Meeting Agenda - Final

LEOFF I Disability Board

City Hall
601 4th Avenue E
Olympia, WA 98501

Contact: Debbi Hufana
360.753.8149

Monday, January 12, 2026 **4:30 PM** **Zoom**

https://us02web.zoom.us/j/83806122195?pwd=ES2eGjCjLVxGW3xyxoVUsEYVlNauSo.1

1. CALL TO ORDER

1.A ROLL CALL

2. APPROVAL OF AGENDA

3. BUSINESS ITEMS

3.A 26-0046 Approval of Case #26-1 Dental

Attachments: Case #26-01

3.B 26-0047 Approval of Case #26-2 Long Term Care

Attachments: Case #26-02

4. OTHER TOPICS

5. ADJOURNMENT

Accommodations

The City of Olympia is committed to the non-discriminatory treatment of all persons in employment and the delivery of services and resources. If you require accommodation for your attendance at the City Advisory Committee meeting, please contact the Advisory Committee staff liaison (contact number in the upper right corner of the agenda) at least 48 hours in advance of the meeting. For hearing impaired, please contact us by dialing the Washington State Relay Service at 7-1-1 or 1.800.833.6384.

City Hall
601 4th Avenue E.
Olympia, WA 98501
360-753-8244

LEOFF I Disability Board

Approval of Case #26-1 Dental

Agenda Date: 1/12/2026
Agenda Item Number: 3.A
File Number:26-0046

Type: decision **Version:** 1 **Status:** In Committee

Title
Approval of Case #26-1 Dental

Report Issue:
Whether to approve payment for dental work in the amount of $7,296.00

Staff Contact:
Debbi Hufana, HR Analyst, Human Resources, 360.753.8149

Background:
Retired LEOFF 1 member is requesting payment for removal of teeth and replacement with dentures in the amount of $7,296.00. The work for removal of teeth is under the board approval amount, however the denture replacement requires board approval. This request is for all associated work and denture.

Attachments:
Application for Payment of Services and treatment plan

Reference:
Section III Procedures to Receive Benefits, Paragraph n

LEOFF Application for Payment of Services Case No: 26-1

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section to Be Completed by LEOFF 1 Member

Member Name: [redacted] Active: _____ Retired: ✓

Member Telepho[redacted] Police: ✓ Fire: _____

Member Address: [redacted]

Alternate Contact/[redacted]

Describe Your Condition and Why It Is Duty Related: All issues stem from his inoperable right knee. In this case his upper teeth have ALL broken off, and he's been unable to stand and care for his dental health. Several doctors are concerned for his cardiac, uti, & bowel health resulting from dental infections

Describe the Service/Treatment Requested: It's universally recommended to remove all upper teeth to maintain a minimum of overall health. We will maintain bottom teeth at all effort.

Total Cost of Treatment/Service: $ 7296.—

Amount Paid by Insurance/Medicare: $ _____.—

Amount Requested from the Board $ 7296.—

LEOFF member-Please attach the Explanation of Benefits statement(s) from your insurance provider(s) and/or Medicare which indicates the

Member Signature:[redacted]

B) This Section To Be Completed by Member's Attending Health Care Provider

Provider's Name: Richard Buck Provider's Telephone: 360-357-9919

Clinic/Office Name: Affordable Dentures and Implants

Provider's Address: 1540 Cooper Point ~~Rd~~ SW Suite 450, Olympia, WA

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

Multple cavities, destroyed dentition / gum infections

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: Remove all upper teeth and remove infection and insert denture

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

alt plan is implat dentures which adds $10,000 to cost

Provider's Signature: Richard Buck DMD Date: 1/9-26

Fax completed form to: (360) 709-2735 or
Mail to: Attn: HR, City Hall, PO Box 1967, Olympia WA 98507-1967

Patient Treatment Case Report

Patient: [redacted]
Provider: Richard Buck, DMD
Phone: (360)357-9919
Office: 1540 Cooper Point Rd
Suite 450
Olympia, WA 98502

Date: 1/9/2026
Chart #: 9256705
SS #:
Birthdate: [redacted]

Case Name: NDWP F/;rab **Priority:** None
Alternate Cases:
Status: Proposed **Last Updated:** 1/9/2026
Comment:
Case Note: The above treatment procedure has been fully explained to me. My questions have been answered to my satisfaction.

