9/5/2023

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 August 1, 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. Discuss conversation with Police Member #4
9. **BOARD COMMENTS/DISCUSSION**

NEXT MEETING DATE:

a. October 3, 2023 @ 11:45 AM

DISABILITY BOARD
REGULAR MEETING
August 1st, 2023

CALL TO ORDER

Jim Kraft called the regular meeting of the Kennewick Disability Board to order at 11:46 a.m. at the Kennewick City Hall Building, 210 W. 6th Ave, in the Cascade Conference Room & Teleconference.

Members Present: Jim Kraft, Police Representative; Gary Williams, Fire Representative; Bill McKay, Mayor; Kathryn Armstrong, Member at Large

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

Member Absent: Bill McKay, Mayor; Brad Beauchamp, Council Member

PUBLIC COMMENT

None presented.

APPROVAL OF MINUTES

Kathryn Armstrong moved, seconded by Gary Williams to approve the minutes of the July 11th, 2023 meeting. The motion passed unanimously.

FIRE CLAIMS

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

POLICE CLAIMS

Gary Williams presented the Police claims in the amount of $2667.00. Kathryn Armstrong moved, seconded by Gary Williams to pay all claims as presented. The motion passed unanimously.

OLD BUSINESS

Follow up on Police Member #20 claim.

NEW BUSINESS

A motion was made by Kathryn Armstrong, seconded by Jim Kraft to reimburse Police Member #2 in the amount of $818.00 for dental repair.

A motion was made by Gary Williams, seconded by Kathryn Armstrong to reimburse Police Member #5 in the amount of $2327.79 for dental work.

A motion was made by Kathryn Armstrong, seconded by Gary Williams to authorize prior approval for dental repair in the amount of $1810.00.

COMMENTS/DISCUSSION

ADJOURNMENT

The meeting adjourned at 12:00 p.m.

NEXT MEETING
Tuesday
September 5th, 2023
@
11:45 AM

APPROVED:

DRAFT – FOR CONSIDERATION 9-5-2023

Prepared by Christie Brown, Disability Board Secretary

MEETING DATE: SEPTEMBER 5, 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
30			$ 1,499.99

$ 7,948.99

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 SEPTEMBER 2023

Meeting Date	ID	Vendor #	Date of Service	Insurance PD	Claim #	Amount	Provider Type
9/5/2023		29	07/01/2023-07/31/2023		LONG TERM CARE	$ 6,449.00	FARMINGTON SQUARE MEMORY CARE
9/5/2023		30	8/17/2023		HEARING AIDS	$ 1,499.99	COSTCO
					TOTAL	$ 7,948.99	
					TOTAL	**$ 7,948.99**	

#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
July 2023	Chronic Dementia / Alzheimers	PHI	$6449.00	

TOTAL: $6449.00

PHI PHI 8/5/2023

Print Name **Signature** **Date**

Board Use Only

PHI

INVOICE

Invoice Period: 07/2023

Send To: PHI

IMPORTANT NOTICE

HAPPY 4th OF JULY

Print date: June 22, 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 # 5086	:CHECKscan Payment	06/05/23	($6,449.00)
		Total Payments	**($6,449.00)**
Credits		**From**	
MC Rent Adjustments		07/01/23 - 07/31/23	($207.00)
		Total Credits	**($207.00)**
Charges		**From**	
Memory Care Rent		07/01/23 - 07/31/23	$5,300.00
Memory Care Level 3		07/01/23 - 07/31/23	$1,300.00

PAID 6/27/23 @ RFCU
Conf #35NP-HP282

PHI

INVOICE

Invoice Period: 07/2023

Charges	From	
Personal Care Package Tier 1	07/01/23 - 07/31/23	$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, please call PHI

#30

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 [ ] _____

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
8-17-23	Hearing aids	Costco	1499.99	

TOTAL: 1499.99

PHI

Print Name

PHI

8-22-23
Date

Board Use Only

COSTCO WHOLESALE

PHI

PHI

HEARING AID

9A Member PHI
F 1555200 BICORE BUNDL [redacted]
KIOSK ORDER# 3699626

SUBTOTAL	1,499.99
TAX	0.00
**** TOTAL	[redacted]

PHI

APPROVED - Purchase
AMOUNT: $1,499.99
08/17/2023 15:54 486 79 6 170

Costco Visa	1,499.99
CHANGE	0.00

TOTAL NUMBER OF ITEMS SOLD = 1
08/17/2023 15:54 486 79 6 170

PHI

Items Sold: 1
9A 08/17/2023 15:54

COSTCO WHOLESALE

8505A W. Gage Blvd
Kennewick WA 99336
(509) 737-0637

Member Copy
Do Not Slip Print

PHI

PHI

PHI

PRINT NAME OF BUYER (INDICATE IF BUYER IS THE SAME AS USER) MEMBERSHIP NO.

