Meeting Agenda - Final

LEOFF I Disability Board

City Hall
601 4th Avenue E
Olympia, WA 98501

Contact: Debbi Hufana
360.753.8149

Monday, August 10, 2026 **4:30 PM** **Zoom**

https://us02web.zoom.us/j/84095048445?pwd=jhWQaPkGLof9QZp1tFOrqTRswQVgJG.1

1. CALL TO ORDER

1.A ROLL CALL

2. APPROVAL OF AGENDA

3. APPROVAL OF MINUTES

3.A 25-0974 Approval of August 11, 2025 LEOFF Board Minutes

Attachments: Minutes

4. BUSINESS ITEMS

4.A 26-0620 Approval of Case #26-6 Vision

Attachments: Case #26-6

4.B 26-0621 Approval of Case #26-7 Medical

Attachments: Case #26-7

4.C 26-0622 Approval of Case #26-8 Dental

Attachments: Case #26-8 #1 partial
Case #26-8 #2 crown
Case #26-8 #3 root canal & filling

4.D 26-0623 Board approval for staff to make recommended updates to policy

5. OTHER TOPICS

6. 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 August 11, 2025 LEOFF Board Minutes

Agenda Date:
Agenda Item Number: 3.A
File Number:25-0974

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

Title
Approval of August 11, 2025 LEOFF Board Minutes

Meeting Minutes - Draft

LEOFF I Disability Board

City Hall
601 4th Avenue E
Olympia, WA 98501

Contact: Debbi Hufana
360.753.8149

Monday, August 11, 2025 **4:30 PM** **Zoom**

https://us02web.zoom.us/j/86859074438?pwd=Ae1Sm7B2c4Lu3uBebyTmlk6s6k6js3.1

1. CALL TO ORDER

The meeting was called to order at 4:31 pm

1.A ROLL CALL

Present: 4 - Chair Jim Cooper, Vice Chair Mark Hansen, Boardmember Steve Cooper and Boardmember Russ Gies

Excused: 1 - Boardmember Kelly Green

2. APPROVAL OF AGENDA

The agenda was approved

3. APPROVAL OF MINUTES

3.A Approval of July 14, 2025 LEOFF Board Minutes

The minutes were approved

4. BUSINESS ITEMS

4.A Approval of Case #25-7 Long Term Care

Boardmember Mark Hansen moved, seconded by Boardmember Steve Cooper, to approve payment for long term care up to the monthly amount allowed by policy. The motion carried by the following vote:

Aye: 4 - Chair Cooper, Vice Chair Hansen, Boardmember Cooper and Boardmember Gies

Excused: 1 - Boardmember Green

5. OTHER TOPICS

6. ADJOURNMENT

The meetng was adjourned at 4:41 pm

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

LEOFF I Disability Board

Approval of Case #26-6 Vision

Agenda Date: 8/10/2026
Agenda Item Number: 4.A
File Number:26-0620

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

Title
Approval of Case #26-6 Vision

Report Issue:
Whether to approve payment for Intense Pulsed Light Therapy.

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

Background:
Retired LEOFF 1 Member is requesting approval of Intense Pulsed Light Therapy in the amount of $1,400 for extreme dry eye. The therapy requested has a success rate of 80 - 90%. Per the health care provider section of the Application for Payment of Services, a dry eye mask and been tried and failed. An alternate treatment is Miebo medicated drops and notes this would be ongoing treatment and cost. I inquired with the members insurance carrier and Miebo is a covered medication on the members plan. I sent an inquiry to the member to see if Miebo has been tried, however I did not receive a response from the member.

Attachments:
Application for Payment and supporting documentation

Reference:
Section III Procedures to Receive Benefits

07/09/2026 08:25 AM (GMT-7)

LEOFF Board Application for Payment of Services **Case No:** _____

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: [redacted]
Member Teleph
Member Addres
Alternate Conta

Describe Your Condition and Why It Is Duty Related: Extreme dry eye. Crazing very blurry vision. Tried other treatments with poor results.

Describe the Service/Treatment Requested: Intense Pulsed Light Therapy. 4 therapy sessions with 80 to 90% success.

