Fire Pension Board Meeting Agenda

December 18, 2024, 9:30 a.m. via Microsoft Teams

1.) Approval of minutes for September 18, 2024

2.) Bills and Pension Rolls:

PENSION ROLL		
Budgeted Amount	$720,000.00	
August 2024	$58,556.20	
Remaining budget	**$217,966.63**	**30.27%**
MEDICAL CLAIMS		
Budgeted amount	$1,792,000.00	
August 2024	$122,904.53	
August 2024 HMA fees	$14,088.48	
Remaining budget	**$764,859.43**	**42.68%**
PENSION ROLL		
Budgeted Amount	$720,000.00	
September 2024	$58,556.20	
Remaining budget	**$159,410.43**	**22.14%**
MEDICAL CLAIMS		
Budgeted amount	$1,792,000.00	
September 2024	$84,275.69	
September 2024 HMA fees	$14,088.48	
Remaining budget	**$666,495.26**	**37.19%**

3.) Action Item:

Member #101	Request for reimbursement for nail lacquer compound for toenail fungus in the amount of $215.68.
Member #144	Reimbursement for orthotics repair in the amount of $110.
Member # 83	Request for reimbursement for two dental crowns in the amount of $916.

Member # 139	Request for reimbursement for a dental crown in the amount of $732.
Member #102	Request for reimbursement for glasses in the mount of $175.63.
Member #39	Request for Long Term Care/Assisted Living. Request includes: ▪ $4,695.00 = Monthly fee for the studio (Room and Board) ▪ $1,600 = level 5 Care ▪ $3,500 = One time Community Fee

4.) Other:

- Move-in costs language proposal (HR)
- Secretary upcoming leave – Acting secretary (Marista)

Fire Pension Board Minutes
City Of Everett
September 18, 2024

DRAFT

The regular meeting of the Fire Pension Board was called to order at 9:30 a.m. on September 18, 2024. Board Members Neyens, Schwab, Vitalich, and Jorve were present. Board Member Franklin was excused. Chelsi Bardwell, Human Resources; and Richard Gray, Finance were also present.

APPROVAL OF MINUTES

The minutes of the meeting of August 21, 2024, were approved.

BILLS AND PENSION ROLLS

PENSION ROLL		
Budgeted Amount	$720,000.00	
July 2024	$58,556.20	
Remaining budget	**$276,522.83**	**38.41%**
MEDICAL CLAIMS		
Budgeted amount	$1,792,000.00	
July 2024	$79,428.45	
July 2024 HMA fees	$14,088.48	
Remaining budget	**$901,852.44**	**50.33%**

Moved by Vitalich, seconded by Schwab, to approve the pension rolls and medical claims as presented.

Roll was called with all members voting yes, except Board Member Franklin who was excused.

Motion carried.

ACTION ITEM

Member #9 Request for reimbursement for GCM Sensor Dexcom (Diabetes Supply) in the amount of $240.

Moved by Vitalich, seconded by Schwab, to approve the request for reimbursement for GCM Sensor Dexcom (Diabetes Supply) in the amount of $240.

DRAFT

Roll was called with all members voting yes, except Board Member Franklin who was excused.

Motion carried.

Member #5 Request for reimbursement for crown and bridge replacement in the amount of $1091.

Moved by Vitalich, seconded by Neyens, to approve the request for reimbursement for crown and bridge replacement in the amount of $1091.

Roll was called with all members voting yes, except Board Member Franklin who was excused.

Motion carried.

Member #81 Request for reimbursement for partial denture in the amount of $3,700.

Moved by Vitalich, seconded by Schwab, to approve the request for reimbursement for partial denture in the amount of $1,500, at the max allowable rate.

Roll was called with all members voting yes, except Board Member Franklin who was excused.

Motion carried.

OTHER:

Chelsi Bardwell, HR, state she would be providing language for a proposal to amend the long-term care policy to address move in costs. This will be followed up with a joint Board meeting.

Discussion ensued regarding medical COLAs, outstanding issues and Medicare coverage, and average medical care costs.

The Board meeting adjourned at 9:54 a.m.

_____
Marista Jorve, Board Secretary

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name
(please print) [redacted]

1. Diagnosis: Toe nail fungus
2. Prognosis: about 6 more months
3. Type of Treatment(s) or Procedure: nail lacquer apply once a day
4. Cost of treatments/service: $ $215.48
5. Request to the board for this specific treatment or procedure:

Board member #101 Fire is asking for reimbursement. This is not covered because it is a compound medication. and it is not confirmed, with a fungal diagnostic test medical necessity

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

not use near an open flame or while smoking.This drug may cause harm if swallowed. If this drug is swallowed, call a doctor or poison control center right away.Tell your doctor if you are pregnant, plan on getting pregnant, or are breast-feeding. You will need to talk about the benefits and risks to you and the baby.

Keep out of reach of children: Store in safety container or secure area.

WIC# 986638

CUT HERE

[redacted]

RX # 0729859-10893 DATE: 07/28/23

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY:6.6 3 REFILLS BEFORE 04/24/24
Refill NDC:45802-0141-67
Retail Price: $90.99 Your Insurance Saved You: $48.09

$ 42.90

PBR: G. SEBASTIAN PLAN: NMHC
MFG:PADAGIS GROUP# E2435
TLS/ / / /MML CLAIM REF# 232094551168046999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828 PH:(503)263-1600

Customer receipt

CUT HERE

[redacted]

RX # 0729859-10893 DATE: 07/28/23

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY:6.6 3 REFILLS BEFORE 04/24/24
Refill NDC:45802-0141-67
Retail Price: $90.99 Your Insurance Saved You: $48.09

$ 42.90

PBR: G. SEBASTIAN PLAN: NMHC
MFG:PADAGIS GROUP# E2435
TLS/ / / /MML CLAIM REF# 232094551168046999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828 PH:(503)263-1600

Duplicate receipt

CUT HERE

Pharmacy use only

SAT 12:00PM
Refill

CICLOPIROX 8% NAIL LACQUER TOP SOLN
45802-**0141**-67
ALPHA

QTY 6.6

LIQUID

COLORLESS

TLS/ / / /MML

not use near an open flame or while smoking.This drug may cause harm if swallowed. If this drug is swallowed, call a doctor or poison control center right away.Tell your doctor if you are pregnant, plan on getting pregnant, or are breast-feeding. You will need to talk about the benefits and risks to you and the baby.

WIC# 986638

Keep out of reach of children: Store in safety container or secure area.

CUT HERE

[redacted]

RX # 0729859-10893 DATE: 08/23/23

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY:6.6 2 REFILLS BEFORE 04/24/24
Refill NDC:45802-0141-67
Retail Price: $90.99 Your Insurance Saved You: $48.09

$ 42.90

PBR: G. SEBASTIAN PLAN: NMHC
MFG:PADAGIS GROUP# E2435
XXX/ / / /LSY CLAIM REF# 232354347686029999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828 PH:(503)263-1600

Customer receipt

CUT HERE

[redacted]

RX # 0729859-10893 DATE: 08/23/23

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY:6.6 2 REFILLS BEFORE 04/24/24
Refill NDC:45802-0141-67
Retail Price: $90.99 Your Insurance Saved You: $48.09

$ 42.90

PBR: G. SEBASTIAN PLAN: NMHC
MFG:PADAGIS GROUP# E2435
XXX/ / / /LSY CLAIM REF# 232354347686029999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828 PH:(503)263-1600

Duplicate receipt

CUT HERE

Pharmacy use only

THU 12:00PM
Refill

CICLOPIROX 8% NAIL LACQUER TOP SOLN
45802-**0141**-67
ALPHA

QTY 6.6

LIQUID

COLORLESS

XXX/ / / /LSY

with use of this drug. This drug may catch on fire. Do not use near an open flame or while smoking. This drug may cause harm if swallowed. If this drug is swallowed, call a doctor or poison control center right away. Tell your doctor if you are pregnant, plan on getting pregnant, or are breast-feeding. You will need to talk about the benefits and risks to you and the baby.

Keep out of reach of children: Store in safety container or secure area.

