

LEOFF Board Application for Payment of Services

Case No: 26-2

Please Print Clearly & Legibly - Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: [REDACTED] Active: [REDACTED] Retired: ☒

Member Telephone: [REDACTED] Police: [REDACTED] Fire: ☒

Member Address: [REDACTED]

Alternate Contact: [REDACTED]

Describe Your Condition and Why It Is Duty Related: Fractured ankle (right) w/ 3 broken bones, which will require surgery.

Describe the Service/Treatment Requested: In home care from 8-12 every day to assist w/ ADL's such as bathing, personal care (showering, brushing teeth, etc), cooking/meal prep, ambulation, toileting.

Total Cost of Treatment/Service: \$ 2,608.94

Amount Paid by Insurance/Medicare: \$ 0

Amount Requested from the Board \$ 2,608.94

assistance w/ dr. appts. End date TBD.

Please attach the Explanation of Benefits statement(s) from your insurance provider(s) and/or Medicare which indicates the amount paid for this treatment/service.

Member Signature: [REDACTED]

Please attach a copy of the Power of Attorney if signed by the alternate contact.

B) This Section To Be Completed by Member's Attending Health Care Provider (attach additional pages as needed)

Provider's Name: T. D. Maniering, D. Provider's Telephone: [REDACTED]

Clinic/Office Name: Olympic Orthopaedic Assoc.

Provider's Address: 3901 Capital Mall Dr. SW Suite Olympia, WA 98502

Describe the Patient's Current Condition and State Whether It Is Duty Related:

Right Trimalleolar ankle fracture/dislocation

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary:

Surgical Treatment of fracture To restore alignment & stability.

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:

Provider's Signature: [Signature] Date: 12-16-25

Fax Completed Form to: (360) 709-2735 or mail to: City Of Olympia HR Dept, PO Box 1967, Olympia WA 98507-1967

**Consent and Service Agreement**

Thank you for choosing Serengeti Care as your Home Care provider. Our goal is to provide you with exceptional service. We trust this partnership will exceed your expectations.

Effective this date: 12/12/25

This Service agreement is made between Serengeti Care: 607 SW Grady Way, Suite 110 Renton, WA 98057, and client:

Client Name



DOB 3/27/45 Social Security Number 5753

Hereinafter referred to as "I" for the service that will be rendered by Serengeti Care as agreed with you and as written on the plan of care.

I understand that:

This service agreement will commence/shall be deemed to have commenced on the date as listed above and will continue until terminated by either party.

At the beginning of care, it has been determined that Serengeti Care will provide care until it is determined that the service is no longer needed. Any change to the agreed-upon schedule must be made through a Serengeti Care Manager and myself, and not with the Caregiver(s) from Serengeti Care.

Time Keeping:

Serengeti Care uses an electronic visit verification (EVV) either by an application on their cellular device or Telephony system to note the time of arrival and departure by the Serengeti Care provider. Telephony requires use of the client's phone. The Serengeti Care Provider will use the client's phone to dial in upon arrival and out upon departure. The Telephony system is a free call, and no charges will apply. In cases where the client has no landline telephone, the care provider may use their cell phones as an alternative.

Holidays:

Services rendered on the following holidays will be billed at 1.5 times the regular hourly/daily rate: New Years Day, Presidents Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Day, Veteran's Day, Martin Luther King, Jr. Day

****Does not apply to VA or AAA/DSHS Clients****

Overtime: Overtime is considered any time worked over 40 hours in a billable week. If you choose to have 1 caregiver for more than 40 hours in a billable week, you will be billed at 1.5 times the regular hourly/daily rate.

****Does not apply to VA or AAA/DSHS Clients****

Meals/Break Periods:

In accordance with State and Federal Labor Laws, Serengeti Care providers are entitled to take a 10- minute break for every 4 hours of consecutive hours worked and a 30-minute meal period after 6 consecutive hours worked. These breaks will continue at the 8-hour and 12-hour marks. These are paid breaks/meal periods, the Serengeti Care provider may not leave the premises while on break and must stop their break should an urgent need arise. They are entitled to resume any unused portion of their break after the need has been met. The client is not responsible for providing any meals to the Serengeti Care Provider during an hourly shift.

When receiving Live-In Care, the Serengeti Care Provider may not spend more than 20% (4 hours) of the time providing housekeeping chores daily. The client is responsible for providing a private sleeping area and all meals for the caregiver. *The caregiver must be allowed 8 hours of sleep on a nightly basis.* Should the caregiver be woken to assist with care during the night, any awake time resulting in a period of no less than 5 hours of uninterrupted sleep will result in the shift (24-hour period) converting from a daily live-in rate to an hourly rate for the full 24-hour block of time.