Total Cost of Treatment/Service: $ 1400.00
Amount Paid by Insurance/Medicare: $ _____
Amount Requested from the Board $ _____

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] Date: June 7, 2026
ttorney 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: Zachary German Provider's Telephone: 360-357-3410
Clinic/Office Name: Vision Health
Provider's Address: 5164 Capital Blvd SE, Tumwater, WA 98501
Describe the Patient's Current Condition and State Whether It Is Duty Related: Variable blurred vision. Noted, related to dry eye

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: Intense pulse light therapy to improve meibomian gland function. Patient has failed dry eye mask and other txs
Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:
Dry eye mask (tried and failed) Meibo medicative drops, but this would be on-going treatment and cost.
Provider's Signature: Zachary German, OD Date: 7/8/2026

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\

[redacted]

City of Olympia
LEOFF 1 Medical Board

This is a request for payment for a medical treatment for severe dry eyes.
I had cataract surgery January 2024 on both eyes. The surgery was not completely successful but with glasses I have clearer vision.
In January of this year I started having very blurry vision. I've gone through a number of tests and treatments but none have been very successful.
The treatment the doctor keeps recommending is Intense Pulsed Light Therapy. I've researched the treatment and the reviews are very favorable with a 80 to 90% success rate.
The cost is $1400.00 for the treatment.

Thank You
[redacted]

INTENSE *PULSED LIGHT* THERAPY

OptiLIGHT IPL is a light-based treatment that uses precise, intense broad spectrum light to address meibomian gland dysfunction (MGD) - one of the key underlying factors in dry eye disease. OptiLIGHT technology, the first and only FDA approved light therapy for the treatment of dry eye disease due to MGD, is designed to deliver safe and precise treatment for improved safety and efficacy. In addition to it's ocular benefits, IPL has a cosmetic benefit in that it improves the color and texture of your skin.

- **Dry Eye Series - 4 OptiLIGHT IPL sessions- $1,400**

  To receive the medical benefits of IPL, a series of 4 sessions spaced 2-4 weeks apart is recommended.

- **Maintenance OptiLIGHT IPL session - $250**

  To maintain the results of your initial IPL series, maintenance IPL sessions are recommended at regular intervals, typically single sessions every 6 months.

- **Single OptiLIGHT session - $400**

  A pay-as-you-go option for patients who prefer to receive one session at a time.

- **OptiLIGHT IPL Photofacial add-on - additional $100 added to above pricing ($400 to package of 4 sessions)**

  A full-face treatment to get the benefit of dry eye treatment plus the cosmetic benefit across your entire face.

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

LEOFF I Disability Board

Approval of Case #26-7 Medical

Agenda Date: 8/10/2026
Agenda Item Number: 4.B
File Number:26-0621

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

Title
Approval of Case #26-7 Medical

Report Issue:
Whether to approve stem cell therapy for knee and shoulder pain as an alternative to surgery.

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

Background:
Retired LEOFF 1 member is requesting approval of stem cell therapy for knee an shoulder pain as alternative to surgery in the amount of $11,000.00. The member has not submitted documentation this therapy was denied by the insurance company.

Attachments:
Application for Payment of Services with supporting documentation

Reference:
Section III Procedures to Receive Benefits

LEOFF Application for Payment of Services Case No: _____

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: [redacted]

Member Teleph

Member Addres

Alternate Conta

Describe Your Condition and Why It Is Duty Related: Continued Shoulder pain Post shoulder replacement - Knee pain and ↓ R.O.M. Following Septic Knee infection From Surgery.

Describe the Service/Treatment Requested:

Mesencymal Stem cell therapy shoulder (R)

Mesencymal Stem Cell therapy Knee (R).

Total Cost of Treatment/Service: $ 5,500.00 per Area

Amount Paid by Insurance/Medicare: $ _____

Amount Requested from the Board $ 11,000.00

LEOFF member-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] Date: 7/28/26

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

Provider's Name: Dr. Vikrant Poudel Provider's Telephone: 360-280-2976

Clinic/Office Name: Sound Regenerative Medicine

Provider's Address: 2637 Capitol Mall Dr SW B-3A Olympia WA 98502

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

(R) Knee Pain Post Surgical Infection

(R) Shoulder Pain Post shoulder replacement.

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

See attached letter. Failed Surgical Intervention on Objective findings ↓ R.O.M. Regenerative medicine is medically necessary

Based This is the Alternative for Surgery.

(R) Shoulder and Knee stem cells to try to avoid surgery.

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

Provider's Signature: _____ Date: 7/26/26

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

Increase to ~~decrease~~ R.O.M.

Costs. above.