WIC# 986638

CUT HERE

[redacted] 09/23/23

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 1 REFILL BEFORE 04/24/24
Refill NDC: 45802-0141-67
Retail Price: $90.99 Your Insurance Saved You: $48.09

$ 42.90

PBR: G. SEBASTIAN
MFG: PADAGIS
XXX/ / / /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 232663364187019999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828 PH: (503)263-1600

Customer receipt

CUT HERE

[redacted] DATE: 09/23/23

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 1 REFILL BEFORE 04/24/24
Refill NDC: 45802-0141-67
Retail Price: $90.99 Your Insurance Saved You: $48.09

$ 42.90

PBR: G. SEBASTIAN
MFG: PADAGIS
XXX/ / / /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 232663364187019999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828 PH: (503)263-1600

Duplicate receipt

CUT HERE

Pharmacy use only

SUN 12:00PM
Refill

CICLOPIROX 8% NAIL LACQUER TOP SOLN
45802-**0141**-67
ALPHA

QTY 6.6

LIQUID

COLORLESS

XXX/ / / /LSY

with use of this drug. This drug may catch on fire. Do not use near an open flame or while smoking. This drug may cause harm if swallowed. If this drug is swallowed, call a doctor or poison control center right away. Tell your doctor if you are pregnant, plan on getting pregnant, or are breast-feeding. You will need to talk about the benefits and risks to you and the baby.

Keep out of reach of children: Store in safety container or secure area.

WIC# 986638

CUT HERE

[redacted]
RX # 0729859-10893 DATE: 10/31/23

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 NO REFILLS - DR. AUTH REQUIRED
Refill NDC: 45802-0141-67
Retail Price: $90.99 Your Insurance Saved You: $48.09

$ 42.90

PBR: G. SEBASTIAN
MFG: PADAGIS
XXX/ / / /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 233043165909011999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828 PH: (503)263-1600

Customer receipt

CUT HERE

[redacted]
RX # 0729859-10893 DATE: 10/31/23

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 NO REFILLS - DR. AUTH REQUIRED
Refill NDC: 45802-0141-67
Retail Price: $90.99 Your Insurance Saved You: $48.09

$ 42.90

PBR: G. SEBASTIAN
MFG: PADAGIS
XXX/ / / /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 233043165909011999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828 PH: (503)263-1600

Duplicate receipt

CUT HERE

Pharmacy use only

WED 12:00PM
Refill

CICLOPIROX 8% NAIL LACQUER TOP SOLN
45802-**0141**-67
ALPHA

QTY 6.6

LIQUID

COLORLESS

XXX/ / / /LSY

with use of this drug. This drug may catch on fire. Do not use near an open flame or while smoking. This drug may cause harm if swallowed. If this drug is swallowed, call a doctor or poison control center right away. Tell your doctor if you are pregnant, plan on getting pregnant, or are breast-feeding. You will need to talk about the benefits and risks to you and the baby.

Keep out of reach of children: Store in safety container or secure area.

WIC# 986638

CUT HERE

[redacted]

RX # 0798962-10893 DATE: 04/11/24

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 5 REFILLS BEFORE 04/11/25
Copy NDC: 45802-0141-67
Retail Price: $90.99 Your Insurance Saved You: $48.03

$ 42.96

PBR: G. SEBASTIAN
MFG: PADAGIS
TRW/EXT/EXT/ /4639016

PLAN: NMHC
GROUP# E2435
CLAIM REF# 241027297809050999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828
PH: (503)263-1600

Customer receipt

CUT HERE

[redacted]

RX # 0798962-10893 DATE: 04/11/24

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 5 REFILLS BEFORE 04/11/25
Copy NDC: 45802-0141-67
Retail Price: $90.99 Your Insurance Saved You: $48.03

$ 42.96

PBR: G. SEBASTIAN
MFG: PADAGIS
TRW/EXT/EXT/ /4639016

PLAN: NMHC
GROUP# E2435
CLAIM REF# 241027297809050999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828
PH: (503)263-1600

Duplicate receipt

CUT HERE

Pharmacy use only

SAT 2:08PM
Copy

CICLOPIROX 8% NAIL LACQUER TOP SOLN
45802-**0141**-67
ALPHA

QTY 6.6

LIQUID

COLORLESS

TRW/EXT/EXT/ /4639016

not use near an open flame or while smoking. This drug may cause harm if swallowed. If this drug is swallowed, call a doctor or poison control center right away. Tell your doctor if you are pregnant, plan on getting pregnant, or are breast-feeding. You will need to talk about the benefits and risks to you and the baby.

Keep out of reach of children: Store in safety container or secure area.

WIC# 986638

CUT HERE

[redacted]

RX # 0798962-10893 DATE: 05/22/24

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 4 REFILLS BEFORE 04/11/25
Refill NDC: 45802-0141-67
Retail Price: $96.99 Your Insurance Saved You: $54.03

$ 42.96

PBR: G. SEBASTIAN
MFG: PADAGIS
XXX/ / / /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 241436025476002999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828
PH: (503)263-1600

Customer receipt

CUT HERE

[redacted]

RX # 0798962-10893 DATE: 05/22/24

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 4 REFILLS BEFORE 04/11/25
Refill NDC: 45802-0141-67
Retail Price: $96.99 Your Insurance Saved You: $54.03

$ 42.96

PBR: G. SEBASTIAN
MFG: PADAGIS
XXX/ / / /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 241436025476002999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828
PH: (503)263-1600

Duplicate receipt

CUT HERE

Pharmacy use only

THU 10:00AM
Refill

CICLOPIROX 8% NAIL LACQUER TOP SOLN
45802-**0141**-67
ALPHA

QTY 6.6

LIQUID

COLORLESS

XXX/ / / /LSY

may catch on fire. Do not use near an open flame or while smoking.This drug may cause harm if swallowed. If this drug is swallowed, call a doctor or poison control center right away.Tell your doctor if you are pregnant, plan on getting pregnant, or are breast-feeding. You will need to talk about the benefits and risks to you and the baby.

Keep out of reach of children: Store in safety container or secure area.

WIC# 986638

CUT HERE

[redacted]

RX # 0814273-10893 DATE: 07/07/24

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 3 REFILLS BEFORE 04/11/25
Copy NDC: 21922-0053-51
Retail Price: $96.99 Your Insurance Saved You: $53.53

$ 43.46

PBR: G. SEBASTIAN
MFG:ENCUBE ETHICALS
LSY/LSY/LSY/ /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 241904429384018999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828 PH: (503)263-1600

Customer receipt

CUT HERE

[redacted]

RX # 0814273-10893 DATE: 07/07/24

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 3 REFILLS BEFORE 04/11/25
Copy NDC: 21922-0053-51
Retail Price: $96.99 Your Insurance Saved You: $53.53

$ 43.46

PBR: G. SEBASTIAN
MFG:ENCUBE ETHICALS
LSY/LSY/LSY/ /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 241904429384018999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828 PH: (503)263-1600

Duplicate receipt

CUT HERE

Pharmacy use only

MON 10:00AM
Copy

CICLOPIROX 8% NAIL LACQUER TOP SOLN
21922-**0053**-51
ALPHA

QTY 6.6

LIQUID

LSY/LSY/LSY/ /LSY

may catch on fire. Do not use near an open flame or while smoking.This drug may cause harm if swallowed. If this drug is swallowed, call a doctor or poison control center right away.Tell your doctor if you are pregnant, plan on getting pregnant, or are breast-feeding. You will need to talk about the benefits and risks to you and the baby.

Keep out of reach of children: Store in safety container or secure area.

WIC# 986638

CUT HERE

[redacted]

RX # 0814273-10893 DATE: 08/06/24

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 2 REFILLS BEFORE 04/11/25
Refill NDC: 21922-0053-51
Retail Price: $96.99 Your Insurance Saved You: $53.53

$ 43.46

PBR: G. SEBASTIAN
MFG:ENCUBE ETHICALS
MJP/ / / /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 242194407771039999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828 PH: (503)263-1600

Customer receipt

CUT HERE

[redacted]

RX # 0814273-10893 DATE: 08/06/24

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 2 REFILLS BEFORE 04/11/25
Refill NDC: 21922-0053-51
Retail Price: $96.99 Your Insurance Saved You: $53.53

$ 43.46

PBR: G. SEBASTIAN
MFG:ENCUBE ETHICALS
MJP/ / / /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 242194407771039999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828 PH: (503)263-1600

Duplicate receipt

CUT HERE

Pharmacy use only

TUE 11:44AM
Refill

CICLOPIROX 8% NAIL LACQUER TOP SOLN
21922-**0053**-51
ALPHA

QTY 6.6

LIQUID

MJP/ / / /LSY

may catch on fire. Do not use near an open flame or while smoking.This drug may cause harm if swallowed. If this drug is swallowed, call a doctor or poison control center right away.Tell your doctor if you are pregnant, plan on getting pregnant, or are breast-feeding. You will need to talk about the benefits and risks to you and the baby.

Keep out of reach of children: Store in safety container or secure area.

