



# Meeting Agenda

## LEOFF I Disability Board

City Hall  
601 4th Avenue E  
Olympia, WA 98501

Contact: Debbi Hufana  
360.753.8149

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**Monday, May 11, 2020**

**5:00 PM**

**Online or via phone**

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### Meeting Registration:

<https://us02web.zoom.us/j/9379396269pwd=ZkFJWtN5UDVqV2RQcTRESVNISEFpQT0>

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**1. CALL TO ORDER**

**1.A ROLL CALL**

**2. OTHERS PRESENT**

**3. APPROVAL OF MINUTES**

**3.A [20-0383](#) Approval of February 10, 2020 LEOFF Board Meeting Minutes**

Attachments: [Minutes](#)

**6. BUSINESS ITEMS**

**4.A [20-0384](#) Approval of Case 20-5 Long Term Care Request**

Attachments: [Case 20-5](#)

**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 February 10, 2020 LEOFF Board Meeting Minutes**

**Agenda Date:** 5/11/2020  
**Agenda Item Number:** 3.A  
**File Number:**20-0383

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

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**Title**

Approval of February 10, 2020 LEOFF Board Meeting Minutes



## Meeting Minutes - Draft

### LEOFF I Disability Board

City Hall  
601 4th Avenue E  
Olympia, WA 98501

Contact: Debbi Hufana  
360.753.8149

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**Monday, February 10, 2020**

**5:00 PM**

**Room 112**

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**1. CALL TO ORDER**

Chair Cooper called the meeting to order at 5:05 p.m.

**1.A ROLL CALL**

**Present:** 5 - Chair Jim Cooper, Vice Chair Jessica Bateman, Boardmember Jack Seward, Boardmember Russ Gies and Boardmember Jody Ramey

**2. OTHERS PRESENT**

HR Analyst Debbi Hufana

**3. APPROVAL OF MINUTES**

- 3.A** [20-0117](#) Approval of December 9, 2019 LEOFF 1 Disability Board Meeting Minutes

**The minutes were approved.**

**4. BUSINESS ITEMS**

- 4.A** [20-0128](#) Approval of Case #20-2 Dental Request

**Boardmember Seward moved, seconded by Boardmember Gies, to approve the dental request in the amount of \$7,635.00 for the LEOFF 1 member. The motion carried by the following vote:**

**Aye:** 5 - Chair Cooper, Vice Chair Bateman, Boardmember Seward, Boardmember Gies and Boardmember Ramey

- 4.B** [20-0140](#) Approval of Case #20-3 Dental Request

**Vice Chair Bateman moved, seconded by Boardmember Gies, to approve the dental request in the amount of \$2,350.00 for the LEOFF 1 member. The motion carried by the following vote:**

**Aye:** 5 - Chair Cooper, Vice Chair Bateman, Boardmember Seward, Boardmember Gies and Boardmember Ramey

- 4.C** [20-0141](#) Approval of Case #20-4 Medical Request

**Vice Chair Bateman moved, seconded by Boardmember Seward, to approve the medical request in the amount of \$1,887.35 for the LEOFF 1 member. The motion carried by the following vote:**

**Aye:**           5 - Chair Cooper, Vice Chair Bateman, Boardmember Seward,  
                    Boardmember Gies and Boardmember Ramey

**5.     ADJOURNMENT**

The meeting was adjourned at 5:33 p.m.



## LEOFF I Disability Board

### Approval of Case 20-5 Long Term Care Request

**Agenda Date:** 5/11/2020  
**Agenda Item Number:** 4.A  
**File Number:**20-0384

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

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**Title**

Approval of Case 20-5 Long Term Care Request

**Report**

**Issue:**

Whether to approve payment for long term care of retired LEOFF 1 member.

**Staff Contact:**

Debbi Hufana, HR Analyst, Human Resources, 360.753.8149

**Background:**

The board must decide whether or not to approve the request for ongoing longterm care for this member. The approximate cost is \$8,520.00 per month.

This request is in accordance with LEOFF 2 Disability Board Policies & Procedures.

