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

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section To Be Completed by Member

Member Name: _____ Active: _____ 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 I coverage

Describe the Service/Treatment Requested: FULL-TIME CARE AT A MEMORY 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: Providence

Provider's Address: 413 Lilly Rd NE, Olympia, WA 98506-5133

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

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

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

KAISER PERMANENTE

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 vetran. 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 receive the care he needs at a memory care facility. Please let me know if any questions.

Sincerely,

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

For: **Unit: S2**

Date: 05/06/20
ID: 9543716-1-1
Account #: 9543716-1

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)	31 to 60 Days	61 to 90 Days	Over 90 Days
$8,145.72	$0.00	$0.00	$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	$-2	$	$ 5,720
2nd 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.