Signature: [redacted]

Ent Date	Prc Date	Visit	Tooth	Surface	Code	Prov	Description	Fee	Pat	Prim Ins	Sec Ins
11/6/2025	11/6/2025	1			D1999.6	DR-RIBL	Denture Care Starter Kit	90.00	90.00	0.00	0.00
11/6/2025	11/6/2025	1	1-16		D5130.0	DR-RIBL	NDWP Full UltimateFit-U	2,285.00	2,285.00	0.00	0.00
1/9/2026	1/9/2026	1			99998	DR-RIBL	Pre Op	0.00	0.00	0.00	0.00
							Visit: 1 Subtotal:	**2,375.00**	**2,375.00**	**0.00**	**0.00**

Ent Date	Prc Date	Visit	Tooth	Surface	Code	Prov	Description	Fee	Pat	Prim Ins	Sec Ins
11/6/2025	11/6/2025	2	3		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	4		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	5		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	6		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	7		D7140.3	DR-RIBL	Routine Ext w/ NDWP	109.00	109.00	0.00	0.00
11/6/2025	11/6/2025	2	8		D7140.3	DR-RIBL	Routine Ext w/ NDWP	109.00	109.00	0.00	0.00
11/6/2025	11/6/2025	2	9		D7140.3	DR-RIBL	Routine Ext w/ NDWP	109.00	109.00	0.00	0.00
11/6/2025	11/6/2025	2	10		D7140.3	DR-RIBL	Routine Ext w/ NDWP	109.00	109.00	0.00	0.00
11/6/2025	11/6/2025	2	11		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	12		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	13		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	14		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	15		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	16		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	17		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
11/6/2025	11/6/2025	2	19		D7210.3	DR-RIBL	Complex Ext w/ NDWP	185.00	185.00	0.00	0.00
1/9/2026	1/9/2026	2			D0330	DR-RIBL	Full Panoramic X-Ray	100.00	100.00	0.00	0.00
1/9/2026	1/9/2026	2			D7921	DR-RIBL	Coll/App Autologous Blood Conc	350.00	350.00	0.00	0.00
1/9/2026	1/9/2026	2			D9248	DR-RIBL	Non IV conscious sedation	255.00	255.00	0.00	0.00
1/9/2026	1/9/2026	2	UL		D7310	DR-RIBL	Alveoloplasty w/ext 4+, quad	280.00	280.00	0.00	0.00
1/9/2026	1/9/2026	2	UL		D7953.1	DR-RIBL	Bone graft-ridge/sock pres/quad	500.00	500.00	0.00	0.00
1/9/2026	1/9/2026	2	UR		D7310	DR-RIBL	Alveoloplasty w/ext 4+, quad	280.00	280.00	0.00	0.00
1/9/2026	1/9/2026	2	UR		D7953.1	DR-RIBL	Bone graft-ridge/sock pres/quad	500.00	500.00	0.00	0.00
							Visit: 2 Subtotal:	**4,921.00**	**4,921.00**	**0.00**	**0.00**

Ent Date	Prc Date	Visit	Tooth	Surface	Code	Prov	Description	Fee	Pat	Prim Ins	Sec Ins
11/6/2025	11/6/2025	3			99992.2	DR-RIBL	Soft Liner - N/C	0.00	0.00	0.00	0.00
11/6/2025	11/6/2025	3			PSTOP	DR-RIBL	Post-op	0.00	0.00	0.00	0.00
							Visit: 3 Subtotal:	**0.00**	**0.00**	**0.00**	**0.00**

Ent Date	Prc Date	Visit	Tooth	Surface	Code	Prov	Description	Fee	Pat	Prim Ins	Sec Ins

