Everett Police Pension Board Meeting Agenda

May 21, 2025, 9:00 a.m. via Microsoft Teams

1.) Approval of minutes for April 16, 2025

2.) Bills and Pension Rolls:

PENSION ROLL		
Budgeted Amount	$515,000.00	
March 2025	$44,695.26	
Remaining budget	**$380,955.77**	**73.97%**
MEDICAL CLAIMS		
Budgeted amount	$1,410,000.00	
March 2025	$75,200.25	
March 2025 HMA fees	$11,001.90	
Remaining budget	**$1,061,885.41**	**75.31%**

3.) Action Item:

Member #131	Request for reimbursement of $128.00 for optical costs in excess of yearly cap.
Member #145	Request for reimbursement of $1,500.00 for dental costs in excess of yearly cap.
Member #37	Request for in-home care in the amount of $2,500.00 per month. This amount is under the Genworth cost of care survey.

4.) Other Items

- RBC Wealth Management update – Michael Brittain

EVERETT
WASHINGTON

RECEIVED
APR 22 2025
CITY OF EVERETT
HUMAN RESOURCES DEPT.

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: Macular Degeneration
2. Prognosis: difficulty with Sun Light
3. Type of Treatment(s) or Procedure: ~~sunglasses to help with sensitivity~~ Purchased Varilux prescription to sunlight
4. Cost of treatments/service: $ 128.00 Balance insurance did not pay.
5. Request to the board for this specific treatment or procedure:

Request reimbursment of $128.00 for out of pocket expenses for what insurance did not pay.

(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

Leavenworth Vision Source
1133 Hwy 2, Suite G
Leavenworth, WA 98826-1439
509-548-7379

Statement of Charges and Payments

Fee Slip Number: 206527
Date Printed: 12/23/2024
Provider: Jason D Barnes OD
Office Phone: 509-548-7379

To: [redacted]

Patient: 25142 [redacted]
Chart #:
Home Phone: [redacted]
Next Appt:

Date of Service	Ord #	SKU #	Qty	Description	CPT	Diagnosis	Amount	Patient Balance
09/06/2024	102699	805289526575	1	R84165	V2020	H52.4	189.00	
				Billed HMA-L			(189.00)	
09/06/2024	102699		1	Varilux Comfort 2 DRx	V2300	H52.4	144.50	
				Billed HMA-L			(80.50)	
09/06/2024	102699		1	Varilux Comfort 2 DRx	V2300	H52.4	144.50	
				Billed HMA-L			(80.50)	
09/06/2024	102699		1	Xperio UV polarized	V2762	H52.4	200.00	
				Billed HMA-L			(200.00)	
				Total Current Charges			128.00	
				Balance Due				128.00
				Other Open Items				0.00
				Please Pay this Amount				128.00

HMA CK #
34568498

Total Charges (Pat. Total + Ins. Total)= 678.00

NOTE: Billed to Insurance: $550.00 plus Sales Tax of 0.00 = $550.00

Thank you for your confidence and trust.

Total Due	128.00	Patient #	25142	Statement Date	12/23/2024
Amount Enclosed		Check #		Patient	[redacted]
		Chart #	L		

Leavenworth Vision Source
1133 Hwy 2, Suite G
Leavenworth, WA 98826-1439
509-548-7379

[redacted]

Checks Unlimited 1-800/210-0603 www.checksunlimited.com

[redacted]

98-6052/3251

12315

3-25 2025

Pay to the order of Leavenworth Vision $ 128 00/100

One-Hundred-Twenty-Eight & 00 Dollars

Security features included. Details on Back.

[redacted]

for

[redacted]

PALM TREE G

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: _____

2. Prognosis: _____

3. Type of Treatment(s) or Procedure: Teeth Extraction

4. Cost of treatments/service: $ 5,578.00

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

Police, LEOFF 1 member #145 had teeth extracted. Total claim was $5,578.00. Member maxed out his dental benefit coverage. Member is requesting $1,500.00 from the board for reimbursement.