WIC# 986638

CUT HERE

[redacted]

RX # 0814273-10893 DATE: 09/01/24

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 1 REFILL BEFORE 04/11/25
Refill NDC: 21922-0053-51
Retail Price: $96.99 Your Insurance Saved You: $53.53

$ 43.46

PBR: G. SEBASTIAN
MFG:ENCUBE ETHICALS
XXX/ / / /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 242457452360060999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828
PH: (503)263-1600

Customer receipt

CUT HERE

[redacted]

RX # 0814273-10893 DATE: 09/01/24

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 1 REFILL BEFORE 04/11/25
Refill NDC: 21922-0053-51
Retail Price: $96.99 Your Insurance Saved You: $53.53

$ 43.46

PBR: G. SEBASTIAN
MFG:ENCUBE ETHICALS
XXX/ / / /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 242457452360060999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828
PH: (503)263-1600

Duplicate receipt

CUT HERE

Pharmacy use only

TUE 9:00AM
Refill

CICLOPIROX 8% NAIL LACQUER TOP SOLN
21922-**0053**-51
ALPHA

QTY 6.6

LIQUID

XXX/ / / /LSY

may catch on fire. Do not use near an open flame or while smoking.This drug may cause harm if swallowed. If this drug is swallowed, call a doctor or poison control center right away.Tell your doctor if you are pregnant, plan on getting pregnant, or are breast-feeding. You will need to talk about the benefits and risks to you and the baby.

Keep out of reach of children: Store in safety container or secure area.

WIC# 986638

CUT HERE

[redacted]

RX # 0814273-10893 DATE: 10/02/24

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 NO REFILLS - DR. AUTH REQUIRED
Refill NDC: 21922-0053-51
Retail Price: $96.99 Your Insurance Saved You: $53.53

$ 43.46

PBR: G. SEBASTIAN
MFG:ENCUBE ETHICALS
XXX/ / / /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 242763745202048999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828
PH: (503)263-1600

Customer receipt

CUT HERE

[redacted]

RX # 0814273-10893 DATE: 10/02/24

CICLOPIROX 8% NAIL LACQUER TOP SOLN
QTY: 6.6 NO REFILLS - DR. AUTH REQUIRED
Refill NDC: 21922-0053-51
Retail Price: $96.99 Your Insurance Saved You: $53.53

$ 43.46

PBR: G. SEBASTIAN
MFG:ENCUBE ETHICALS
XXX/ / / /LSY

PLAN: NMHC
GROUP# E2435
CLAIM REF# 242763745202048999

Walgreens 1080 SW 1ST AVE CANBY, OR 970133828
PH: (503)263-1600

Duplicate receipt

CUT

Pharmacy use only

FRI 9:00AM
Refill

CICLOPIROX 8% NAIL LACQUER TOP SOLN
21922-**0053**-51
ALPHA

QTY 6.6

LIQUID

XXX/ / / /LSY

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name
(please print) [redacted]

1. Diagnosis: _____

2. Prognosis: _____

3. Type of Treatment(s) or Procedure: Orthotics repair

4. Cost of treatments/service: $ 110.00

5. Request to the board for this specific treatment or procedure:

Member # 144 is requesting reimbursement for orthotics repair. This is not covered under medicare nor HMA.

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

Custom Foot Orthoses fabricated for:
Practitioner: Michael Esber, DPM
[redacted]
Rx#:WK3-14351-10

LVC-SunCityWest
14418 W MEEKER BLVD
SUN CITY WEST, AZ-85375-5283
Tel: 480-788-5621 Fax: 480-779-1277

RECEIPT OF PAYMENT

Date: 12/19/2023
Transaction No: 000000001303

[redacted]

Amount:	Payment Type:	Payment ID:	Card No:	Card Brand:	Date:	Auth Code:
$ 110.00	Credit Card	38959	x7129	VI	Tue 2023-12-19 01:39:56 PM MST	93924D

Card Entry Mode
Manual

Signature
I agree to pay above total amount according to card issuer agreement.

APPOINTMENT CARD

Patient Name: [redacted]

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name
(please print) [redacted]

1. Diagnosis: Dental Crowns
2. Prognosis: Ø
3. Type of Treatment(s) or Procedure: 2 dental Crowns
4. Cost of treatments/service: $ 916.00
5. Request to the board for this specific treatment or procedure:

Member #83 Fire met dental maximum benefit and is requesting reimbursement.

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

October 21, 2024

City of Everett
Fire Pension Board
2930 Wetmore
Everett, WA 98201

On June 11, 2024, I had 3 X-rays and Core Build Up for 2 needed Crowns.
HMA paid these **in full** - $332.00.
($42 for x-rays – D0220 and $290 for Core Build Up – D2950.)

On July 8, 2024, I had two Crowns done-Crown 3 & Crown 4 – D2740.
HMA paid one in full - $1,583.00.
HMA paid the second on at $647.00

I still owed Madrona Dental Care: $916.00 (which I paid on 06/11/2024.)

I'm requesting the Pension Board reimburse me for my out-of-pocket expense of $916.00.

Thank you,
[redacted]

[redacted]

Enclosed:
Claim Form for $916.00
Madrona Dental Care Statement
HMA EOB dated 06/11/2024
HMA EOB dated 07/08/2024

EVERETT
WASHINGTON

City of Everett
Fire & Police Pension
2930 Wetmore EVERETT,
WA 98201
(425) 257-7024

CLAIM FORM

PENSION BOARD APPROVAL:
I certify that the named patient is authorized to receive the described medical care at the expense of the City of Everett Uniformed Personnel Pension Fund. Payment is approved by board action this date. I am authorized to authenticate and certify said claim.

City Clerk or Secretary of Board _____ Date _____

TO BE COMPLETED BY EMPLOYEE

[redacted]

☐ POLICE
☐ FIRE
☐ MALE
☐ FEMALE

THIS SPACE FOR OFFICE USE ONLY

ACCOUNT NUMBER	VOUCHER NO.	VENDOR NO.	DESCRIPTION	AMOUNT
☐ 6375380000250 ☐ 6385380000250			☐ MED SERV ☐ RX ☐ CHIRO SERV ☐ REIMB ☐ OTHER	

I certify that the information and charges here shown are true and correct, and that these services and/or medications were received by me and that I am liable for these charges. I hereby authorize all doctors, pharmacists, hospitals or other instiutions rendering care and treatment to furnish the Fire/Police Pension Board with full information regarding treatment rendered (including copies of their records). I also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish the Fire/Police Pension Board with information regarding benefits to which I may be entitled. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby assign benefit to the supplier/vendor below.

DATE October 21, 2024

EMPLOY [redacted]

STATEMENT OF ATTENDING PHYSICIAN OR OTHER SUPPLIER/VENDOR CHA [redacted]

DIAGNOSIS AND CONCURRENT CONDITIONS
(IF DIAGNOSIS CODE OTHER THAN ICDA USED, GIVE NAME)

REPORT OF SERVICES (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE IF USED (IF CODE OTHER THAN CPT ★★ USED, GIVE NAME	CHARGES
7/8/24	Madrona Dental Care	Crown 4	D2740	1,563.00
			HMA Paid $647.00	
			owed me	

DO NOT WRITE IN THIS SPACE

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

TOTAL CHARGES $ 916.00

TOTAL PAYMENTS $ _____

DATE	SUPPLIER/VENDOR NAME (PRINT)	SIGNATURE	TELEPHONE
STREET ADDRESS	CITY OR TOWN	STATE OR PROVIDENCE	ZIP CODE

514-409 (REV. 6/06)

PENSION BOARD

Madrona Dental Care
1019 24th St
Anacortes , WA 98221
info@madronadentalcare.com
www.madronadentalcare.com
+1 (360) 293-4695

card number

expiry date *security code*

full name (as appears on card)

signature

[redacted]

Outstanding:	Ins Est.:	Your Portion:
$3,458.00	$1,272.00	$2,186.00

Enclosed amount:

Please detach and return this part of the statement with your payment to ensure proper processing

Please keep this part of the statement for your records

Patient Name	[redacted]
Statement Date	06/11/2024
Print Date	06/11/2024

Date	Description	Provider	Amount	Credit	Balance
06/11/2024	**Invoice #52304: $3,458.00**				
	D0220 Intraoral Periapical Xray 3	Brandon Tyler	$42.00		
		HMA-Healthcare Management Administrators	*$0.00*		
	D2950 Core Build Up 3	Brandon Tyler	$290.00		
		HMA-Healthcare Management Administrators	*$120.00*		
	D2740 Crown 4	Brandon Tyler	$1,563.00		$3,458.00
		HMA-Healthcare Management Administrators	*$370.50*		
	D2740 Crown 3	Brandon Tyler	$1,563.00		
		HMA-Healthcare Management Administrators	*$781.50*		
		Outstanding Balance			**$3,458.00**

Total Charges	Total Patient Payments	Total Ins. Payments	Total Adjustment	Outstanding Balance
$3,458.00	$0.00	$0.00	$0.00	$3,458.00

Estimated Remaining Insurance	$1,272.00
Estimated Remaining Ins. Adjustment	$0.00