ADDRESS

TELEPHONE NO.

Item Description	Item #	Model / Description	Manufacturer Warranty	Unit Price	Total Amount
Bundle	**1555200**	**Rexton BiCore C R-Li Bundle**		**1499.99**	**1499.99**
Left Hearing Aid		*Rexton BICORE LI PAIR RIC Digital* *Loss & Damage Warranty* *Battery Size Rechargeable*	36 mths 24 mths		
Right Hearing Aid		*Rexton BICORE LI PAIR RIC Digital* *Loss & Damage Warranty* *Battery Size Rechargeable*	36 mths 24 mths		
Accessory		*Rexton BiCore Portable Charger*	36 mths		
Accessory		*Rexton BiCore Standard Charger*	36 mths		
Accessory		*BICORE LI PAIR*	_____ mths		
Left Receiver		Rexton Mini 2.0 M, 2	36 mths	0.00	0.00
Right Receiver		Rexton Mini 2.0 M, 2	36 mths	0.00	0.00
				Tax (if applicable)	_____
				Total	_____

☐ Check ☐ Cash ☐ Credit Card ☐ Debit

Manufacturer warranty periods are noted above.

PHI

[Rev. 2/10/23]

180-DAY RETURN POLICY: During the 180-day trial period following the Dispensing Date, you may return the hearing aid, component, ear mold, and accessories for any reason to receive a full refund provided you return the item to the Costco Hearing Aid Center in the same condition as when purchased, ordinary wear and tear excluded. The 180-day trial period shall commence from the date the hearing aid is originally delivered to you or the date this purchase agreement is delivered to you, whichever is later. No cancellation fee will be assessed by the Costco Hearing Aid Center.
LAST DAY TO RETURN ITEMS FOR FULL REFUND: _____

MANUFACTURER WARRANTY POLICY: Beginning on the Dispensing Date, as identified below, the hearing aid, components, ear mold and accessories you purchased are warranted by the manufacturer to be free from all defects in materials and workmanship, and the manufacturer agrees to make all necessary repairs or, at the manufacturer's option, provide a replacement without charge to the buyer during the warranty periods noted above.

ONE-TIME REPLACEMENT POLICY FOR LOSS OR DAMAGE: Beginning on the Dispensing Date, if the hearing aid you purchased is warranted for damage (as noted above) and is damaged beyond repair or is warranted for loss (as noted above) and is lost or stolen, the manufacturer will provide a one-time replacement with a comparable model for the same ear, at no additional charge. You will receive only one replacement of your hearing aid whether that replacement is provided under the damage policy or the loss policy. The manufacturer's warranty policy will continue to apply to the replacement hearing aid for the remainder of the manufacturer's warranty period indicated above. If you find the lost or stolen hearing aid after replacement, it becomes the property of the manufacturer and must be returned to the Costco Hearing Aid Center. **Please note that the hearing aid replaced under the Loss or Damage Policy cannot be returned for a refund.**

Buyer's Acknowledgement: I, the buyer, acknowledge that the hearing aid specialist or audiologist has:

- Advised me that the hearing aid is being sold by **[check one of the following]**:
  ☑ a licensed hearing aid specialist _____ a licensed audiologist.
- Scheduled a follow-up appointment to take place at the Costco Hearing Aid Center where the hearing aid was purchased.
  Follow-up Appt.: _____
- Advised me that any examination or representation made by a licensed hearing aid specialist or an audiologist in connection with the practice of fitting and selling of this hearing aid is not an examination, diagnosis, or prescription by a person licensed to practice medicine in this state, and shall not be considered a medical examination, opinion or advice.
- Advised me that all hearing aids are new on initial sale.
- Advised me that the hearing aid has been specifically built to fit the acoustic needs of my particular loss and is not intended to be used on any other ear except the one tested.
- Advised me that the use of a hearing aid will not restore normal hearing, nor will it prevent further hearing loss.
- Reviewed with me the 180-Day Trial Period, Manufacturer Warranty, Loss Policy and Damage Policy, as they apply to my purchase.
- Provided me with a copy of Washington's "Notice to Buyer" (WAC 246-828-290).

BUYER'S INITIALS: PHI

I hereby purchase from Costco Hearing Aid Center the hearing aid as shown above, and hereby acknowledge that I have read and understand the information in the Purchase Agreement.