**Attachments:**

Application for Payment of Services  
Kaiser Permanente documentation of need letter  
Garden Courte Invoice for May 2020 Services  
Page 11 of Admission Agreement for member

**Reference:**

Section III Procedures to Receive Benefits, E. Long Term Care

**LEOFF Board Application for Payment of Services**Case No: 20-5

Please Print Clearly &amp; Legibly - Incomplete Form Will Be Returned

**A) This Section To Be Completed by Member**

Member Name: \_\_\_\_\_ Live: \_\_\_\_\_ Retired: \_\_\_\_\_

Member Telephone: \_\_\_\_\_ Police: \_\_\_\_\_ Fire: X

Member Address: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Alternate Contact Telephone: \_\_\_\_\_

Describe Your Condition and Why It Is Duty Related: Part of Plan 1 coverageDescribe the Service/Treatment Requested: FULL-TIME CARE AT AMEMORY CARE COMMUNITY. Jim is a risk to himself and his caregiver and require professional care.Total Cost of Treatment/Service: \$ 9000/mo.Amount Paid by Insurance/Medicare: \$ 0

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: \_\_\_\_\_ Date: 4/20/2020

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: Michael Mondress Provider's Telephone: \_\_\_\_\_Clinic/Office Name: ProvidenceProvider's Address: 413 Lilly Rd NE Olympia, WA 98502-5133Describe the Patient's Current Condition and State Whether It Is Duty Related: seeattached form

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

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome &amp; Costs: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Date: 4/20/2020

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



4/20/2020

Olympia WA 98501

MRN: 00350423

To Whom It May Concern,

..... has been in my care since 2017 and previous to that in the care of my practice partners since 1998. .... cognitive decline accelerated after his hospitalization in 9/2016 for encephalitis. His cognitive function never recovered to baseline after this illness in setting of his history of PTSD as a Vietnam war veteran. Since 8/2019 .... dementia has progressively worsened to the point that his spouse, who is DPOA and has been his sole care giver, is unable to provide care that .... needs to maintain his basic activities of daily living. In my medical opinion, .... would be able to receive the care he needs at a memory care facility. Please let me know if any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Deepti Paturi", written over a horizontal line.

Deepti Paturi, DO  
Olympia Family Medicine 1N  
Phone 360-923-7200 opt 3  
Fax 360-923-7169

**Invoice**For: **James Anderson, Unit: S2****Please make payment to:**

Garden Courte  
626 Lilly Road NE  
Olympia, WA 98506  
(360) 491-4435

**Balance Due: \$8,145.72****Amount Paid: \_\_\_\_\_**

Date: 05/06/20

ID: 9543716-1-1

Account #: 9543716-1

**Responsible Party:**

626 Lilly Road NE, Unit #S2  
Olympia, WA 98501

*Separate here and return top portion with your payment***Please make payment to:**

For:

**Unit: S2**

Date: 05/06/20

Garden Courte  
626 Lilly Road NE  
Olympia, WA 98506  
(360) 491-4435

ID: 9543716-1-1

Account #: 9543716-1

Page: 1 of 1

**Current Monthly Charges for 05/01/2020 to 05/31/2020**

Date	Description	Days/Visits/Units	Amount
05/06/20	ALZ Move In Fee (5/6/2020 to 5/31/2020)	26	\$1,000.00
05/06/20	ALZ-Private With Bath (5/6/2020 to 5/31/2020)	26	\$4,797.36
05/06/20	Level 4 - MC (5/6/2020 to 5/31/2020)	26	\$2,348.36

**Last Statement Balance: \$0.00****Payments and Credits: \$0.00****Charges: \$8,145.72****Current Balance Due: \$8,145.72**

**Current (0 to 30 Days)**  
\$8,145.72

**31 to 60 Days**  
\$0.00

**61 to 90 Days**  
\$0.00

**Over 90 Days**  
\$0.00

**Terms**

Due Upon Receipt



### Authorization for Photographs for Identification or Security

The Resident Group agrees to allow The Community to photograph the Resident for identification or security purposes. These photographs may be used to help identify and locate the Resident in the event of an unauthorized absence or elopement from The Community but shall otherwise be kept confidential. This Authorization does not extend to photographs taken for clinical or treatment purposes; or photographs taken for media, marketing, or publication purposes. Additional information regarding photography is located in the Resident Handbook.

### Injuries Resulting from Falls

The Resident Group acknowledges that The Community cannot prevent all falls that may be sustained by Resident while in The Community's care. The Resident Group acknowledges that the Resident may suffer from conditions causing the Resident to be more prone to falling and The Community cannot prevent these falls. The Resident Group also acknowledges that falls may be caused by the Resident's failure to follow The Community's direction.

### Admission Rates and Fees

Community Fee		\$	\$2,000
Discount If Applicable		\$	-\$500
Reservation Deposit		\$	-\$500
Community Fee Balance			\$1,000
Private Studio w/Bath	S-2	\$	\$ 5,720
2 <sup>nd</sup> Resident		\$	\$N/A
Level 4		\$	\$2,800
Pet		\$	\$0
Admin Fees (Long Term Care, etc)		\$	\$0
Monthly Total		\$	\$8,520
Community Fee Balance			\$1,000
Due at Signing (Prorated for May 2020)		\$	\$8,145.72

### Additional Services and Fees

As of the date of this agreement you have selected the following additional services:

#### Hair Salon Services

You will pay the stylist directly for services.