Felecia Dicks
PO Box 31562
Augusta, GA 30903
706-951-3051

69973

RECEIVED
OCT 03 2013
SC Court of Appeals

October 2, 2013

The Honorable Jenny Abbott Kitchings
Clerk, South Carolina Court of Appeals
Edgar Brown Building
1205 Pendleton St.
Columbia, SC 29201

Re: Felecia Dicks Wilson v. Cedar Fair L.P. d/b/a Carowinds Amusement Park
Appellate Case #2012-212327

Dear Ms. Kitchings:

I am respectfully requesting a thirty (30) day extension of time in which to file and serve my "Final Brief and associated documentation" for my appeal. I am currently the care-giver for my father Willie Dicks and my step-mother Emma Hayman Dicks.

My father is currently under Trinity Hospital Hospice care, of which we were just notified verbally last week that the services he receives through the Hospice program will be terminated. It seems that they allow a certain period of time for the patient to expire and if does not take place during that time frame then the patient is discharged from Hospice and then must utilize other services. Due to my disability I am physically unable to care for my father without help. My step-mother who had been caring for my father along with the Hospice services had to undergo tendon reconstruction surgery on her right hand September 4, 2013. When I agreed to assist her during recovery we thought that it would only be for two (2) weeks this has been extended to six (6) weeks, and this is before she can even begin therapy to be able to use her hand again.

I do realize that all of this is truly a personal issue, however I must assist my step-mother as much as I can and also secure other services for my father, there is no one else. I am the oldest of four children and my three brothers live in California. This has been a very difficult process. I have been assured by my father's social worker that something will be

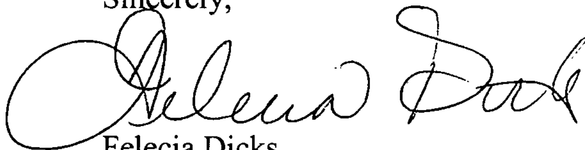
in place very soon.

While I am asking for a thirty (30) day extension any additional time will be appreciated.

I have enclosed a check for the $25.00 filing fee along with proof of service of this letter to Carowinds representative. I have also enclosed a portion of the discharge paperwork regarding my step-mother's surgery, documentation of the current care through Trinity Hospital Hospice and the written notice of discharge from the Trinity Hospital Hospice program.

Thank you in advance for your understanding and consideration of this request.

Sincerely,



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Augusta, GA 30903

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

Thomas A. Russo, Circuit Court Judge

RECEIVED
OCT 03 2013
SC Court of Appeals

Appellate Case No. 2012-212327
Case No. 2009-CP-46-3103

Felecia Dicks Wilson — Appellant

v.

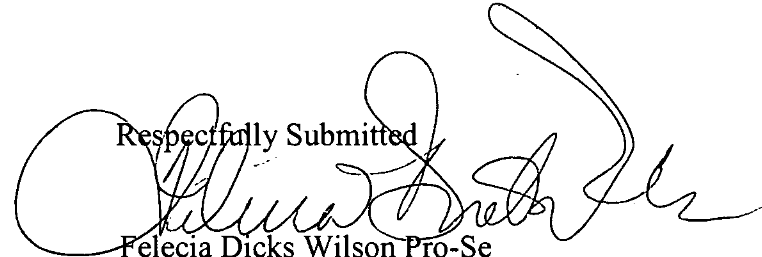
Cedar Fair Entertainment Co.
Cedar Fair, LP d/b/a Carowinds
Amusement Park — Respondent.

PROOF OF SERVICE

I certify that I have served the letter requesting additional time to file my "Final Brief" and other associated documents on Cedar Fair Entertainment Co. Cedar Fair, LP d/b/a Carowinds Amusement Park by depositing a copy of it in the United States Mail, postage prepaid, on October 2, 2013, addressed to the Respondent's Attorney of record Joseph E. Thoensen Richardson Plowden & Robinson PA 1900 Barnwell Street Columbia, SC 29201

October 2, 2013

Respectfully Submitted



Felecia Dicks Wilson Pro-Se
Post Office Box 31562
Augusta, GA 30903-3051

Trinity Home Care Service of Augusta
Notice of Medicare Non-Coverage

RECEIVED
OCT 03 2013
SC Court of Appeals

Patient name: **Patient number:**

The Effective Date Coverage of Your Current Hospice
Services Will End: 10/3/13

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Hospice services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: to appeal, or if you have questions.