Buyer: PHI 08/17/2023

User (if different from Buyer): _____ **Purchase Date:** _____
Signature

Sold by: PHI

Supervisor (if applicable): _____ **License No.:** _____
Signature

Print Name and Title

DELIVERY RECEIPT

Received by: _____ **Dispensing Date:** _____
Signature

Dispensed by: PHI **License No.:** _____

Supervisor (if applicable): _____ **License No.:** _____
Signature

Print name and Title

Manufacturer's Name and Reg. No.: _____

Notice to Buyer

NOTICE TO BUYER UNDER WASHINGTON STATE LAW CHAPTER 18.35 RCW

Do not sign this agreement before you read it or if any spaces intended for the agreed terms are blank. You are entitled to receive a copy of this agreement at the time you sign it. The seller's business address must be shown on the agreement.

Section 1 CANCELLATION - WITHIN THREE DAYS

You may cancel this agreement within three days, without explaining your reasons, if the seller solicited it in person and you signed it at a place other than the seller's business address.

To cancel this agreement without explaining your reasons, you must notify the seller in writing that you are canceling the agreement. You may deliver the written notice to the seller at the seller's business address. Alternatively, you may send the written notice by certified mail, return receipt requested, to the seller at the seller's business address.

Your written notice must be postmarked or delivered by midnight of the third business day after you signed this agreement.

Any merchandise you received under this agreement must be in its original condition. You must return it to the seller's business address or make it available to the seller at the same place it was delivered to you.

The seller must refund to you all deposits, including any down payment, and must return to you all goods traded in as part of the agreement.

You will incur no additional liability for canceling the agreement.

Section 2 RESCISSION - WITHIN THIRTY DAYS

You may rescind (or terminate) the agreement within thirty days, for reasonable cause. This thirty-day period is called the "rescission period."

To rescind this agreement, you must notify the seller in writing that you are rescinding the agreement for reasonable cause pursuant to RCW 18.35.185(1). (Reasonable cause does not include cosmetic concerns or a mere change of mind.) You may deliver the written notice to the seller at the seller's business address. Alternatively, you may send the written notice by certified mail, return receipt requested, to the seller at the seller's business address.

Your written notice must be postmarked or delivered by midnight of the thirtieth day after delivery of the hearing instrument.

Any merchandise you received under this agreement must be in its original condition, except for normal wear and tear. You must return it to the seller's business address or make it available to the seller at the same place it was delivered to you.

The seller must refund to you all deposits, including any down payment, and must return to you all goods traded in as part of the agreement. However, for each hearing instrument you return, the seller may keep either one hundred fifty dollars or fifteen percent of the total purchase price, whichever is less, plus the price originally charged for custom-made earmolds.

The seller must refund your money and return your traded goods, or have them postmarked and in the mail to you, within ten business days after receiving your notice of rescission.

You will incur no additional liability for rescinding the agreement.

Section 3 EXTENSION OF RESCISSION PERIOD

If you notify the seller within the thirty-day rescission period that your hearing instrument has developed a problem that constitutes reasonable cause to rescind the agreement or that prevents you from evaluating your hearing instrument, the seller must extend the rescission period. The rescission period stops running on the date you notify the seller of the problem and starts running again on the date the seller notifies you that your hearing instrument is ready for redelivery.

You and the seller may agree to a rescission period longer than thirty days.

Whenever the rescission period is extended, the seller must provide you written notice of the last date upon which you may demand a refund and return of traded goods.

Section 4 NOTICE OF HEARING ASSISTIVE TECHNOLOGIES

Prior to initial fitting and purchase you must be informed, both orally and in writing, about the uses, benefits, and limitations of current hearing assistive technologies. Hearing assistive technologies can supplement your hearing aid and increase the intelligibility and clarity of speech in environments where hearing instruments alone may not provide optimal comprehension. Hearing assistive technology options can allow hearing aids to connect wirelessly and through direct connection to other electronic sound sources and assistive listening systems, compliant with the Americans with Disabilities Act.

I am aware that the hearing instrument(s) referenced in this document include (please select all that apply):

☐ Telecoil
☐ Bluetooth
☐ Other technology (specify) _____

By signing this receipt, you acknowledge that you have been informed of your rescission rights and hearing assistive technologies and that you have read and understand these rights.

