7/11/2023

DISABILITY BOARD AGENDA
210 W. 6TH AVE, KENNEWICK CITY HALL
CASCADE CONFERENCE ROOM

11:45 AM

1. **CALL TO ORDER**
2. **ATTENDANCE**
3. **PUBLIC COMMENT**
4. **APPROVAL OF MINUTES**
   a. Approval of June 6, 2023 Meeting Minutes
5. **FIRE CLAIMS**
   Summary of claims for signature.
   a. Fire Claims for Consideration
6. **POLICE CLAIMS**
   Summary of claims for signature.
   a. Police Claims for Consideration
7. **UNFINISHED BUSINESS**
8. **NEW BUSINESS**
   a. Consideration of Dental Care Reimbursement for Police Member #12.
9. **BOARD COMMENTS/DISCUSSION**

NEXT MEETING DATE:

a. August 1, 2023 @ 11:45 AM

DISABILITY BOARD
REGULAR MEETING
June 6, 2023

CALL TO ORDER

Dan Legard called the regular meeting of the Kennewick Disability Board to order at 11:53 a.m. at the Kennewick City Hall Building, 210 W. 6th Ave, in the Cascade Conference Room & Teleconference.

Members Present: Brad Beauchamp, Council Member; Bill McKay, Mayor; Kathryn Armstrong, Member at Large

Staff Present: Christie Brown, Secretary; Dan Legard, Finance Director

Member Absent: Jim Kraft, Police Representative; Gary Williams, Fire Representative

PUBLIC COMMENT

None presented.

APPROVAL OF MINUTES

Kathryn Armstrong moved, seconded by Bill McKay to approve the minutes of the May 2, 2023 meeting. The motion passed unanimously.

FIRE CLAIMS

Dan Legard presented the Fire claims in the amount of $6647.99. Bill McKay moved, seconded by Kathryn Armstrong to pay all claims as presented. The motion passed unanimously.

POLICE CLAIMS

Dan Legard presented the Police claims in the amount of $425.00. Kathryn Armstrong moved, seconded by Bill McKay to pay all claims as presented. The motion passed unanimously.

OLD BUSINESS

Update on WSLEA Conference May 9-12, 2023

NEW BUSINESS

A motion was made by Bill McKay, seconded by Kathryn Armstrong to reimburse Police Member #2 in the amount of $3478.50 for dental work.

COMMENTS/DISCUSSION

Meeting was reschedule for July 11, 2023

ADJOURNMENT

The meeting adjourned at 12:00 p.m.

NEXT MEETING
Tuesday
July 11, 2023
@
11:45 AM

APPROVED:

DRAFT – FOR CONSIDERATION 7-11-2023

Prepared by Christie Brown, Disability Board Secretary

MEETING DATE: JULY 11, 2023

FIRE PENSION BOARD

FROM: CHRISTIE BROWN, SR. ACCOUNTING SPECIALIST/ DISABILITY BOARD SECRETARY

RE: FIRE PERSONNEL BUDGET NO. J2517210 . 520012

VENDOR#	LAST NAME	FIRST NAME	TOTAL
29			$ 6,449.00
32			$ 317.00

$ 6,766.00

JIM KRAFT, POLICE REPRESENTATIVE

GARY WILLIAMS, FIRE REPRESENTATIVE

KATHRYN ARMSTRONG, MEMBER AT LARGE

BILL MCKAY, COUNCIL MEMBER

BRAD BEAUCHAMP, COUNCIL MEMBER

LEOFF-1 CLAIMS - FIRE JULY 2023

Meeting Date	ID	Vendor #	Date of Service	In	Claim #	Amount	Provider Type
7/11/2023		29	05/01/2023-05/31/2023		LONG TERM CARE	$ 6,449.00	FARMINGTON SQUARE MEMORY CARE
7/11/2023		32	2/16/2023		EYE GLASSES	$ 317.00	BLINK EYECARE
					TOTAL	$ 6,766.00	
					TOTAL	**$ 6,766.00**	