Your Portion	**$2,186.00**

Account Credit
$0.00

** These transactions will not affect the running balance.*

Next Scheduled Treatment Appointment	Next Scheduled Hygiene Appointment
07/08/2024 3:00 PM with Matthew Gray	11/11/2024 10:00 AM

Healthcare Management Administrators
PO Box 85016
Bellevue, WA 98015-5016

Forwarding Service Requested

HMA

Explanation of Benefits

THIS IS NOT A BILL

[redacted]

14,229

Customer Care

Have Questions? www.accesshma.com
Toll Free: (800) 869-7093
Hours: Monday - Friday 6 AM to 6 PM PST

Group Name: CITY OF EVERETT
Group #: 020188
Member ID: [redacted]
Date: 10/16/2024

DETAILED CLAIM BREAKDOWN FOR [redacted]

Provider: BRANDON TYLER DDS
Claim #: 8277516402

Date & Type of Service	Amount Billed	Member Discount	Amount Not Covered	Reason Code	Amount Covered	Other Insurance Paid	Paid: Paid At	Paid: What Your Plan Paid	Patient Responsibility: Deductible Amount	Patient Responsibility: Co-Insurance Amount	Patient Responsibility: Co-pay Amount
07/08-07/08/2024 DENTAL MAJOR	$1,563.00	$0.00	$0.00	26	$1,563.00	$0.00	100%	$1,563.00	$0.00	$0.00	$0.00
07/08-07/08/2024 DENTAL MAJOR	$1,563.00	$0.00	$916.00	DX 26	$647.00	$0.00	100%	$647.00	$0.00	$0.00	$0.00
TOTALS	**$3,126.00**	**$0.00**	**$916.00**		**$2,210.00**	**$0.00**			**$0.00**	**$0.00**	**$0.00**

COB Credit:	**$0.00**
Adjustments:	**$0.00**
Plan Paid:	**$2,210.00**

Amount You May Owe: $0.00

Reason Code/Description	
26	THIS IS AN ADJUSTMENT TO A PREVIOUSLY PROCESSED CLAIM.
DX	THE DENTAL MAXIMUM BENEFIT HAS BEEN MET.

THIS IS NOT A BILL

What if I need help understanding a denied claim? Contact us at (800) 869-7093 if you need help understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide you or pay for an item or service (in whole or in part).

How do I file an appeal? Complete and send in the Request for Appeal within 180 days of this notice. The form is available online at https://www.accesshma.com/news-and-resources/member-forms or call us to have one mailed to you.

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. If you wish to designate someone to act as your authorized representative, please complete the Appointment of Authorized Representative section of the Appeal Form available online at https://www.accesshma.com/news-and-resources/member-forms

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be conducted on an expedited basis. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by calling (800) 869-7093.

Can I provide additional information about my claim? Yes, you may supply additional information. Please send documentation (medical records, clinical notes, from your treating physician(s), etc.) that you wish to have considered as part of your appeal to: Healthcare Management Administrators, PO Box 85016, Bellevue, WA 98015, ATTN: Appeals Department

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us. All requests need to be submitted in writing. You may complete the Authorization to Disclose Protected Health Information form online at https://www.accesshma.com/news-and-resources/member-forms or mail it to us at: Healthcare Management Administrators, PO Box 85016, Bellevue, WA 98015, ATTN: Appeals Department

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at (866) 444-3272. Additionally, a consumer assistance program may be able to assist you. Please note that not all states have Consumer Assistance programs available. If one is available in your area, we have included that information for you on this document. For the most current program available in your area, please go online to: https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc

Healthcare Management Administrators, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Healthcare Management Administrators
PO Box 85016
Bellevue, WA 98015-5016

Forwarding Service Requested

**********SCH 5-DIGIT 98221
89
[redacted]

HMA

[SF-]

Explanation of Benefits

THIS IS NOT A BILL

Customer Care

Have Questions? www.accesshma.com
Toll Free: (800) 869-7093
Hours: Monday - Friday 6 AM to 6 PM PST

Group Name: CITY OF EVERETT
Group #: 020188
Member ID: [redacted]
Date: 08/19/2024

Hi [redacted]

This Explanation of Benefits (EOB) gives you information about how an insurance claim submitted by you or your healthcare provider (such as a doctor, hospital, or pharmacy) was handled on your behalf. There is a lot of information packed into this document:

- The Summary of Activity shows the amount billed by your healthcare provider, any discounts that were applied, the amount your health plan paid, and any balance you owe to your provider (which you may have already paid).
- The Detailed Claim Breakdown section breaks everything down for you.
- The My Spend and Family Spend sections show how much of the claim was applied to your deductible. It also shows the remaining amount needed to meet your deductible, as well as where you are with your out-of-pocket maximum for the year.

Each time you receive an EOB, review it closely and compare it to the bill or statement from your healthcare provider. If you have any questions, contact us at the phone number provided in the box at the top of this page.

THIS IS NOT A BILL

[SF-]

DETAILED CLAIM BREAKDOWN FOR [redacted]

Provider: BRANDON TYLER DDS
Claim #: 8277516401

Date & Type of Service	Amount Billed	Member Discount	Amount Not Covered	Reason Code	Amount Covered	Other Insurance Paid	Paid: Paid At	Paid: What Your Plan Paid	Patient Responsibility: Deductible Amount	Patient Responsibility: Co-Insurance Amount	Patient Responsibility: Co-pay Amount
06/11-06/11/2024 DENTAL MAJOR	$1,563.00	$0.00	$1,563.00	SQ	$0.00	$0.00	100%	$0.00	$0.00	$0.00	$0.00
06/11-06/11/2024 DENTAL MAJOR	$1,563.00	$0.00	$1,563.00	SQ	$0.00	$0.00	100%	$0.00	$0.00	$0.00	$0.00
06/11-06/11/2024 DENTAL MAJOR	$290.00	$0.00	$0.00		$290.00	$0.00	100%	$290.00	$0.00	$0.00	$0.00
06/11-06/11/2024 DENTAL PREVENTIVE	$42.00	$0.00	$0.00		$42.00	$0.00	100%	$42.00	$0.00	$0.00	$0.00
TOTALS	**$3,458.00**	**$0.00**	**$3,126.00**		**$332.00**	**$0.00**			**$0.00**	**$0.00**	**$0.00**
							COB Credit:	**$0.00**			
							Adjustments:	**$0.00**			
							Plan Paid:	**$332.00**	Amount You May Owe:		$3,126.00

DETAILED CLAIM BREAKDOWN FOR [redacted]

Provider: JONG LIU MD
Claim #: 8252872001

Date & Type of Service	Amount Billed	Member Discount	Amount Not Covered	Reason Code	Amount Covered	Other Insurance Paid	Paid: Paid At	Paid: What Your Plan Paid	Patient Responsibility: Deductible Amount	Patient Responsibility: Co-Insurance Amount	Patient Responsibility: Co-pay Amount
06/13-06/13/2024 DIAGNOSTIC X-RAY	$43.00	$34.96	$0.00	CX	$8.04	$6.43	100%	$1.61	$0.00	$0.00	$0.00
TOTALS	**$43.00**	**$34.96**	**$0.00**		**$8.04**	**$6.43**			**$0.00**	**$0.00**	**$0.00**
							COB Credit:	**$0.00**			
							Adjustments:	**$0.00**			
							Plan Paid:	**$1.61**	Amount You May Owe:		$0.00

Reason Code/Description	
SQ	DENTAL PLAN REQUIRES BOTH THE PREP AND SEAT DATE. ONCE RECEIVED CLAIM WILL BE RE-CONSIDERED. _____
CX	CHARGE REDUCED TO THE MEDICARE ALLOWANCE, THE PATIENT IS NOT RESPONSIBLE FOR THIS AMOUNT.

THIS IS NOT A BILL

What if I need help understanding a denied claim? Contact us at (800) 869-7093 if you need help understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide you or pay for an item or service (in whole or in part).

How do I file an appeal? Complete and send in the Request for Appeal within 180 days of this notice. The form is available online at https://www.accesshma.com/news-and-resources/member-forms or call us to have one mailed to you.

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. If you wish to designate someone to act as your authorized representative, please complete the Appointment of Authorized Representative section of the Appeal Form available online at https://www.accesshma.com/news-and-resources/member-forms

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be conducted on an expedited basis. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by calling (800) 869-7093.