Letter of Medical Necessity

Patient: [redacted]
DOB: *11/09/1949*
Provider: *Dr. Brian Wilmovsky*
Date: *7/24/26*

To whom it may concern,

I am writing on behalf of my patient, [redacted] to request authorization for treatment**.**

The patient has experienced Right knee and shoulder pain, that is an 8 out of 10 on the pain scale. The patient had knee surgery 30 years ago which resulted in massive infection in his right knee leading to significant scar tissue damage. The patient had a total knee replacement 12 years ago, but still has significant pain as well as palpatory tenderness in the medial and posterior aspects of the right knee. The patient had a positive theater sign knee test which indicates inflammation and degeneration. X- ray revealed large amounts of scar tissue damage and calcification in the posterior right knee and medial right knee. The patient does not wish to undergo another surgery based on his past poor outcome. I recommend referral for regenerative medicine stem cell therapy to decrease pain and symptoms and increase range of motion. Furthermore the patient also experiences 8 out of 10 pain post right shoulder surgery. X-ray findings revealed shoulder replacement hardwear. The exam revealed a significantly decreased range of motion. Palpatory findings revealed pain and tenderness in the supraspinatus tendon along with bicipital tenderness. The patient exhibited pain with empty can test and bicipital tendon test. The patient also wishes to not endure another shoulder surgery as well. I recommended a referral to stem cell therapy in the right shoulder soft tissue to decrease pain and symptoms and increase range of motion. These opinions are based on medical necessity for Mr. McBride based on his unresolved surgical therapy and continued pain levels on an 8 of a scale of 10, X-ray findings and physical exam.

Please contact my office at soundregenerativemedicine@gmail.com if additional documentation is required.

Sincerely,

Brian Wilmovsky D.C, C.C.W.P

Sound regenerative Medicine
2627 Capitol Mall drive SW Suite B-3A
Olympia, WA, 98502
(360) 280 - 7876

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

LEOFF I Disability Board

Approval of Case #26-8 Dental

Agenda Date: 8/10/2026
Agenda Item Number: 4.C
File Number:26-0622

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

Title
Approval of Case #26-8 Dental

Report Issue:
Whether to approval dental procedures for LEOFF 1 retiree.

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

Background:
Retired LEOFF 1 member is requesting reimbursement for three dental procedures in the amount of $7,522.77. There are 3 separate requests in this case:

#1 - request for partial to replace teeth #'s 19, 20, 22, 23, 29, 30 & 31 in the amount of $2,700.00 - member has been reimbursed for the extractions of the teeth over the last few months. The requests for the extractions were under $2,000 per tooth which can be approved by staff. There was no mention when reimbursement requests came in the member was replacing with a partial.

#2 - request for payment of core buildup and crown for tooth #21 in the amount of $2,126.50. This work was completed in September 2025.

#3 - request for fillings and root canal on tooth #6. Tooth #6 was filled on March 9, 2026 at a cost of $764.27 (this work was done at the same time as tooth #7 and was within the staff approval limit). On March 10, 2026 the member had a root canal done in the amount of $1,932.00 for a total repair cost for tooth #6 of $2,696.27. The total is above staff level approval.

Attachments:
Application for Payment of Services 26-8 #1 and documentation
Application for Payment of Services 26-8 #2 and documentation
Application for Payment of Services 26-8 #3 and documentation

Reference:
Section III Procedures to Receive Benefits

LEOFF Board Application for Payment of Services Case No: _____

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: [redacted]

Member Telephon

Member Address:

Alternate Contact: _____ Alternate Contact Telephone: _____

Describe Your Condition and Why It Is Duty Related: Not related

replace missing teeth

Describe the Service/Treatment Requested: replace missing teeth

Total Cost of Treatment/Service:	$ 2900.00	$2,700.00
Amount Paid by Insurance/Medicare:	$ Ø	
Amount Requested from the Board	$ 2900.00	$2,700.00

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] Date: _____

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: Paul Isaacson Provider's Telephone: (360)357-8075

Clinic/Office Name: Olympia Advanced Dentistry.

Provider's Address: 1105 4th Ave East Ste A Olympia, WA 98506

Describe the Patient's Current Condition and State Whether It Is Duty Related: Non duty related.

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: replacement for lower partial, to restore chewing function due to loss of teeth from perio health and decay

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

No other options, implants will be more costly.