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

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

[redacted]

BILLING DATE
03/25/2025

GUARANTOR NAME AND MAILING ADDRESS
[redacted]

PATIENT	TOOTH	SURF	DESCRIPTION	CHARGE	CREDIT
[redacted]			Complete denture - maxillary	3022.00	
	3		Extraction-surgical/erupt tooth	426.00	
	5		Extraction-surgical/erupt tooth	426.00	
	7		Extraction-surgical/erupt tooth	426.00	
	8		Extraction-surgical/erupt tooth	426.00	
	9		Extraction-surgical/erupt tooth	426.00	
	11		Extraction-surgical/erupt tooth	426.00	
			VISA/MC Payment -Thank You		-3078.00

PRIOR BALANCE		CURRENT CREDITS		CURRENT CHARGES		NEW BALANCE		DENTAL INS. EST.		PLEASE PAY
0.00	-	3078.00	+	5578.00	=	2500.00	-	2500.00	=	0.00

PATIENT	DATE	TIME	REASON

 DLWLK 1

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board May. 2, 25

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

Member Name
(please print) [redacted]

1. Diagnosis: LYMPHOMA - CHEMO-THERAPY
2. Prognosis: TERMINAL
3. Type of Treatment(s) or Procedure: WEEKLY CHEMO-
4. Cost of treatments/service: $HOME CARE. $2500 MONTH
5. Request to the board for this specific treatment or procedure:

HOME CARE - BY PANAMA HOME CARE.COM
REFER - HOME CARE SERVICES - CHEMO - SEVERE
REACTIONS - NOTE - DR. LETTERS FOR BEST INFO
MUCH CHEAPER THAN A FACILITY

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

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2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

See attachments
1. Dr. letters
2. Panama Home Care.

April, 2025

TO WHOM IT MAY CONCERN

I am the primary care doctor for Mr. [redacted] He has been my 85 year old patient since 2005, when I diagnosed him with lymphoma (cancer).

During the past 24 years as my patient, he has been challenged with many medical conditions, cardiology Stent, prosthetics in both knees, severe osteoarthritis in both shoulders, macular degeneration in his right eye, several prostate operations

All of which he has as my patient ,he has done well.

However, his indolent lymphoma has transformed into B cell aggressive cancer. He received preliminary tests here in Panama, but my recommendation was to return to the USA where he was originally treated.

Mr. [redacted] is now in the Seattle area under treatment.

For the past several years, [redacted] has had a young medical care giver. Unfortunately, he has now started his internship and will no longer be available to assist [redacted]

It is my recommendation that [redacted] be provided with an assistant to assist with his growing medical treatments. His protocol requires Chemotherapy every 3 weeks for several months. Here in Panama this will require trips to Panama City. He should at this time be most comfortable at home, where his Nature Reserve is most conducive for recovery. Panama Home Care can provide those services as required.

E-mail: benjamingoldman@hotmail.com
Number phone: +507 6675-9058

Thank you for your consideration and feel free to contact me for any further questions.

DR Manuel Espinosa

April, 2025

TO WHOM IT MAY CONCERN

My name is Farid K. Palacios S. ID 4-825-2194, I am a graduate medical student, presently working internship at Hospital Regional Rafael Hernandez in David, Panama
I have been Mr. [redacted] caregiver for the last several years, tending to his many medical conditions relating to his age and co- morbidities .

At this time because of my duties as intern, I am unable to provide him with the necessary help he needs, which is especially critical, since his recent diagnosis with aggressive cancer, which will require daily supervision .
It is my recommendation that Mr. [redacted] be provided in house [at home] assisted living support.
His primary doctor Dr. Manuel Espinosa concurs with this and will submit his separate recommendation .

This is my email: faridkpalacios1998@gmail.com
My phone number: +507 6575-1480

Thank you for your consideration and feel free to contact me if you have any questions or concerns.