See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

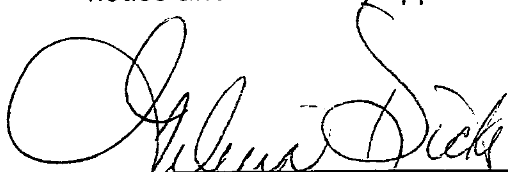
  Plan contact information ____

  ____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.



Signature of Patient or Representative

10-1-2013
Date

Contact Serial Number

CSN:1000001710259

University Hospital

1350 Walton Way Augusta, GA, 30901

After Visit Summary-Discharge Instructions

Emma G Dicks

Admission Information

	Provider	Department	Dept Phone
9/4/2013	WILLIAM HOWARD HUDSON, MD	Uh Day Surgery Periop Services	706-774-2439

Follow-up Information

Follow up with WILLIAM HOWARD HUDSON, MD. Schedule an appointment as soon as possible for a visit on 9/10/2013. 1020AM

Contact information:
811 13th St
Ste 20
Augusta Georgia 30901
706-722-3401

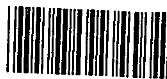
Allergies as of 9/4/2013

	Reactions
Latex	Gloves caused a rash once

Your medications As of 9/4/2013 10:55 AM

TAKE these medications, which you are ALREADY TAKING

	Why are you taking this medication	Take your next dose at:	Quantity/Refills	AM	Noon	PM	Bedtime	PRN
Arava 20 MG tablet Generic drug: leflunomide Take 20 mg by mouth daily.			Refills: 0					
aspirin 81 mg chewable tablet Take 81 mg by mouth daily.			Refills: 0					
azelastine-fluticasone 137-50 mcg/spray Spray Place 2 sprays into each nostril daily.			Qty: 3 g Refills: 0					
CALCIUM 600 ORAL Take 1 tablet by mouth daily.			Refills: 0					
folic acid 1 MG tablet Commonly known as: FOLVITE Take 1 mg by mouth daily.			Refills: 0					
furosemide 20 MG tablet Commonly known as: LASIX Take 1 tablet (20 mg total) by mouth daily.			Qty: 30 tablet Refills: 11					


1ROI

...portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance ...tability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Willie Dicks
Patient's Name | 9/10/1940 Date of Birth | 180000 2 Medical Record Number

2512 Drumcliff Ct
Address | Hephzibah GA 30815 City, State, Zip | 706-790-3516 Telephone Number

I authorize the use and disclosure of health information about me as described below:

Trinity Hospice
Facility Authorized to Release my Health Information

Trinity Hospice
Agency or Individual(s) Authorized to Receive my Health Information

2813 Wrightsboro Rd.
Address | Augusta GA 30904 City, State, Zip | 706-729-6000 Telephone Number

Health Information that may be used / disclosed is limited to the following:
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation(s)
- ☐ Progress Notes
- ☐ Emergency Room Record
- ☐ Operative Note(s)
- ☐ Imaging/X-ray
- ☐ X-ray Reports
- ☐ Lab
- ☑ Entire Record
- ☐ Pathology Report
- ☐ Other *(specify)*

Health Information that may be used / disclosed is limited to the following periods of healthcare:
From (date): 4/11/2012 To (date): 4/11/2014 Account Number:
From (date): To (date): Account Number:

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):
- ☐ Treatment/Consultation
- ☑ At Request of Patient
- ☐ Research
- ☐ Marketing
- ☐ Billing or Claims Payment
- ☐ At Request of Employer
- ☐ Other

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

If applicable, I agree to the release of my medical or billing records containing the **sensitive information** listed above. ☐ Yes ☐ No

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 60 days after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Insurance Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

X Emma Dicks
Patient's or Authorized Personal Representative's Signature* | 4/11/2012 Date | 4 pm Time

Spouse
Relationship to Patient / Authority to Act on Patient's Behalf | Interpreter, if Utilized

Rita O'Keefe RN
Witness's Signature | Expiration Date or Event

☐ **Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.*

Authorization to Use and Disclose
Protected Health Information
HIM-1401G (Revised 07/10, 11/10) Page 1 of 1
WHITE - Medical Record CANARY - Recipient

Patient Label