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Healthcare Management Administrators, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Patient Statement

Madrona Dental Care
1019 24th St
Anacortes , WA 98221
info@madronadentalcare.com
www.madronadentalcare.com
+1 (360) 293-4695

[redacted]

Chk #3098
1,270.00
From Dentist
10/23/24

card number

expiry date *security code*

full name (as appears on card)

signature

Outstanding:	Ins Est.:	Your Portion:
$0.00	$0.00	$0.00

Enclosed amount:

Please detach and return this part of the statement with your payment to ensure proper processing

Please keep this part of the statement for your records

Patient Name [redacted]
Statement Date **10/22/2024**

Date	Description	Provider	Amount	Credit	Balance
06/11/2024	**Invoice #52304: $3,458.00**				
	D2740 Crown 3	Brandon Tyler	$1,563.00		
		HMA-Healthcare Management Administrators	*$1,563.00*		
	D0220 Intraoral Periapical Xray 3	Brandon Tyler	$42.00		
		HMA-Healthcare Management Administrators	*$42.00*		
	D2950 Core Build Up 3	Brandon Tyler	$290.00		$3,686.00
		HMA-Healthcare Management Administrators	*$290.00*		
	D2740 Crown 4	Brandon Tyler	$1,563.00		
		HMA-Healthcare Management Administrators	*$647.00*		
06/11/2024	**Patient Pay #52305 *(Visa Card)***			$2,186.00	$1,500.00
	D2740		$781.50		
	D0220		$42.00		
	D2950		$170.00		
	D2740		$1,192.50		

Date	Description	Provider	Amount	Credit	Balance
06/27/2024	**Insurance Pay #52659** ***(Check 333895624)***			$228.00	$1,272.00
	City of Everett by HMA-Healthcare Management Administrators		$150.00		
	D1110		$78.00		
	D0120				
07/08/2024	**Invoice #52794: $0.00**				
	D2740 Crown 4	Brandon Tyler	$0.00		
		HMA-Healthcare Management Administrators	*$0.00*		$1,272.00
	D2740 Crown 3	Brandon Tyler	$0.00		
		HMA-Healthcare Management Administrators	*$0.00*		
08/20/2024	**Claim #53680**				$1,272.00
	City of Everett by HMA-Healthcare Management Administrators				
08/20/2024	**Claim #53681**				$1,272.00
	City of Everett by HMA-Healthcare Management Administrators				
08/20/2024	**Patient Overpayment* #53683**				
	$212.00				
08/20/2024	**Insurance Pay #53684** ***(Check 339383380)***			$332.00	$1,152.00
	City of Everett by HMA-Healthcare Management Administrators		$42.00		
	D0220		$290.00		
	D2950				
10/22/2024	**Patient Overpayment* #55292**				
	$1,058.00				
10/22/2024	**Insurance Pay #55293** ***(Check 345717028)***			$2,210.00	$0.00
	City of Everett by HMA-Healthcare Management Administrators		$1,563.00		
	D2740		$647.00		
	D2740				
10/22/2024	**Credit Refund* #55301** ***(Check 3098)***		$1,270.00		$0.00
		Outstanding Balance			**$0.00**

Total Charges	Total Patient Payments **	Total Ins. Payments **	Total Adjustment	Outstanding Balance
$3,458.00	$916.00	$2,770.00	$0.00	$0.00

Estimated Remaining Insurance	$0.00
Estimated Remaining Ins. Adjustment	$0.00

Your Portion $0.00

Account Credit

$0.00

Statement Summary:

Total Charges	$3,458.00
Total Patient Payments **	$916.00
Total Insurance Payments **	
City of Everett by HMA-Healthcare Management Administrators	$2,770.00
Total Insurance Write-Offs	
Total Office Adjustments	$0.00
Total Refunds	$1,290.00

** These transactions will not affect the running balance.*

*** The payments displayed are before the refund was applied.*

Next Scheduled Treatment Appointment	Next Scheduled Hygiene Appointment
No Scheduled Appointment	11/11/2024 10:00 AM

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name
(please print) [redacted]

1. Diagnosis: Dental Crown
2. Prognosis: _____
3. Type of Treatment(s) or Procedure: Dental Crown
4. Cost of treatments/service: $ 732.00
5. Request to the board for this specific treatment or procedure:

Member #139, Fire is requesting reimbursement for the amount he paid of $732.00

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

[redacted]

10-01-2024

City of Everett
Police and Fire Pension Board
Request to the Board
From [redacted], retired LEOFF-1 (Fire)

Dear Board,

I understand that I can request up to $1,500.00 in additional dental coverage beyond the HMA coverage. I had to put $1,500.00 down on my creditcard for dental service in regards to stem implant for a future crown to an upper front tooth. After HMA payment for all the overall dental service for that there was a total bill of $3,253.00. I did receive a refund of $768.00 of my $1,500.00 creditcard payment. That left a total of $732.00 of the $1,500.00 on my deposit not refunded and means that I paid $732.00 out of my pocket. Therefor, I am requesting that be approved to be reimbursed to me. I do still have several additional dental bills pending action with HMA and expect those to exceed the maximum total offered by the Pension Board I will submit those for hopeful partial payment up to the maximum, and will expect that I will be paying even more after that coverage out of pocket.

Thank you,

[redacted] retired fire

[redacted]

Premier Periodontics - Everett

- Received this July 27, 2024
- Premier called me on July 23, 2024 to tell me HMA DENIED my claim as it needs to go to Primary care Medicare 1st! False

Pay This Amount

$1,451.00

Upon Receipt

Statement Date 06/30/2024

Account Number
90027633

We appreciate your prompt payments.

Office Number
EVRT

- Total bill is $3,253.00; they had me put $1,500.00 on credit card the day of service when I had been told by the City that all I needed to do was to show my HMA card,

Questions? Please contact us at
(425) 252-1136

Pay Online
(Recommended)

To pay online scan QR code or go to
https://pay.yourdentistoffice.com
Payment ID 2696-1560273089 [redacted]

they said they would pay back to my creditcard after receiving payment from HMA! (Now, I will need to follow up on that too.)

Date	Description	Patient Name	Code	TH	Charge	Est Ins	Est Pat	Credit	Balance
06/13/2024	NEW Patient Consult	[redacted]	D0140N		$59.00	$59.00			$59.00
06/13/2024	Cone Beam CT Full 2 Jaw View W/wo Cranium		D0367		$250.00		$250.00		$309.00
06/13/2024	Surg Removal Erupted Tooth		D7210	9	$222.00	$222.00			$531.00
06/13/2024	Bone Graft At Time Of Implant Placement		D6104	9	$393.00		$393.00		$924.00
06/13/2024	GTR Implant-non-resorb		D6107	9	$508.00		$508.00		$1,432.00
06/13/2024	*Immediate* Surgical Implant - Endosteal		D6010S	9	$1,800.00		$1,800.00		$3,232.00
06/13/2024	Intraoral - Peripical First Radiographic Image		D0220		$21.00	$21.00			$3,253.00
06/13/2024	PMT PAT-Master Card / Visa		PP008					$1,500.00	$1,753.00
06/13/2024	ZSAME		ZSAME						$1,753.00

Current	Over 30	Over 60	Over 90	Total Account Balance
$1,753.00	$0.00	$0.00	$0.00	$1,753.00

ESTIMATED INSURANCE	$302.00
ESTIMATED PATIENT	$1,451.00

* Refunded only $768.00 of the $1,500 charged on credit card as down payment
*HMA did not pay entire bill

PREMIER PERIODONTICS - EVERETT
931 PACIFIC AVE
EVERETT, WA 98201

#7812 Evident Alliance
13401 N.E. Bel Red Road, Suite A-7
Bellevue, WA 98005
425-437-2806 (09/05/24)

Pay This Amount	$1,451.00
Due Date	Upon Receipt
Account Number	90027633
Enter Amount Enclosed	

☐ Has your insurance or patient information changed?
Please check this box and indicate any changes on the reverse side.

62 [redacted]

Please make checks payable to: **Premier Periodontics - Everett**

PREMIER PERIODONTICS - EVERETT
931 PACIFIC AVE
EVERETT, WA 98201

plus Pd $1,500.00 on credit card as they REQUIRED on 6-13-2024

184069626

Statement of Services Rendered

PREMIER

931 Pacific Ave
Everett, WA 98201
Ph # : 425-252-1136
Fax # : 425-259-1235

*Check on Credit Card reimbursement @ next Sept. Appt.