Provider's Signature: Paul E Isaacson DMD Date: 6/22/2026

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\

Olympia Advanced Dentistry

Name [redacted]

.: TREATMENT CASE

Fills

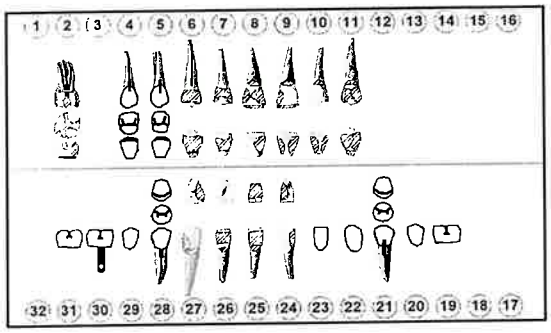
DATE	VISIT	TOOTH	SURF	CODE	PROV	DESCRIPTION	FEE	PATIENT
06/22/2026	1	19*31		D5214	XX03	Mand partl-cast metal w/resin	2600.00	2600.00
06/24/2026	1			00003	XX03	Lab Fees	100.00	100.00
						Visit 1 Totals:	2700.00	2700.00

:: INSURANCE PROVIDER(S) ::

Primary Secondary

:: TOTALS ::

Fee	Patient
2700.00	2700.00



:: FINANCIAL SUMMARY ::

Treatment Plan Total	2700.00
Estimated Deductible to be Applied	0.00
Estimated Insurance Payment	0.00
Estimated Patient's Portion	2700.00

:: DENTAL INSURANCE BENEFITS ::

		Patient		Family	
		Primary	Secondary	Primary	Secondary
Annual plan benefits		0.00	0.00	0.00	0.00
Paid Benefits YTD		0.00	0.00	0.00	0.00
Pending Insurance Estimate YTD		0.00	0.00	0.00	0.00
Estimated Benefits Remaining YTD		0.00	0.00	0.00	0.00
Benefits Expire		NA	NA		
Deductible Owed YTD	Standard	0.00	0.00	0.00	0.00
	Preventative	0.00	0.00	0.00	0.00
	Other	0.00	0.00	0.00	0.00

Alternate Cases:

Case notes:

Treatment Plan for lower plate #19 – 31

Confirmed by dentist partial is to replace teeth #'s 19, 20,22,23,29,30 & 31 adn the cost is $2,700.00 - DH

1105 4th Ave E, Suite A
Olympia, WA 98506 PHONE: (360)357-8075

www.olympiaadvanceddentistry.com

REPORT DATE: 07/20/2026

01

08/07/2026 01:47 PM (GMT-7)

LEOFF Application for Payment of Services Case No: 26-8 #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 Telephone: [redacted] Police: _____ Fire: X

Member Address: [redacted]

Alternate Contact/Phone: _____ Email [redacted]

Describe Your Condition and Why It Is Duty Related: dental

Describe the Service/Treatment Requested: repair, crown #21

Total Cost of Treatment/Service: $ 2126.50

Amount Paid by Insurance/Medicare: $ _____

Amount Requested from the Board $ 2126.50

LEOFF member-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] Date: 9-5-25

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

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

Provider's Name: Paul Isaacson DDS Provider's Telephone: (360) 357-8075

Clinic/Office Name: Olympia Advanced Dentistry

Provider's Address: 1105 4TH Ave E. ste:A Olympia, WA 98506

Describe the Patient's Current Condition and State Whether It Is Duty Related:
Extensive breakdown around old restoration needing full coverage protection to maintain tooth #21

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary:
#21 Full crown restoration to help maintain tooth functionality

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs:
None, tx required to maintain tooth #21

Provider's Signature: Paul E Isaacson DDS Date: 9-5-2025

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

W:\LEOFF\FORMS\Application for Payment of Services 2012B.docx 4/20/2012

STATEMENT OF SERVICES RENDERED

Olympia Advanced Dentistry
1105 4th Avenue East, Suite A
Olympia, WA 98506-4018

(360)357-8075

CHART NO.	PAGE NO.
100879	1

BILLING DATE
09/05/2025

GUARANTOR NAME AND MAILING ADDRESS

[redacted]

PATIENT	TOOTH	SURF	DESCRIPTION	CHARGE	CREDIT
[redacted]			D9230:Analgesia-inhal of nitrou	85.00	
	21		D2740:Crown - porcelain/ceramic	1651.00	
	21		D2745:SEAT APC	0.00	
	21		D2950:Core buildup, include any	401.00	
			VISA/MC Payment -Thank You		-2126.50

PRIOR BALANCE		CURRENT CREDITS		CURRENT CHARGES		NEW BALANCE		DENTAL INS. EST.		PLEASE PAY
-10.50	-	2126.50	+	2137.00	=	0.00	-	0.00	=	0.00

PATIENT	DATE	TIME	REASON
[redacted]	Thursday - September 18, 2025	9:30 am	PerMaint, PC
	Monday - January 19, 2026	9:30 am	PerMaint, PC