**** Live-In Care does not apply to VA or AAA/DSHS Clients**** Initials 

Supplies:

The client is responsible for supplying all items needed for their direct care. This includes but is not limited to briefs, pads, gloves, cleaning supplies and other personal hygiene supplies. Serengeti Care can assist with coordinating/obtaining of such supplies when requested by client.

**** Does not apply to VA or AAA/DSHS Clients****

Safe from Abuse:

Serengeti Care values the safety of both our clients and our employees. By entering into this agreement, you agree to provide a safe working environment that is free from any emotional, racial, physical, financial, or sexual abuse. Violating these terms will result in the cancellation of services. Likewise, the client is entitled to be free from any emotional, racial, physical, financial, or sexual abuse/exploitation.

Initials AG

Tips/Gifts:

Serengeti Care staff are not allowed to accept tips or gifts of any kind without prior authorization by the General Manager. Do not pay your caregiver directly for any services rendered.

Initials AG

Direct Hire:

Client/Client Representative agrees to not offer direct employment to any Serengeti Care provider for a period of 180 days following completion of services rendered. In the event the client/representative violates this agreement, the client shall pay a sum of \$18,000 as liquidated damages.

**** Does not apply to AAA/DSHS Clients****

Initials AG

Billing/Invoices:

Serengeti Care invoices for care are provided on a weekly basis. Our billing cycles run Sunday at 12:00 AM through Saturday at 11:59 PM. Invoices will be sent electronically unless otherwise requested.

Email address for Invoices:

[REDACTED]

Initials AG

Payments:

Payment for services will be established via Auto Pay or check. Auto Pay can be made via Credit/Debit or via ACH payment. Forms are provided for your completion to enroll into AutoPay. Your card/account will be charged for services provided the previous week.

For Clients/Client Representatives requesting to pay via check, a 2 -week prepayment for

services will be collected at the time the Service Agreement is established. The 2 -week prepayment will be in the amount equal to 2-weeks' worth of scheduled care. The pre-

payment will be immediately applied to your account. Should services cancel prior to fully using the pre-payment amount, Serengeti Care will reimburse the Client/Client Representative for any unused portion of the pre-payment within 20 days of services ending.

Clients/Client Representatives paying by check will be charged a late fee in the amount of \$45 dollars for any invoice unpaid within 14 days of receipt. 3 or more late payments will result in mandatory enrollment in Autopay.

A 25% interest rate per year will be added to any unpaid balance after 30 days. Client agrees to pay all collection costs including attorney's fees incurred in the collection of this account if not paid in full within 90 days of invoice.

**** Does not apply to VA or AAA/DSHS Clients****

Initials AS

Insurance:

Client/Client Representatives assume all responsibility for the payment of any and all sums that become due for stated services, including third-party billings to their insurance company. Serengeti Care cannot bill Insurance companies for services rendered unless there is prior authorization/assignment of benefits on file. Submitting invoices to the client's insurance company is not a guarantee of payment.

Rates: Initials AS

I agree to pay Serengeti Care for the services rendered at the following rates:

\$ 44.00 /hr.

\$ 7 days a week. ~~1 hr.~~

*Additional ~~\$10/hr.~~ COVID-19 Hazard pay when applicable. Initials AS

Mileage

Mileage driven by the Serengeti Care provider on behalf of the client will be billed at the standard annual rate set by the IRS.

Should the client desire the Serengeti Care provider to use the client's vehicle to avoid mileage charges, the client agrees to notify their insurance carrier and have the provider approved by their insurance company as a driver of their vehicle. Client agrees to fully indemnify Serengeti Care for any losses it sustains as a result of failure by their insurance company to cover any liability incurred from accidents, damage, or injuries during such vehicular operation.

**** Mileage Rate does not apply to VA or AAA/DSHS Clients****

Cancellation of Service:

Serengeti Care will not be liable if care cannot be provided when all reasonable efforts have been exhausted to provide the agreed-upon care. The client understands they are responsible for having a backup plan in place should Serengeti be unable to render care.

**** Does not apply to VA or AAA/DSHS Clients****

The client agrees any scheduled shift canceled without 24-hour notice for any reason will be billed at the full hourly rate. This does not include client expiration or change in medical condition.

Initials AB

Authorization

By signing, I am freely giving my consent to have Serengeti Care provide me with care services. I understand by signing, my records may be shared with additional care providers who are providing me with direct care services (e.g., Doctors, Physical Therapists, Occupational Therapists, Hospice, etc..) in the coordination of care.

Initials AB

I understand the charges and terms and conditions of this agreement are subject to change by Serengeti Care upon verbal or written notice.

I agree to the conditions and terms as set herein this Consent & Service Agreement.

Serengeti Care Representative

By: Barbie Durant

Barbie Durant
(Printed Name)

(Signature)

Title: Branch Manager

Date: 12-12-25

Client/Responsible Party

[Redacted Signature]

(Signature)

Power of Attorney? ☐ Yes ☒ No

Date: 12-12-25