#29

LEOFF I – CERTIFICATION CLAIM FORM – FIRE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Fire Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [X] Per board approval

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
May 2023	Chronic Dementia / Alzheimers	PHI		$6449.00

TOTAL: $6449.00

PHI

Print Name **Signature** 5/30/2023 **Date**

Board Use Only

PHI

INVOICE

Invoice Period: 05/2023

Send To: PHI

IMPORTANT NOTICE

Happy Mothers Day

Print date: April 20, 2023

Account Summary

Prior Balance	Payments	Credits	Charges	TOTAL DUE
$6,449.00	($6,449.00)	($207.00)	$6,656.00	$6,449.00

Account Detail

Prior Balance			**$6,449.00**
Payments		**Date**	
Check # PHI	:CHECKscan Payment	04/05/23	($6,449.00)
		Total Payments	**($6,449.00)**
Credits		**From**	
MC Rent Adjustments		05/01/23 - 05/31/23	($207.00)
		Total Credits	**($207.00)**
Charges		**From**	
Memory Care Rent		05/01/23 - 05/31/23	$5,300.00
Memory Care Level 3		05/01/23 - 05/31/23	$1,300.00

P

INVOICE

Invoice Period: 05/2023

PHI

Charges	From	
Personal Care Package Tier 1	05/01/23 - 05/31/23	$56.00
	Total Charges	**$6,656.00**
TOTAL DUE for PHI		**$6,449.00**

Please make check payable to PHI and include the above resident's name and unit number. Payments for EFT, Credit Card, or Debit Card are now available! Use the Resident & Family Portal button on our homepage at PHI to setup your preferred payment method.

If you have any questions regarding this invoice please contact our office. Thank you!

Remit Payment To: PHI

Friendly Reminder:
Please remit payment by the 1st of the month to avoid late fees.
If you have questions regarding your bill, PHI

PAID 4/22/23
@ RFCU
CONF #

PHI

#32

LEOFF I – CERTIFICATION CLAIM FORM – FIRE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Fire Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [X] Other [X] Regence

Date of Service	Condition or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
2/16/2023	Rx eye glasses	PHI		$317.00
	Regence Claim	PHI		

TOTAL: $317.00

Print Na PHI 6/9/2023
Date

Board Use Only

Send payments to:

PHI

Bill To

PHI

Invoice

Service Date	Invoice Date	Invoice #
02/16/2023	02/16/2023	206640355

Patient	Patient #
PHI	

Provider	Tax ID
PHI	

Code	Description	Price	Qty	Disc	Tax	Adjs	Paid	Balance
V2702	Lab Supplied Custom Measurements	$20.00	1	$0.00	$0.00	-$10.00	$0.00	$10.00
	Billed to Insurance - Invoice 206640329 : ($20.00)							
	Transfer In - Coinsurance/Copay - Amount applied to patient copayment : $10.00							
V2750	Lab Supplied Anti-Reflective Premium	$165.00	1	$0.00	$0.00	-$80.00	$0.00	$85.00
	Billed to Insurance - Invoice 206640329 : ($165.00)							
	Transfer In - Coinsurance/Copay - Amount applied to patient copayment : $85.00							
V2781	Custom Progressive iD Mystyle 2 Hoya	$297.50	1	$0.00	$0.00	-$122.5	$0.00	$175.00
	Billed to Insurance - Invoice 206640329 : ($297.50)							
	Transfer In - Coinsurance/Copay - Amount applied to patient copayment : $175.00							
V2782	Lab Supplied Trivex	$90.00	1	$0.00	$0.00	-$43.00	$0.00	$47.00
	Billed to Insurance - Invoice 206640329 : ($90.00)							
	Transfer In - Coinsurance/Copay - Amount applied to patient copayment : $47.00							
PAYMENT	Credit Card (Other) - 02/16/2023							-$317.00