08/07/2026 01:50 PM (GMT-7)

LEOFF Board Application for Payment of Services Case No: 26-8 #3

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: [redacted]

Member Telephone: [redacted]

Member Address: [redacted]

Alternate Contact: _____ Alternate Contact Telephone: _____

Describe Your Condition and Why It Is Duty Related: Root canal & eval treatment required on #6 [redacted]

Describe the Service/Treatment Requested: Root canal & eval

3/4/26

Total Cost of Treatment/Service: $ 1932.00 + 764.27 = 2696.27

Amount Paid by Insurance/Medicare: $ 0

Amount Requested from the Board $ 1932.00 3/10/26

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] Date: 3-10-26

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: RAJNISH ROHILA Provider's Telephone: 360-491-6995

Clinic/Office Name: Olympia Endodontic Group

Provider's Address: 208 Lilly Rd NE Suite D Olympia, WA 98506

Describe the Patient's Current Condition and State Whether It Is Duty Related: Tooth #6 pulp is necrotic with swelling.

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: endodontic therapy needed to treat root canal infection.

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

Provider's Signature: [signature] Date: 3-10-26

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\

STATEMENT OF SERVICES RENDERED

Olympia Advanced Dentistry
1105 4th Avenue East, Suite A
Olympia, WA 98506-4018

(360)357-8075

CHART NO.	PAGE NO.
100879	1

BILLING DATE
03/09/2026

GUARANTOR NAME AND MAILING ADDRESS

[redacted]

PATIENT	TOOTH	SURF	DESCRIPTION	CHARGE	CREDIT
[redacted]			Intraoral Periapical Images	40.00	
			Intraoral-periapical each add'l	35.00	
			Analgesia-inhal of nitrous oxid	100.00	
	6	L	Resin-one surface, anterior	254.00	
	6	MDLF	Resin-4+ w/incis angle-anterior	463.00	
	7	MDLF	Resin-4+ w/incis angle-anterior	463.00	
			Senior Citizen Courtesy		-67.75
			VISA/MC Payment -Thank You		-1287.25
			$175.00 split between #6 + #7 = $87.50 each		
	3/9/26	#6	$804.50 less 5% - 40.23		$764.27
	3/9/26	#7	$550.50 less 5% - 27.52		$522.98
			#6 new board approval - additional work on 3/9/26		

PRIOR BALANCE		CURRENT CREDITS		CURRENT CHARGES		NEW BALANCE		DENTAL INS. EST.		PLEASE PAY
0.00	-	1355.00	+	1355.00	=	0.00	-	0.00	=	0.00

PATIENT	DATE	TIME	REASON
[redacted]	Thursday - April 23, 2026	10:30 am	AnlgNitOx, PerMaint

STATEMENT OF SERVICES

Date	Name	Dr	Code	Description	Th / Surface Check #	Amount	Balance
3/10/2026	[redacted]	RR	0140	EXAM - LIMITED PROBLEM FOCUSED	6	128.00	128.00
3/10/2026		RR	0220	X-RAYS, FIRST PERIAPICAL	6	49.00	177.00
3/10/2026		RR	0364	CBCT SCAN	6	375.00	552.00
3/10/2026		RR	3310	ROOT CANAL-ANTERIOR	6	1202.00	1754.00
3/10/2026		RR	2330	COMPOSITE RESIN, 1 SURFACE-	6 L	223.00	1977.00
3/10/2026		RR	9230	NITROUS	6	135.00	2112.00
3/10/2026		RR	0004	PAYMENT-CREDIT CARD, THANK YOU		-1932.00	180.00
3/10/2026		RR	0060	REDUCE BALANCE - PROF COURTESY		-180.00	0.00
	Tooth #6		3/10/26 3/9/26	$1,932.00 $ 764.27 $2,696.27			

Balance	Current	Over 30	Over 60	Over 90	Over 120	2026 Payments
0.00	0.00	0.00	0.00	0.00	0.00	1932.00

Account Information

[redacted]

Account # 703995
Home 360-528-7392

Last Billing
Last Private Payment 3/10/2026
Budget 0.00

Thank you!

Provider

Rajnish Rohila DDS
208 Lilly Rd Ne Suite D
Olympia, WA 98506

360-491-6945

Billing Date

7/20/2026

Patient	Next Appointment Date	Time	Reason

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

LEOFF I Disability Board

Board approval for staff to make recommended updates to policy

Agenda Date: 8/10/2026
Agenda Item Number: 4.D
File Number:26-0623

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

Title
Board approval for staff to make recommended updates to policy