Farid Palacios
4-825-2194

Dr. Farid K. Palacios S.
Médico interno
7351-24

Dr. Farid K. Palacios S.
Médico interno
7351-24

www.PanamaHomeCare.com

Home Health Care for Expats

Por beneficio de todos

Client Service Agreement

Date: 16 December 2024

Client: [redacted]

Patient: [redacted]
Date of Birth: [redacted]
Identification: retain copy on file

Requested - photo of cedula; doctor's contact info

Diagnosis: TBD w medical evaluation LYMPHOMA - CANCER

Preliminary Notes: Have a plan that will pay for home care. Retired police officer from state of Washington. [redacted] years. Requires live in caregiver. **starting to lose eyesight. Knee replacements; stints** - CHEMOTHERPHY - CANCER

Plan Objectives: Plan for escalating care from present to end of life. Medical evaluation, to determine level of service needed. Live in caregiver needed for help with daily living. Further assistance tbd.

Contacts:

Emergency Contact: [redacted]
Phone: [redacted]
Relationship: [redacted]
Address [redacted]

Secondary Family Contact (stateside): [redacted]

Medical

Doctor: Name: MANUEL ESPINOZA - GOLDMAN
Telephone: 507 6675 9058

Specialists - Type, Name and telephone:

DR. BENITO A. CASTILLO RIOS - HEMPTOLOGY - CANCER
CHOP - 265-2231 - 611/264 5155 PANAMA CLINIC
PANAMA

Non-Medical Home Care Services Agreement

This agreement is made effective as of December 10th 2024 by and between [redacted] residing a[redacted]anama, hereinafter r[redacted] as the "Client", and Panama Home Care, hefeinafter referred to as the "Service Provider".

1. **Services** - the Service Provider agrees to provide non-medical home care services to the Patient as described in the attached Schedule A.
2. **Schedule of Services** - Services will begin - date TBD. Schedule of services is attached hereto in Schedule B.
3. **Fee for Services** -
   - **A.** Live in Caregiver monthly rate is $ 2,500.00 .
   - **B.** If applicable, Room and board will be provided to live-in caregivers who will reside on site to be available and provide round the clock care and a monthly rate will apply.
   - **C. Additional services** such as Doctor's visits, medications, medical tests, x-rays, transportation, and other expenses as incurred. Expenses will vetted by care coordinator and pre-approval will be sought. Allowance for emergency expenses may be sought.
     1. Initial medical evaluation and house call by Medical doctor - $200
     2. Further tests - radiology, blood tests etc will be charged at cost.
   - **D. Payments** will be Electronic Transfer to the account information below. Payments to be made in advance of the 1st and 15th for monthly clients and at the beginning of the week for other clients. Payment for Additional Services/ Expenses for the month will be due with the month end payment.
     - Bank: Banistmo
     - [redacted]
4. **Independent Contractor Status** - The Service Provider is engaged as an independent contractor. This Agreement does not create an employer-employee relationship between the Patient and the Service Provider nor the Service Provider's Representative.

5. **Caregiver** - The Service Provider will appoint a primary care giver to provide home care services to the client as described in the attached Schedule A. The Representative agrees to perform these services under the terms and conditions set forth in this agreement. Weekend relief services will be provided by as required.
6. **Term of Contract** - Services will begin 2025-5-1 YYYY/MM/DD and continue for as long as required. Services may be terminated with 30 days notice by either party.
7. **Duties and Responsibilities** - In addition to the services provided by the caregiver as outlined in Schedule A the care coordinator will serve as the point of contact to address any concerns and provide and/or arrange any additional services requested by the client.
8. **Confidentiality** - The Service Provider agrees to keep all personal and health information of the Patient confidential and secure except as otherwise required by law and/or at the Patient/Client's request.
9. **Termination** - This agreement may be terminated by either party with 14 days' written notice to the other party. Parties agree to provide maximum notice possible.
10. **Entire Agreement** - This agreement, along with Schedules A and B, constitute the entire agreement between the parties, superseding all prior agreements, whether written or oral.
11. **Amendments** - must be made in writing and signed by both parties.
12. Limit of Liability Clause
    - **A.** **Scope of Services**: Our home health care services are provided with the utmost care and professionalism. Our liability is limited to the scope of services explicitly agreed upon in the service agreement.
    - **B.** **No Guarantees**: While we strive to provide high-quality care and support, we do not guarantee specific outcomes or results. Any suggestions or advice offered by our caregivers or staff are for informational purposes only and should not be considered medical advice. Only doctors can provide medical advice.
    - **C.** **Limited Liability**: To the fullest extent permitted by law, Panama Home Care and its employees, agents, and subcontractors shall not be held liable for any direct, indirect, incidental, special, or consequential damages arising out of or in connection with the provision of services. This includes, but is not limited to, personal injury, property damage, loss of data, or financial loss.
    - **D.** **Indemnification**: The client agrees to indemnify, defend, and hold harmless Panama Home Care, its employees, agents, and subcontractors from and