Sub-Total	$572.50
Discounts	$0.00
Tax	$0.00
Total Amount	$572.50
Adjustments	-$255.50
Payments Received	$317.00
Credits Granted	$0.00
Balance Due	$0.00

MEETING DATE: JULY 11, 2023

POLICE PENSION BOARD

CC: CHRISTIE BROWN, ACCOUNTING SPECIALIST/ DISABILITY BOARD SECRETARY

RE: POLICE PERSONNEL BUDGET NO. J2517210 . 520012

VENDOR#	LAST NAME	FIRST NAME	TOTAL
15			$ 11.51
2			$ 3,478.50
			$ 3,490.01

JIM KRAFT, POLICE REPRESENTATIVE

GARY WILLIAMS, FIRE REPRESENTATIVE

KATHRYN ARMSTRONG, MEMBER AT LARGE

BILL MCKAY, COUNCIL MEMBER

BRAD BEAUCHAMP, COUNCIL MEMBER

LEOFF-1 CLAIMS - POLICE JULY 2023

Meeting Date	ID	Vendor #	Date of Service	Insura	Claim #	Amount	Provider
7/11/2023		15	6/12/2023		RX PHARMACY	$ 11.51	ELK DRUG
7/11/2023		2	4/27/2023		DENTAL	$ 3,478.50	HANSEN FAMILY DENTAL
					Total:	**$ 3,490.01**	

#15

LEOFF I – CERTIFICATION CLAIM FORM – Police

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [ ] _____

Date of Service	Condition or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
6-12-2023	folic acid	PHI	11.51	11.51

TOTAL: 11.51

PHI

June 17-2023
Date

Board Use Only

[redacted]

[redacted]

FOLIC ACID 1 MG TABS
EA [CHARTWELL]
NDC: 62135-210-10 Qty: 90

[redacted]

[redacted]

[redacted]

CASH

Your Cost: $11.51

Sale

[redacted]

Receipt: 41263
Date: 06/13/23 04:26pm
Cashier:
Register:
Customer:

[redacted]

[redacted]

Item	Flags	Qty	Price	Value
Rx 193619-01	RF			$0.00
Rx 203832-00	RF			$11.51

Flags: T=Taxable F=FSA R=Rx P=Promo

Rx count:2

Subtotal	$11.51
Exempt	$0.00
Total	**$11.51**
Tender Credit	$11.51

Mastercard Card - Approved
Amount:$11.51

[redacted]

Transaction:CREDIT

[redacted]

Response Code:00
Entry Method:Contactlcc

[redacted]

#2

LEOFF I – CERTIFICATION CLAIM FORM – POLICE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [✓] LEOFF 1

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
4-27-2023		PHI	$ 3,478 50	$ 3,478 50

PHI PHI

TAL: $ 3,478 50

4-28-2023
Date

Board Use Only

Last dental reimb 9/1/2020 $ 391.50 infect. Tooth
1/10/2020 372.60 Frac. Tooth

PHI

4-27-2023

#10 has internal resorption and has infected area at apex of root...tooth has hopeless prognosis and because PHI has limited remaining tooth a bridge is necessary for him to be able to chew and function...

PHI

JAMES HANSEN, DMD

6615 W. ARGENT • PASCO, WA 99301 • TEL: (509) 547-9951 • FAX: (509) 547-3008

PHI

April 27, 2023

PHI

PHI

PHI

Account Aging	
Current:	$3,257.00
30 Days:	$0.00
60 Days:	$0.00
90 Days:	$0.00
Contract:	$0.00
Balance Due:	$3,257.00
Estimated Insurance:	$0.00
Balance Due Now:	**$3,257.00**