PHI

08/17/2023
Date

08/17/2023
Date

_____ _____
Delivery Acknowledgment - Signature of Purchaser Date

Buyer's Initials: PHI

COSTCO HEARING AID CENTER

Member Name: PHI

WAIVER OF MEDICAL EVALUATION REQUIREMENT

I have been advised by PHI that my best interest would be served if I had a medical evaluation by a licensed physician (preferably by a physician who specializes in diseases of the ear) before purchasing a hearing aid. I do not wish a medical evaluation before purchasing a hearing aid.

Member Signature: PHI Date: 08/17/2023

By signing the above line, you are also stating that you are 18 years of age or older, you have read and understand the notice, and you have made an informed decision to purchase hearing aids without being seen by a physician.

FOR STAFF ONLY

Check one of these boxes and sign below:

☐ I have written medical clearance from a medical doctor on file for the member named above.

☑ I reviewed the Medical Evaluation Waiver with the member named above.

PHI

08/17/2023
Date

PHI
License #

Medical Waiver Form (09/01/2022)

MEETING DATE: SEPTEMBER 5 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
5			$ 2,327.79
2			$ 818.00
12			$ 1,599.00
			$ 4,744.79

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 SEPTEMBER 2023

Meeting Date	ID	Vendor #	Date of Service	Insurance	Claim #	Amount	Provider
9/5/2023		5	7/18/2023		DENTAL	$ 2,327.79	IDEAL DENTISTRY
7/12/2023		2	7/12/2023		DENTAL	$ 818.00	HANSEN FAMILY DENTAL
8/8/2023		12	8/8/2023		HEARING AIDS	$ 1,599.00	HEARING HEALTHCARE
					Total:	**$ 4,744.79**	

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
7/18/23	Tooth implant	PHI	$ 2,327.79	$ 2,327.79

PHI

TOTAL: 2,327.79

7/19/23
Date

Board Use Only

July 19, 2023

Dear Board Members;

Attached (issue #1) is an itemized billing for the last remaining treatment I will require in the restoration of a tooth (implant) I lost due to dry mouth conditions caused by my CPAP machine. As your records will reflect, this has been an ongoing situation for the last several months and was previously approved for reimbursement by the board.

PHI

Thank you for your attention to this matter and I look forward to hearing from you.

PHI

PHI

July 18, 2023

PHI

ID: PHI

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

Date	Patient	Provider	Transaction	Tth	Surface	Fee
7/18/2023	PHI		DELCN - DELIVER CROWN (Standard Fee $0.00) (Adjust $0.00) (Fee $0.00)			$0.00
7/17/2023			Credit Adj - 7% senior discount for ($175.21)			
			Acct Pmt - Visa Credit Card for ($2,327.79)			
			D6058 - ABUTMENT SUPPORTED PORC/CERAMIC CROW (Standard Fee $1,709.00) (Adjust $0.00) (Fee $1,709.00)	13		$1,709.00
			D6057 - CUSTOM ABUTMENT (Standard Fee $794.00) (Adjust $0.00) (Fee $794.00)	13		$794.00

	SubTotal:	$2,503.00
	Tax:	$0.00
	Charge(s):	$2,503.00
-	Payment(s):	$2,327.79
-	Adjustment(s):	$175.21
	Balance Due:	$0.00

Contract Balance	Estimated Insurance	Previous Balance	Charge(s)	Payment(s)	Adjustment(s)	Balance Due Now
$0.00	$0.00	$0.00	$2,503.00	$2,327.79	($175.21)	**$0.00**

Future Family Appointments:

Patient:	Next Appointment:	Patient:	Next Appointment:	Patient:	Next Appointment:
PHI					

Thank You for Visiting our Office. We appreciate your patronage. Have a Great Day!

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 [✓] PHI

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
7-12-2023	Crown front Tooth	PHI	$818.00	$818.00

TOTAL: $818.00

7-19-2023
Date

PHI

Board Use Only

PHI

7-12-2023

PHI

Appointment on 7-12-23
Limited Exam , Xray of # 8, Build up and crown completed .

#8 existing MLFI composite fill. Recurrent decay on all surfaces...IFL chip in the composite material...Necessitates removing all remaining decay and fill. After decay and fill removed 50% tsr b/u f/c required.

PHI

This means my front tooth fell apart.