against any and all claims, damages, losses, and expenses (including attorney's fees) arising out of or resulting from the provision of home health care services, except to the extent that such claims, damages, losses, or expenses are caused by the gross negligence or willful misconduct of Panama Home Care.

E. **Force Majeure**: Panama Home Care shall not be liable for any failure or delay in the performance of services due to causes beyond its reasonable control, including, but not limited to, acts of God, natural disasters, pandemics, war, civil unrest, or government regulations.

F. **Dispute Resolution**: Any disputes arising out of or in connection with this agreement shall be resolved through mediation or arbitration, as mutually agreed upon by the parties. Any legal actions shall be governed by the laws of Panama.

G. **Severability**: If any provision of this limit of liability clause is found to be unenforceable or invalid, the remaining provisions shall remain in full force and effect.

Signatures

By their signatures below, the parties hereby agree to the terms and conditions of this Agreement.

Client:

[redacted]

Client

April 1, 2025

Date

Service Provider: Panama Home Care

Jacob Froese

Jacob Froese

April 20, 2025

Date

Schedule A - Services

Non-medical Services may include but are not limited to:

- Personal care
- Assistance with daily living activities
- Bathing - in shower or bed-bath
- Toileting - including use of adult diapers as required
- Meal preparation
- Grocery shopping
- Light housekeeping
- Companionship
- Accompaniment for medical appointments

Schedule B - Schedule of Services

I. Medical evaluation and referral to specialists - as required.

A. **Initial Medical evaluation - $** 500.00

II. Live - in Caregiver - **Weekly - 5-6 days / week with respite caregiver on primary caregiver's days off**

A. 24/7 care

III. Additional services to be arranged as needed.

TRANSPORTATION FOR MEDICAL VISITS.

AIR FARE DAVID TO BTY -

7. Advanced Care Planning

A. **Legal and Financial Planning**: Assistance with advance directives, power of attorney, and financial planning.

- Last Will and Testament: required? Legal contact?
- Transportation of remains if required

Client indicates - this has been taken care of.

B. **End-of-Life Wishes**: Discussions about the patient's wishes for end-of-life care and ensuring they are documented and respected3.

- list of those requiring notification. ARRANGED.

C. **Funeral arrangements:** burial/cremation

Details: CREMATION

8. Coordination of Care

A. **Care Coordinator**: A dedicated care coordinator to manage appointments, medications, and communication between different healthcare providers.

B. **Regular Reviews:** weekly calls with the Care Coordinator

Care Coordinator will be Jacob Froese 507-6396-7657 call/whatsapp or email homehealthcarepanama@gmail.com

9. Technology and Equipment

A. **Medical Equipment**: Provision of necessary medical equipment such as hospital beds, oxygen supplies, emergency call device and mobility aids.

B. **Telehealth medical appointments**.

Type to enter text ON PREMESES

10. Community Resources

A. **Local Services:** potential for organizing volunteers from local expat community

Type to enter text AVAILABLE - BOUCHE CARE GIVERS

11. Other Services

A. **Yard and home maintenance**

B. **Transportation**

C. PROVIDER

Type to enter text