Date :	6/13/2024
Account # :	90027633
Account Balance :	1,753.00
Office # :	EVRT

[redacted]

Thursday, June 13, 2024

Date	Description	Chart #	Patient Name	Check #	Code	Th	Surf	Charges	Credits
	Previous Balance								0.00
6/13/2024	NEW Patient Consult		[redacted]		D0140N			59.00	
	Cone Beam CT Full 2 Jaw View W/wo Craniu...				D0367			250.00	
	Surg Removal Erupted Tooth				D7210	9		222.00	
	Bone Graft At Time Of Implant Placement				D6104	9		393.00	
	GTR Implant-non-resorb				D6107	9		508.00	
	Immediate Surgical Implant - Endosteal...				D6010S	9		1,800.00	
	Intraoral - Peripical First Radiographic...				D0220			21.00	
	PMT PAT-Master Card / Visa TransFirst ID: 9002 CTroutID: 000000009002			OPENED GE					-1,500.00
							Total of Today's Activity :	**3,253.00**	**-1,500.00** credit card *
							Total Balance for the Account :	**1,753.00**	

Account Balance as of : 6/13/2024

Current	Over30	Over60	Over90	Over120	Total Balance
1,753.00	0.00	0.00	0.00	0.00	1,753.00
				Estimated Insurance	302.00
				Estimated Patient	1,451.00

Reg Cont. Bal.	Ort Cont. Bal.
0.00	0.00
	0.00
	0.00

Messages :

We appreciate your prompt payments.

Comments :

No Future Appointments

Statement of Services Rendered

PREMIER

931 Pacific Ave
Everett, WA 98201
Ph # : 425-252-1136
Fax # : 425-259-1235

[redacted]

Date :	9/17/2024
Account # :	90027633
Account Balance :	0.00
Office # :	EVRT

Tuesday, September 17, 2024

Date	Description	Chart #	Patient Name	Check #	Code	Th	Surf	Charges	Credits
	Previous Balance								**0.00**
6/13/2024	NEW Patient Consult		[redacted]		D0140N			59.00	
	Cone Beam CT Full 2 Jaw View W/wo Craniu...				D0367			250.00	
	Surg Removal Erupted Tooth				D7210	9		222.00	
	Bone Graft At Time Of Implant Placement				D6104	9		393.00	
	GTR Implant-non-resorb				D6107	9		508.00	
	Immediate Surgical Implant - Endosteal...				D6010S	9		1,800.00	
	Intraoral - Peripical First Radiographic...				D0220			21.00	
	PMT PAT-Master Card / Visa TransFirst ID: 9002 CTroutID: 000000009002			OPENEDGE					-1,500.00
	ZSAME				ZSAME				
7/10/2024	Post Op				ZPOST				
8/20/2024	PMT INS - Credit Card (Dos:06/13/24) CTroutID: 000000009485			OpenEdge					-2,521.00
	AUTO - Insurance Adjustment							768.00	
	AUTO - Xfer Ins Amt To Patient								-768.00
9/9/2024	REFUND - Patient							768.00	
							Total of Today's Activity :	**4,789.00**	**-4,789.00**
							Total Balance for the Account :		**0.00**

Account Balance as of : 9/17/2024

Current	Over30	Over60	Over90	Over120	Total Balance
0.00	0.00	0.00	0.00	0.00	0.00
				Estimated Insurance	0.00
				Estimated Patient	0.00

Reg Cont. Bal.	Ort Cont. Bal.
0.00	0.00
	0.00
	0.00

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name
(please print) [redacted]

1. Diagnosis: Glasses
2. Prognosis: _____
3. Type of Treatment(s) or Procedure: Glasses
4. Cost of treatments/service: $ 175.63
5. Request to the board for this specific treatment or procedure:

Member #102, Fire is requesting reimbursement for balance he paid.

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

EVERETT
WASHINGTON

City of Everett
Fire & Police Pension
2930 Wetmore EVERETT,
WA 98201
(425) 257-7024

CLAIM FORM

PENSION BOARD APPROVAL:
I certify that the named patient is authorized to receive the described medical care at the expense of the City of Everett Uniformed Personnel Pension Fund. Payment is approved by board action this date. I am authorized to authenticate and certify said claim.

City Clerk or Secretary of Board _____ Date _____

TO BE COMPLETED BY EMPLOYEE

[redacted]

ACCOUNT NUMBER	VOUCHER NO.	VENDOR NO.	DESCRIPTION
☐ 6375380000250 ☐ 6385380000250			☐ MED SERV ☐ RX ☐ CHIRO SERV ☐ REIMB ☐ OTHER

I certify that the information and charges here shown are true and correct, and that these services and/or medications were received by me and that I am liable for these charges. I hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish the Fire/Police Pension Board with full information regarding treatment rendered (including copies of their records). I also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish the Fire/Police Pension Board with information regarding benefits to which I may be entitled. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby a[redacted]

DATE 10-23-24

STATEMENT OF ATTENDING PHYSICIAN OR OTHER SUPPLIER/VENDO[redacted]

DIAGNOSIS AND CONCURRENT CONDITIONS
(IF DIAGNOSIS CODE OTHER THAN ICDA USED, GIVE NAME)

REPORT OF SERVICES (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE IF USED (IF CODE OTHER THAN CPT ** USED, GIVE NAME	CHARGES
10-11-24		Glasses		725.63
		HMA Billed		550.00
		Balance Paid	Reimburse	175.63

DO NOT WRITE IN THIS SPACE

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

TOTAL CHARGES $ 175.63

TOTAL PAYMENTS $ _____

DATE	SUPPLIER/VENDOR NAME (PRINT)	SIGNATURE	TELEPHONE
STREET ADDRESS	CITY OR TOWN	STATE OR PROVIDENCE	ZIP CODE

514-409 (REV. 6/06)

PENSION BOARD

SUGAR • HOUSE VISION

Sugar House Vision
2178 S 900 East, Suite 4
Salt Lake City, UT 84106

801-484-2020
sugarhousevision@gmail.com

Printed 10/11/24

[redacted]

Next Appt 8/22/22 2:45 PM
Number 21767
Patient [redacted]
Doctor Ross J Chatwin OD

Date	Description	Units	Amount
10/11/2024	Constitution PAL	2	$299.00
10/11/2024	Polycarbonate	1	$40.00
10/11/2024	Independence Blue AR	1	$125.00
10/11/2024	Transitions® Gen S Gray/Brown	1	$149.00
10/11/2024	Frame	1	$100.00
10/11/2024			

Payments

10/11/24	Card	$175.63

$713.00
Tax: $12.63
$725.63

$175.63

Insurance Billed (credit)
$550.00

Notes

Other Adjustments

Balance Due
$0.00

All Accounts Are Due 30 Days from Date Of Service.
Accounts over 60 days are charged $2.00 per month

Office questions, new products or, LASIK? visit: www.sugarhousevision.com

HEALTH
UNIVERSITY OF UTAH

MORAN
EYE CENTER

Patient Information

Patient Name	Legal Sex	DOB
[redacted]	[redacted]	[redacted]

Visit Information

	Provider	Location
9/17/2024 8:20 AM	William R Barlow	Moran

Department

Name	Address	Phone	Fax
Moran Eye Center Ophthalmology	65 Mario Capecchi Dr Salt Lake City UT 84113	801-581-2352	801-581-8822

Glasses Prescription

	Sphere	Cylinder	Axis	Dist VA	Add
Right	-1.25	+1.75	013	20/20-2	+3.00
Left	-1.50	+2.50	163	20/40-1	+3.00

Type: progressive
Expiration Date: 9/17/2026
UV 400 block

Electronically Signed By: William R Barlow, MD

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name [redacted]
(please print)

1. Diagnosis: Stage IV lymphoma
2. Prognosis: starting 10/31/24
3. Type of Treatment(s) or Procedure: SNF
4. Cost of treatments/service: $ 9,795.00
5. Request to the board for this specific treatment or procedure:

Fire member #39 is requesting approval for assisted living. Includes $4,695 monthly fee, $1,600 level 5 care, and $3,500.00 one time community fee.

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

Providence Regional
Cancer Partnership
1717 13th Street Everett, WA 98201

[redacted]

11/6/2024

To Whom It May Concern:

I am writing on behalf of my patient, [redacted] to document medical necessity for assisted living in long term care. [redacted] was diagnosed with stage IV large B cell lymphoma (ICD: C83.38) in August 2024. Due to deconditioning from recent prolonged hospitalization, and weakness, fatigue, and memory decline due to his diagnosis and ongoing treatment, [redacted] requires a walker and wheelchair for mobility as well as assistance with instrumental activities of daily living (iADLs). [redacted] has also recently had bouts of dizziness and a fall. It is my recommendation that [redacted] continue to reside in an assisted living facility for the reasons listed above. Any further questions, please contact me at 425-297-5560.