TIME 09:44 AM

PHI

DATE 7/12/2023

ACCOUNT HISTORY REPORT

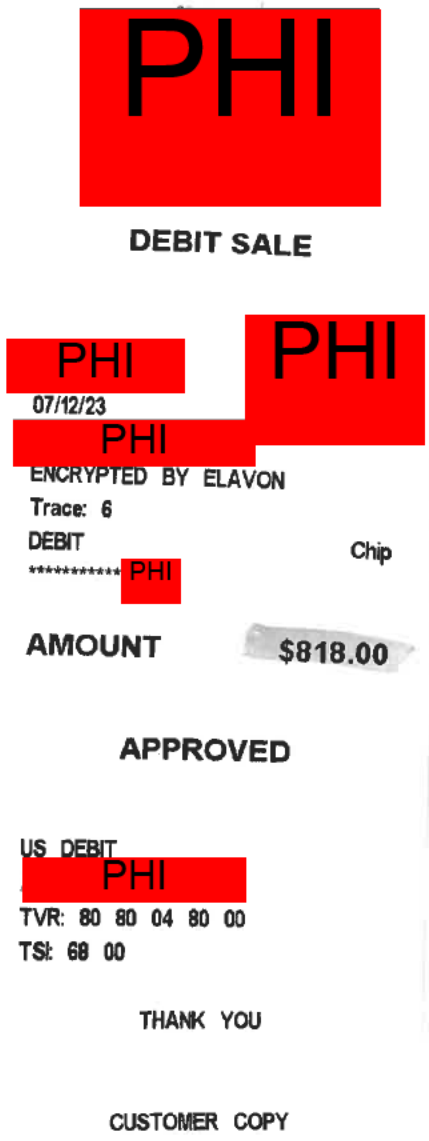
FOR

PHI

From Jul 12, 2023 To Jul 12, 2023

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

Date	Name	Provider	Type	Description	Debit	Credit
	PHI	PHI	>>>>>>>>> Sum of all account activity prior to 7/12/2023			
7/12/2023			Service	02740 1-Crown Porcelain/Ceramic Tooth 8	$1,589.00	
7/12/2023			Service	00220 Periapical single, first Tooth 8	$47.00	
7/12/2023			Acct Pmt	Visa		$818.00
					$1,636.00	$818.00


PHI

DEBIT SALE

PHI PHI

07/12/23

PHI

ENCRYPTED BY ELAVON

Trace: 6

DEBIT Chip

********** PHI

AMOUNT $818.00

APPROVED

US DEBIT

PHI

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
8-8-23	Hearing Loss	PHI	~~6198.00~~ 1599.—	0
			1599.—	
		TOTAL:	~~6198.00~~	

PHI

P

8-25-23
Date

Board Use Only

Costco Comparison
Board allows $1599.—

PHI

PHI

Delivery of Hearing Aid Contract

"Notice to Buyer"

The undersigned person licensed to fit and dispense hearing aids ("Licensee") hereby acknowledges receipt of the sum of $_____ as a deposit on the hearing aid(s) as described as follows:

Hearing Aid OTICON (Make) REAL 1 miniRITE R (Model) Serial No. B43G56 (RT)

Hearing Aid OTICON (Make) REAL 1 miniRITE R (Model) Serial No. F13GL4 (LT)

which is/are new X or used and/or reconditioned ___ delivered to:

PHI

"Patient"

Terms of Sale

I understand the total purchase price of the above described hearing aid(s) is $6.398.00, to be paid in full within 30 days from the date of 07-26-23.

I understand that if I decide not to keep the above described hearing aids I will return them in the original condition within 30 days from the date of 07-26-23, and Hearing Healthcare Associates will refund 100% of any deposit that was left on the above described hearing aid(s).

In keeping the above described hearing aid(s) **after the 30 days** from the above date, I understand that they will be considered purchased. I understand that if I return the hearing aids within 30 days from 08-26-23 (the purchase date) I will be charged a fee of $150.00 per hearing aid or 15% of the price whichever is less. I also understand that the described hearing aid(s) can not be returned past the 30 days from the purchase date.

PHI

Patient/Legal Guardian Signature

7-31-23

Date

I understand and agree to the *"Terms of Sale,"* and I have read the *"Notice to Buyer"* and the *"Purchaser Rescission Rights"* printed on the reverse side of this "Delivery of Hearing Aid Contract."

PHI

Audiologist/Specialist

License Number PHI

PHI

August 8, 2023
9:33 AM

PURCHASE

PHI

VISA CREDIT
AID A0 00 00 00 03 10 10

Custom Amount	$6.198.00
Total	$6,198.00
	$6,198.00

PHI

To:

LEOFF 1 Disability Board

From:

PHI

August 25th, 2023

With this letter I am submitting a claim for hearing aids that were purchased at PHI on August 8th, 2023. I understand that the Board will only pay what similar hearing aids would have cost at Costco.

Thank You,

PHI