Date	Transaction	Tth	Surface	Fee
4/27/2023	00220 - Periapical single, first	9		$23.50
	06740 - Crown-Porc/Ceramic	9		$794.00
	06740 - Crown-Porc/Ceramic	10		$794.00
	06245 - Pontic-Porcelain/Ceramic	10		$764.50
	06740 - Crown-Porc/Ceramic	11		$794.00

SubTotal:	$3,170.00
Tax:	$0.00
Charge(s):	$3,170.00
+ Previous Balance:	$87.00
Balance Due:	$3,257.00

Contract Balance	Estimated Insurance	Previous Balance	Charge(s)	Payment(s)	Adjustment(s)	Balance Due Now
$0.00	$0.00	$87.00	$3,170.00	$0.00	$0.00	**$3,257.00**

PHI

Thank You for Visiting our Office. Have a Nice Day!

PHI

April 27, 2023

PHI

ID: 11952

Account Aging	
Current:	$3,478.50
30 Days:	$0.00
60 Days:	$0.00
90 Days:	$0.00
Contract:	$0.00
Balance Due:	$3,478.50
Estimated Insurance:	$0.00
Balance Due Now:	**$3,478.50**

PHI

Date	Transaction	Tth	Surface	Fee
4/27/2023	07210 - Surgical Erupted	10		$221.50

SubTotal:	$221.50
Tax:	$0.00
Charge(s):	$221.50
+ Previous Balance:	$3,257.00
Balance Due:	$3,478.50

Contract Balance	Estimated Insurance	Previous Balance	Charge(s)	Payment(s)	Adjustment(s)	Balance Due Now
$0.00	$0.00	$3,257.00	$221.50	$0.00	$0.00	**$3,478.50**

PHI

Thank You for Visiting our Office. Have a Nice Day!

PHI

DEBIT SALE

PHI PHI

04/27/23

PHI

ENCRYPTED BY ELAVON

Trace: 8

DEBIT

PHI Chip

AMOUNT $3,478.50

APPROVED

US DEBIT

AID: A0000000980840

TVR: 80 80 04 80 00

TSI: 68 00

THANK YOU

CUSTOMER COPY

12

LEOFF I – CERTIFICATION CLAIM FORM – POLICE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [ ] _____

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
2-14-23	Fractured infected tooth	PHI	2420.00	2420.00

PHI

TOTAL: 2420.00

6-1-23
Date

Board Use Only

Last payment on this claim
8/12/22

To whom it may concern,

PHI attended for extraction #30 on 5/16/2022. The tooth was determined to be non-restorably fractured and abscessed. I have advised that this tooth be replaced with an implant upon sufficient healing time.

Thank you

PHI

PHI

STATEMENT

05/31/2023

PHI

Amount Due	Date Due	Amount Enclosed
0.00	Upon Receipt	

PHI

CREDIT CARD TYPE _____

_____

3 DIGIT CSV _____

EXPIRES _____

AMOUNT APPROVED _____

NAME _____

SIGNATURE _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

Total:	$276.00
-Ins Estimate:	$276.00
=Balance:	**$0.00**

0-30	31-60	61-90	over 90
276.00	0.00	0.00	0.00

PHI

PHI

PHI

Date	Patient	Code	Tooth	Description	Charges	Credits	Balance
				Balance Forward			614.00
02/14/2023		D9230		inhalation of nitrous oxide/analgesia, anxiolysis	53.00		667.00
02/14/2023		D6010	30	surgical placement of implant body: endosteal implant	2,074.00		2,741.00
02/14/2023		Pay		Credit Card PHI $2,420.00		2,420.00	321.00
02/14/2023		Claim		Pri Claim $2,127.00 FFD Membership Plan Received 02/14/2023 NO PAYMENT Writeoff: $321.00			
02/14/2023		InsPay		Insurance Payment for Claim 02/14/2023 Payment: $0.00 Writeoff: $321.00		321.00	0.00
02/14/2023		Stmt		Statement-InPerson			

PHI

PHI

PHI