Sincerely,

Raisa Epistola, MD
Optum-Providence Regional Cancer Partnership
Phone: 425-297-5560
Fax: 425-297-5561

ASSISTED LIVING
SERVICE FEES

WE OFFER A VARIETY OF LIVING ACCOMMODATIONS DESIGNED AROUND THE CHOICE AND PERSONALIZATION OF EACH RESIDENT'S INDIVIDUAL NEEDS

ASSISTED LIVING

STUDIO	Starting at $4,695
ALCOVE	Starting at $4,895
ONE BEDROOM	Starting at $5,595
TWO BEDROOM	Starting at $6,295

LEVEL OF CARE

LEVEL 1	$200	LEVEL 7	$2,300
LEVEL 2	$550	LEVEL 8	$2,650
LEVEL 3	$900	LEVEL 9	$3,150
LEVEL 4	$1,250	LEVEL 10	$3,650
LEVEL 5	$1,600	LEVEL 11	$4,300
LEVEL 6	$1,950	LEVEL 12	$5,000

ONE TIME COMMUNITY FEE	$3,500
SECOND PERSON FEE	$950 + Care

INCLUDED IN YOUR MONTHLY FEE

- Spacious accommodations
- Staff available around the clock
- Full-service dining
- 24-hour emergency response
- Housekeeping services
- Daily activities, events, or outings
- Scheduled transportation services
- Exercise, health, and wellness services
- Life Alert® pendant

In addition to the exceptional services we offer, residents have full use of our community's amenities, including our full-service dining room, community rooms, library, and salon/barbershop.

The Gardens
at Marysville
A PEGASUS SENIOR LIVING COMMUNITY

(360) 469-6498 | 9802 48th Dr NE, Marysville, WA 98270 | PegasusSeniorLiving.com

RESIDENCY AGREEMENT

THIS RESIDENCY AGREEMENT ("Agreement"), dated Oct 11th, 2024 is between [redacted] ("Resident, You or Your") and [redacted] ("Guarantor, Sponsor, Legal Representative, self-declared or declared by the Resident as their Responsible Party, You or Your") and **Welltower Pegasus Tenant, LLC**, d/b/a **The Gardens of Marysville** ("Community", We, Us, or Our").

You will occupy Apartment # 122 at the Community, located at **9802 48th Drive NE, Marysville, WA 98270** beginning on Oct 18, 2024. You must qualify as required under state law to live in this Community, which is licensed as an Assisted Living & Memory Care Community. All fees will be paid thirty (30) days in advance and are due on the first day of each month except those fees due prior to move in as discussed in Section VII.

Please consider seeking legal/professional advice before signing this Agreement.

I. YOUR ACKNOWLEDGMENT OF YOUR RESPONSIBILITIES AND RISKS:

You acknowledge the desire to remain as independent as possible in Your daily living activities. You acknowledge Your understanding and acceptance, without reservation or coercion, that residing in this Community will not prevent You from facing risks to Your health and safety. By signing this Agreement, You agree to assume certain risks and carry out certain responsibilities. You specifically acknowledge and accept all the responsibility and liability for Your choices and understand that any of these choices may involve serious risks to Your health and safety. Many of these choices will include activities You engage in daily, whether You are in the Community enjoying group activities, participating in activities on Your own, or with Community representatives or others off-site. Your selection of services that You purchase and that We provide is solely Your personal choice. The Community will make representatives available to discuss Our services with You if We believe a certain service may benefit You. If You decline a recommended service, We will document Your decision and discuss whether continuing to live in the Community is appropriate given the level of risk Your choice causes for You and for the Community. When issues arise relating to Your decisions that question Your continued residency, We will include, if necessary, You, a Your responsible or Legal Representative, family members, physician, or others that can provide valuable information.

II. Voluntary Binding Arbitration Agreement (Appendix K)

III. BASIC SERVICES

Included in Your Basic Services monthly fee of $ 4695.00 We will provide You with the following:

A. ***Community Living in*** Apartment # 122 is available so long as You adhere to this Agreement, Resident handbook, all applicable laws and regulations, and policies that are incorporated in this Agreement by reference.

1. You may presently, or in the future, receive or become a beneficiary of financial assistance or reimbursement for fees paid to Us. Until such time the payment begins, You will remain responsible for all fees under the terms of this Agreement. When Your reimbursement begins, You may request to share an Apartment or move into a studio Apartment so You may continue living with Us if You cannot afford a larger Apartment or live alone.

2. If You share an Apartment, the person sharing the Apartment with You will be required to enter into a separate Residency Agreement and meet all of its terms, including being responsible for all fees and the cost of sharing the Apartment. Neither of You will be responsible for the fees of the other, unless that individual is Your spouse, Your legal partner, and/or You are the legal guardian of that Resident and ordered by the Court to make payments for housing and other personal services or are the power of attorney for the Resident. In the event that either Resident desires to live alone, that Resident will need to sign a new Agreement, including spouses or legal partners. The Resident remaining in the Apartment after the other moves out, will pay the monthly fee of the Apartment at its full rate at the time one of the residents moves out, which maybe more than the rate paid for the Apartment at the time the remaining resident first moved in.

3. Apartment changes occur because residents no longer are compatible. If You experience problems with the Resident You share the Apartment with, We will assist You to reach an amicable solution to the problem. However, if either party must change apartments, the party moving will bear all costs related to the move and number 2 above applies.

4. Maintenance of Your Apartment is included in the monthly fee and performed by Us. If You should damage, destroy, or cause wear or tear beyond that of normal use of Your Apartment, You will be responsible for all replacement or repair costs at the time it occurs if during the term of the Agreement or at the time this Agreement terminates.

   a. Alterations or changes to Your Apartment including, but not limited to, the

VI. EXCLUDED SERVICES

We are not licensed nor are We responsible for providing medical services or any services that we are not licensed to provide as mandated by the State of Washington. Any health care or nursing- related services are limited to those described in Appendix A, which describes service levels and/or Appendix C describing optional pay for fee services. We may assist you in arranging for other services through a home health or hospice agency, as long as the services you are requesting are legally able to be provided in the Community.

VII. TERMS

A. ***Terms of Agreement*** are ***month to month*** unless terminated as described below in Section VIII. **If You should terminate this Agreement without giving the proper notice as outlined in Section VIII below, You will be responsible for the Basic Services fees that would have been due from You to Us until the end of the term.**

B. ***Fees*** include the following:

1. All fees are due and payable prior to moving in as discussed in Appendix D and incorporated in this Agreement.

2. Your first fee due to Us, excluding the move in fees, totals $ 4295.00, and is based on the information You provided Us prior to move in. This fee may increase or decrease based upon your needs, risk level, and wants. For example, changing Apartment types or Assisted Living Service Levels will result in fee changes (See Appendix A). Also moving from the Assisted Living side of the community to the secure Memory Care Unit will result in a fee change and signing a new Agreement.

3. Our preferred Method of payment for all fees is through Automated Clearing House (ACH) (See Appendix JJ).

C. ***Late and non-payment*** of all fees will be immediately addressed by Us with You. If You make a payment after the fifth (5th) day, of the month, it is a late payment and Your next fee will include a late charge assessment of two hundred and fifty dollars (***$250.00***). ***Returned checks are considered late payments.*** We will also charge a $30.00 returned payment fee for each check or automatic withdrawal returned by a financial institution for NSF.

D. ***Refunds*** are for those Residents giving proper written notice terminating this Agreement as discussed in Section VIII, transferring to a Community providing a higher level of care, or on their death. Regardless of any refund due, You continue to remain

Appendix D
PRE-MOVE-IN FEES

Community Fee:
A Community Fee in the amount of $ 3600.00 is required prior to or upon move-in. This fee covers the costs of the assessment process, preparation of service plans and documentation. general upkeep, and maintenance of the common areas of the community and grounds and normal cleaning and preparation of the apartment once the resident is discharged. This fee does not cover damages beyond normal wear and tear. This is a non-refundable fee.

Pet Deposit Fee:
A pet fee in the amount of $ 0.00 is required prior to or upon move-in for any resident who chooses to keep a pet on the premises, and you will be required to complete a separate pet agreement for this. This fee does not cover damage caused by the pet to the resident's apartment or the common areas or property of the community. This fee also does not cover pet care, including feeding, clean-up, walking, etc. This fee is for the normal wear and tear that is additional to keeping a pet on the premises. This fee is non-refundable.

First Month's Rent:
A fee for the first month's rent (or prorated for the number of days left in the month) of $ 4695 is required prior to or upon move-in. Rental and care charges are pre-billed and will be due on the 1st day of each month. If the resident is moving in toward the end of the month, they will also receive an invoice for the following month, which will be due by the 1st of the following month.

Care Service Fee:
Based upon Your initial service evaluation, You should expect that the initial Service Fee will be $ 1600.00 per month. This fee will be prorated for upon move-in for Your first month.

Medication Management Fee: If Applicable, based upon Your initial service evaluation, You should expect the Medication Management fee of $_____per month. This fee will be prorated for upon move-in for Your first month.