* Recommended Case

4

Ent Date	Prc Date	Visit	Tooth	Surface	Code	Prov	Description	Fee	Pat	Prim Ins	Sec Ins
11/6/2025	11/6/2025	5			D0002	DR-RIBL	NDWP Final	0.00	0.00	0.00	0.00
							Visit: 5 Subtotal:	**0.00**	**0.00**	**0.00**	**0.00**
Ent Date	**Prc Date**	**Visit**	**Tooth**	**Surface**	**Code**	**Prov**	**Description**	**Fee**	**Pat**	**Prim Ins**	**Sec Ins**
11/6/2025	11/6/2025	6			99992.3	DR-RIBL	Wax Try-In N/C	0.00	0.00	0.00	0.00
1/9/2026	1/9/2026	6			99992.3	DR-RIBL	Wax Try-In N/C	0.00	0.00	0.00	0.00
							Visit: 6 Subtotal:	**0.00**	**0.00**	**0.00**	**0.00**
Ent Date	**Prc Date**	**Visit**	**Tooth**	**Surface**	**Code**	**Prov**	**Description**	**Fee**	**Pat**	**Prim Ins**	**Sec Ins**
11/6/2025	11/6/2025	7			99985	DR-RIBL	Delivery N/C	0.00	0.00	0.00	0.00
							Visit: 7 Subtotal:	**0.00**	**0.00**	**0.00**	**0.00**
							Total:	**7,296.00**	**7,296.00**	**0.00**	**0.00**

Treatment Plan Total	**7,296.00**
Estimated Deductible to be Applied	**0.00**
Estimated Insurance Payment	**0.00**
Estimated Patient's Portion	**7,296.00**

Dental Insurance Benefits		**Patient**	
		Primary	**Secondary**
Annual Plan Benefits		**0.00**	**0.00**
Paid Benefits YTD		**0.00**	**0.00**
Pending Insurance Est. YTD		**0.00**	**0.00**
Est. Benefits Remaining YTD		**0.00**	**0.00**
Benefits Expire			
Deductible Owed YTD	**Standard**	**0.00**	**0.00**
	Preventive	**0.00**	**0.00**
	Other	**0.00**	**0.00**
Primary Dental Insurance			
Secondary Dental Insurance			

Pt must have care giver present to assist in transfering pt to the chair.

* Recommended Case

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360-753-8244

LEOFF I Disability Board

Approval of Case #26-2 Long Term Care

Agenda Date: 1/12/2026
Agenda Item Number: 3.B
File Number:26-0047

Type: decision **Version:** 1 **Status:** In Committee

Title
Approval of Case #26-2 Long Term Care

Report Issue:
Whether to approve payment for in home long term care - rate of $44.00 per hour

Staff Contact:
Debbi Hufana, HR Analyst, Human Resources, 360.753.8149

Background:
Retired LEOFF 1 member is requesting approval for in home long term care while recovering from ankle surgery. The length of care is to be determined by the member's health care provider and at this time the member is requesting $2,608.94. The rate for in home care is $44.00 per hour. Staff would suggest approving this request for up to the long term care amount allowed by policy while member requires care to recover from surgery.

Attachments:
Application for Payment of Services and contract with in home LTC provider

Reference:
Section III Procedures to Receive Benefits, Paragraph n

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: _____ Retired: X

Member Telepho[redacted] Police: _____ Fire: X

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 (shaving, brushing teeth, etc), cooking/meal prep, ambulation, toileting, assistance w/ dr. appts. End date TBD.

Total Cost of Treatment/Service: $ 2,608.94

Amount Paid by Insurance/Medicare: $ Ø

Amount Requested from the Board $ 2,608.94

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 Signatur[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. DeMartini M.D. Provider's Telephone: _____

Clinic/Office Name: Olympia Orthopaedic Assoc.

Provider's Address: 3901 Capital Mall Dr. SW Suite A 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

Revised 12/27/07

Location: \\Calvin\Personnel\Forms\

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 [redacted]

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 AG

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 AG

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

$ 44.00 /hr.

$ 7 days a week. /

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

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 AG

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 AG

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

(Printed Name)

Barbie Durant

(Signature)

Title: Branch Manager.

Date: 12-12-25

Client/Responsible Party

[redacted]

(Signature)

Power of Attorney? ◯ Yes ⊘ No

Date: 12-12-25