	6.5
RBC	4.34		x10^6/uL	4.00	6.00
Hgb	11.9		g/dL	11.0	18.0
Hct	35.8		%	35.0	60.0
MCV	82.5		fL	80.0	99.9
MCH	27.4		pg	27.0	31.0
MCHC	33.3		g/dL	33.0	37.0
RDW	14.6	H	%	11.6	13.7
Plt	316.		x10^3/uL	150.	450.
MPV	7.9		fL	7.8	11.0

SAWYER, BRENNAN
12/05/2005 M
1410868 UC
222-22-22226m. 05/17/2005
CCP/CCP 3224716

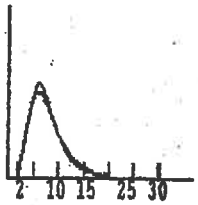
R Wingard
JW 12/5/05



WBC HISTOGRAM



RBC HISTOGRAM



PLT HISTOGRAM

Manual Differential

Segs 40 Baso ____ Tox Gran ____
Bands 1 Atp. Lym 1 NRBC ____
Lymphs 47 Meta ____ Vacuol ____
Mono 8 Myleo ____ Other ____
Eos 3 Blast ____

RBC Morphology

Normal ____ Polychrom ____ Sickle Cell ____
Microcyte ____ Baso Stippling ____ Other ____
Macrocyte ____ Hypochromia ____ ____
Spherocyte ____ Target Cells ____
Eliptocyte ____ Stomatocyte ____

Platelet Estimation/Morphology

Completed By TC Date 125 Time 513

Adequate ____
Decreased ____
Increased ____
Clumps ____
Large ____

S.C. DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
BUREAU OF LABORATORIES

TELEPHO.
(803) 896-08[illegible]

8231 PARKLANE ROAD
COLUMBIA, S.C. 29223

CLIA #42-D0658606

M12957

CONFIDENTIAL LABORATORY REPORT

0000062[illegible]

breamaster sample

SUBMITTED BY : LEXINGTON MEDICAL CENTER PARENT NAME : KELLY
NAME:RICHARDSON, ? PAT ID:051401143 FIRST FEEDING:N/A
BIRTH:05/17/05 SEX:M RACE:W PRINT DATE:05/25/05

SPEC NO:M140143 PBM:27
LOC ID:000214790
SPEC TYP:FILTER PAPER
COLL-DT:05/19/05
RECV-DT:05/20/05

CPT NO	TEST NAME	RESULT
84437	T4 (NEONATAL)	NORMAL
83020	HEMOGLOBINOPATHY	NORMAL
82775	GALACTOSE	NORMAL TOTAL GALACTOSE TRANSFERASE ENZYME NORMAL
84231	17-OHP	NORMAL
99999	IRT	NORMAL
82261	BIOTINIDASE	NORMAL
99999	ACYLCARNITINE PROFILE	NORMAL
	AMINO ACID PROFILE	NORMAL

dlw

DHEC-1318 (REV. 8-96)

LEXINGTON MEDICAL CENTER
BATESBURG-LEESVILLE
338 E. COLUMIA AVE
BATESBURG-LEESVILLE, SC. 29070

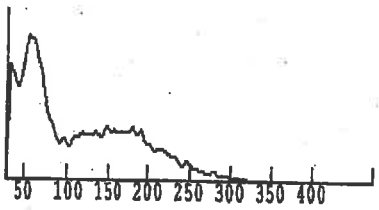
☐ CBC/AUTO DIFF ☐ CBC/MANUAL DIFF ☐ HGB ☐ HCT ☐ PLT ☐ WBC

ID: 05172005
WB

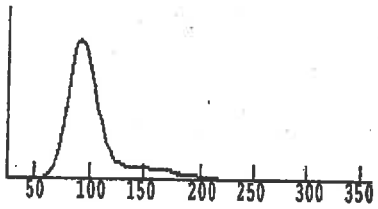
07-29-05
Coll. DATE 12:05 Coll. TIME 1205 Coll. By ES
Completed Patient By

				Limits 1	
WBC	8.9	*	x10^3/uL	4.5	10.5
LY	49.7	1	%	20.5	51.1
MO	8.4	1	%	1.7	9.3
GR	41.9	IL	%	42.2	75.2
LY#	4.4	*H	x10^3/uL	1.2	3.4
MO#	0.7	*H	x10^3/uL	0.1	0.6
GR#	3.7	*	x10^3/uL	1.4	6.5
RBC	3.42	L	x10^6/uL	4.00	6.00
Hgb	10.6	L	g/dL	11.0	18.0
Hct	31.4	L	%	35.0	60.0
MCV	91.7		fL	80.0	99.9
MCH	30.8		pg	27.0	31.0
MCHC	33.6		g/dL	33.0	37.0
RDW	14.1	H	%	11.6	13.7
Plt	147.	L	x10^3/uL	150.	450.
MPV	8.3		fL	7.8	11.0

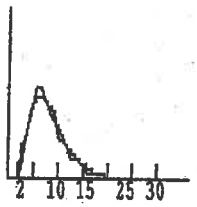
SAWYER, BRENNAN T 07/29/05 1410868 UC
222-22-2222 10m 05/17/2005 CCP/CCP 3213898



WBC HISTOGRAM



RBC HISTOGRAM



PLT HISTOGRAM

Manual Differential

Segs 31 Baso ____ Tox Gran ____
Bands 9 Atp. Lym ____ NRBC ____
Lymphs 41 Meta ____ Vacuol ____
Mono 16 Myleo ____ Other ____
Eos 3 Blast ____

RBC Morphology

Normal ✓ Polychrom ____ Sickle Cell ____
Microcyte ____ Baso Stippling ____ Other ____
Macrocyte ____ Hypochromia ____ ____
Spherocyte ____ Target Cells ____
Eliptocyte ____ Stomatocyte ____

Platelet Estimation/Morphology Completed By ____ Date 7/29 Time 1240

Adequate ____
Decreased ✓
Increased ____
Clumps ____
Large few

Called/Faxed to ____ Date ____ Time ____ Tech ____