Date: 10-11-2024 By [redacted]
Resident/Responsible [illegible]

Date: 10/11/2024 By: _____
Executive Director

Pegasus

Negotiated Service Plan
Resident Name [redacted]
Report Run: 10/11/2024 5:42:01 PM

as Washington Evaluation - Pre-Move In

Name: [redacted]
Room:
Billing ID: 12189918
Customer ID: 2189918

Evaluation Begin Date: 10/11/2024 03:46 pm EDT
Evaluation Submit Date: 10/11/2024 03:46 pm EDT
Assessment Model ID: 137
Reviewer: falon.messer

Service Plan from
Service Plan Date: 10/11/2024 03:46 pm EDT

Diagnosis: No data to display.

Allergies: No data to display.

Diagnosis and Allergies Are Established As Of: 10/11/2024

Code Status: Not Known

Emergency Situation Assistance:

Cognitive, Psycho-Social Capabilities

Orientation

Need:	Expected Results:	Service:	Delegating Par
Resident is alert and oriented to person, place and time. Care Partners should report any changes or concerns	Resident will continue to be Alert and Oriented with no deviation from baseline	Care Partners will report any changes	Care Partner

Activities of Daily Living/Physical Functioning

Oral Care

Need:	Expected Results:	Service:	Delegating Par
Resident is independent with task. Care Partners are to report any changes or concerns.	Any evidenced concerns will be reported to HWD or ED.	Resident's care needs will be met, either independently or with assistance.	Care Partner

Dressing and grooming

Need:	Expected Results:	Service:	Delegating Par
Resident is independent with task. Care Partners are to report any changes or concerns.	Any evidenced concerns will be reported to HWD or ED.	Resident's care needs will be met, either independently or with assistance.	Care Partner

Bathing

Need:	Expected Results:	Service:	Delegating Par
Resident requires physical assistance for all showering/ bathing needs.	Resident maintains independent and is clean, odor free and well groomed.	Staff will provide assistance gathering all bathing supplies, assisting in and out of shower, washing and drying resident, while encouraging resident to participate in the task, while maintaining resident dignity. 2 time(s) per Week	Care Partner

Bathroom Assistance

Need:	Expected Results:	Service:	Delegating Par
Resident is independent with task. Care Partners are to report any changes or concerns.	Any evidenced concerns will be reported to HWD or ED.	Resident's care needs will be met, either independently or with assistance. [redacted] utilizes disposable undergarments for incontinence needs. [redacted] s independent with his toileting. Staff to monitor and report any concerns to nurse and/or ED.	Care Partner

Mobility, Transfer, Escort

Transfers and Mobility

Need:	Expected Results:	Service:	Delegating Par
Resident is independent with task. Care Partners are to report any changes or concerns.	Any evidenced concerns will be reported to HWD or ED.	Resident's care needs will be met, either independently or with assistance. [redacted] has a history of 2 falls in the last six months. Staff to monitor mobility and report any concerns to nurse and/or ED.	Care Partner

Status Checks?

Need:	Expected Results:	Service:	Delegating Par
Resident requires status checks during the night. Care partners will observe resident periodically throughout the night to assist with or help ensure safety.	Resident will have status checks periodically throughout the night.	Checks will be made periodically throughout the night.	Care Partner

Escort assistance

Need:	Expected Results:	Service:	Delegating Par
Resident is independent with task. Care Partners are to report any changes or concerns.	Any evidenced concerns will be reported to HWD or ED.	Resident's care needs will be met, either independently or with assistance.	Care Partner

Assistive Devices

Need:	Expected Results:	Service:	Delegating Par
Resident uses an assistive device for mobility. Care partners to help ensure resident is using.	Resident will utilize device to maintain mobility and help ensure decreased risk during mobility.	Resident will maintain safe mobility. [redacted] utilizes a 2W walker.	Care Partner

Fall Risk

Need:	Expected Results:	Service:	Delegating Par
Fall Interventions- Resident has experienced two or more falls in the past year and one or more of the following fall risk factors are present; fear of falling, poor balance, poor vision, cognitive impairment, use of multiple medications and/or the use of psychotropic medications, or incontinence. Requires direct interventions that are customized to the identified risk factors.	Resident will have no additional falls, any new concerns will be reported and fall interventions remain in place as needed.	Established fall interventions will be followed and adjusted as needed. [redacted] has had two falls in the last six months. Staff to monitor and report any concerns to nurse and/or ED.	Care Partner

Nutrition, Dining Services

Diet Order

Need:	Expected Results:	Service:	Delegating Par
Resident is on a regular diet	Resident is on a regular diet without restrictions	Care Partners to report any concerns	Care Partner

[illegible]l Reminders

Need:	Expected Results:	Service:	Delegating Par
Resident is independent with task. Care Partners are to report any changes or concerns.	Any evidenced concerns will be reported to HWD or ED.	Resident's care needs will be met, either independently or with assistance.	Care Partner

Dining Assistance

Need:	Expected Results:	Service:	Delegating Par
Resident is independent with task. Care Partners are to report any changes or concerns.	Any evidenced concerns will be reported to HWD or ED.	Resident's care needs will be met, either independently or with assistance.	Care Partner

Health Related Services

Chronic Pain

Need:	Expected Results:	Service:	Delegating Par
Resident has Chronic Pain and will need assistance to manage pain.	Pain management assistance will be provided by Care Partners as indicated through positioning, use of ice packs or other directives, and/or assistance of medications provided by designated or licensed associates as ordered by physician.	Resident's pain will be managed at a level that is tolerable for the resident or communicated to the physician for changes as needed. [redacted] utilizes a PRN for pain management.	Health & Welln

Chronic Illness

Need:	Expected Results:	Service:	Delegating Par
Resident has chronic diagnosis. Care Partners will report any change of condition outside of residents baseline.	Changes in condition will be reported.	Resident will have changes reported so that new treatments can be implemented if needed.	Care Partner

Acute Illness

Need:	Expected Results:	Service:	Delegating Par
[illegible]artners will report any behaviors or symptoms that are different from residents baseline. Care Partners will report any changes or concerns.	Any changes from baseline will be reported to nurse as change of condition.	Change of condition will be reported to nurse/MD for further direction.	Care Partner

Skin Care Needs

Need:

Resident is independent with task. Care Partners are to report any changes or concerns.

Expected Results:

Any evidenced concerns will be reported to HWD or ED.

Service:

Resident's care needs will be met, either independently or with assistance.

Delegating Par

Care Partner

Medication Assistance

Need:

Resident requires assistance with medications. Medication Associates to assist with medication administration per physician's orders.

Expected Results:

Resident will receive medications as ordered.

Service:

Resident will receive medications as ordered.

Delegating Par

Medication Tec

Resident Utilizes Home Health

Need:

Resident on Home Health Services. Third Party to coordinate and communicate care with physician, Staff nurse and family.

Expected Results:

Resident will meet or exceed home health care goals.

Service:

Resident will meet or exceed home health care goals.

Assured Home Health for PT/OT.

Delegating Par

Health & Welln

Laundry and Housekeeping

Housekeeping

Need:

Resident will have weekly housekeeping services

Expected Results:

Apartment will be cleaned weekly

Service:

Community housekeeping services will clean apartment weekly and report concerns

1 time(s) per Week

Delegating Par

Housekeeper

Laundry

Need:

Resident will have weekly laundry services

Expected Results:

Resident will have one load linens/towels and one load clothing washed weekly by Community staff

Service:

Resident will have clean clothing available weekly

1 time(s) per Week

Delegating Par

Care Partner

Care: Resident Care - 5

Secondary Care: Incontinence Management: Incontinence Supply Program 0 , Non-Approved Packaging: Non Community Med Package Fee Level 0

Administrator or Designee Title Date 10/11/24

Community Nurse or Designee Title Date

Resident Date

Family Member [redacted]

Resident Representative

Please circle one of the followi

Conservator No Legal Rep

The Resident/Responsible Party has been provided with a copy of this Functional Needs Service Plan [redacted]

24 Hour/Day Emergency Response System and awake Resident Care attendants available.

Plan based on a current assessment and information provided by the Resident, Legal Representative, Responsible Party or Physician.

**Key access by the community staff to your apartment may be needed for the following reasons: (1) medication delivery, (2) during an emergency, (3) by representatives from Housekeeping and/or Maintena

Focus	Goal	Interventions	Position	Freq/Resolved
• At risk for impaired cognitive function/dementia or impaired thought processes r/t C/A Date Initiated: 09/10/2024	[redacted] will maintain current level of cognitive function through the review date. Target Date: 12/28/2024	• Engage in simple, structured activities that avoid overly demanding tasks.	NG SS	
		• Needs supervision/assistance with all decision making. (SPECIFY)	NG SS	

Allergies	No Known Allergies	D.O.B.	[redacted]	Physician	Nishita Bhumkar
Facility	Mountain View Rehabilitation and Care Center				
Resident	[redacted]	Admission Date	09/10/2024	Location	C 12 W

Name	Signature	Date	Name	Signature	Date