



6/3/2025

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

4:30 PM

- 1. CALL TO ORDER**
- 2. ATTENDANCE**
- 3. PUBLIC COMMENT**
- 4. APPROVAL OF MINUTES**
 - a. Approval of the minutes dated May 6, 2025
- 5. FIRE CLAIMS**
- 6. POLICE CLAIMS**
- 7. NEW BUSINESS**
 - a. Claim: Police Member #5 requesting reimbursement and pre-approval for dental work
 - b. Claim: Fire Member #21 requesting pre-approval of long-term care services
- 8. UNFINISHED BUSINESS**
 - a. Claim: Police Member #23 requesting reimbursement for hearing aids
- 9. BOARD COMMENTS/DISCUSSION**
- 10. CONCLUSION**

NEXT MEETING DATE: JULY 1, 2025

**DISABILITY BOARD
REGULAR MEETING
May 6, 2025- DRAFT**

1. **CALL TO ORDER:** Police Representative Jim Kraft called the regular meeting of the Kennewick Disability Board to order at 4:30 p.m.

2. **ATTENDANCE:**

Board Members Present:

Gretl Crawford, Mayor
Chuck Torelli, Mayor Pro Tem
Jim Kraft, Police Representative
Dennis Waters, Fire Representative
Kathryn Armstrong, Member-At-Large

City Staff Present:

Brandi Ralston, Board Secretary
Jessica Platt, Finance Director

3. **PUBLIC COMMENT:** NONE

4. **APPROVAL OF MINUTES:** The minutes of April 1, 2025, were unanimously approved as presented.

5. **FIRE CLAIMS:** NONE

6. **POLICE CLAIMS:** NONE

7. **NEW BUSINESS:**

a. **Claim: Police Member #5 is requesting reimbursement for a dental claim:** The Board briefly discussed the claim. Mrs. Ralston informed the Board that an additional dental claim for the same issue will be on the June meeting agenda as it was not submitted prior to the cut off date for the May meeting. **The motion to approve Police Member #5's claim, in the amount of \$452.00, was unanimously approved as presented.**

b. **Claim: Police Member #4 is requesting reimbursement for a glasses claim:** The Board briefly discussed the claim. **The motion to approve Police Member #4's claim, in the amount of \$111.88, was unanimously approved as presented.**

8. **UNFINISHED BUSINESS:** NONE

9. **BOARD COMMENTS/DISCUSSION:**

Ms. Ralston noted that a two claims were submitted after the April 15th deadline for the May meeting. Those claims will be included on the June agenda. Ms. Ralston informed the Board that she has been working with the family of a Fire member that is facing declining health, the family is working on getting the information together for a claim for long-term care. Finally, Ms. Ralston noted that she received a letter from a hearing doctor for a member but no additional information has been submitted in regards to a claim, she will follow up with the member.

Mr. Kraft noted that he received a claim from a member and gave it to Ms. Ralston for processing for the June meeting.

ADJOURNMENT: Mr. Kraft concluded the meeting at 4:40 p.m.

Draft

Brandi Ralston, CPRO
Disability Board Secretary

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
4/29/25	Dental Injury	Col. Basin Surgeons Dr. Black	\$ 169.00	\$ 169.00

TOTAL: \$ 169.00
 Date 4/30/25



Board Use Only	<p align="center">RECEIVED</p> <p align="center">APR 30 2025</p> <p align="center">CITY OF KENNEWICK CITY CLERK'S OFFICE</p>	Member #5
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April 30, 2025

TO: Kennewick Disability Board
RE: Ongoing Dental Injury

Dear Board Members;

In reference to my latest correspondence to you (April 1, 2025) regarding an injury to one of my teeth that occurred back in July of last year (also see correspondence dated September 9th) and, after discussing the matter with my Board representative, Jim Kraft, it was suggested that I obtain cost estimates for the surgical extraction of the tooth and implant (prosthetic replacement) of the tooth.

As you will note in prior correspondence, I injured the tooth while eating a salad with walnuts in it and bit down on a piece of a walnut shell, cracking a lower molar on the right side of my jaw. This has been definitively diagnosed as a fractured tooth in previously submitted correspondence but, since it has yet to become chronic, I have not gone ahead with extraction. I have been informed that the tooth, which does flair up from time to time, will eventually abscess or possibly get infected so I will, in the very near future, be forced to get it removed and begin the lengthy process of getting an implant put in its place.

On April 29th, I saw the oral surgeon, Dr. Black at Columbia Basin Oral Surgeons in Kennewick and had the tooth and jaw evaluated for an implant. The cost of this evaluation was \$169.00 (claim for reimbursement attached). I was able to get the cost of the prosthetic tooth, which will be put in place by Clearwater Dental via email thus saving the cost of an office call.

As you will note in the attached documents, the proposed cost of surgically removing the tooth and prepping the area for an implant (Columbia Basin Oral Surgeons) is \$5,516.00 and the cost of the implant (Clearwater Dental) is proposed to be \$2,810.00 for a total of \$8,326.00.

These documents are being submitted to the Board for your consideration and pre-approval. I'm hopeful the tooth does not abscess or become chronic between now and the time this request is reviewed. If it does, I will be forced to proceed on an emergency basis.

Thank you for your consideration in this matter.



Columbia Basin Oral & Maxillofacial Surgeons

512 N Young Street
 Kennewick WA - 99336
 Ph: (509) 783-7600
 Email: info@cboms.com

LEDGER

Patient Name
 Address



Date : 04/29/2025

Date	Description	Tooth/ Area	Provider	Max Allowed	Ins. Amt.	Pat. Amt.	Running Total
04/29/2025	Rcpt. #429770- Pat. payment of \$169.00 credited by CREDIT/DEBIT CARD - VISA(Dated: 4/29/2025)			\$0.00	\$0.00	(\$169.00)	\$0.00
04/29/2025	Completed D0140 - Limited oral evaluation - problem focused (DOS: 4/29/2025) at CBOMS		Black, Matthew	\$169.00	\$0.00	\$169.00	\$169.00
Total				\$169.00	\$0.00	\$0.00	

Balance Summary as on 04/29/2025

Patient Name	0 - 30	31 - 60	61 - 90	91 - 120	Over 120	Balance	Combined Balance	Contracted Balance	Rem. Contract Amount
Patient	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	Insurance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			

Provider License Information

1. Black, Matthew : DE 61025296

Summary for the selected period

Balance due Patient	:	\$0.00		Unapplied Credits	:	\$0.00
Total Balance	:	\$0.00		Balance due Insurance	:	\$0.00
Total Adjustments	:	\$0.00		Net Balance	:	\$0.00

Case Report - Extraction

Patient: [REDACTED]
 DOB: [REDACTED]
 Resp. Party: [REDACTED]
 Primary Insurance: No insurance
 Secondary Insurance: No insurance

Columbia Basin Oral & Maxillofacial Surgeons
 512 N Young Street
 Kennewick, WA 99336
 Email: info@cboms.com
 Phone: (509) 783-7600

Treatment Plan Estimate

Treatment Plan: Extraction

Date	Code	Th/Surf	Tx Provider	Status	UCR	Ins. Est	Pat. Est
04/29/2025	D0140 - Limited oral evaluation - problem focused		MKBLAC: Black, Matthew	Proposed	\$134.00	\$0.00	\$169.00
Phase 1					\$134.00	\$0.00	\$169.00
04/29/2025	D7210 - Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	30	MKBLAC: Black, Matthew	Proposed	\$435.00	\$0.00	\$435.00
04/29/2025	D7953 - Bone replacement graft for ridge preservation - per site	30	MKBLAC: Black, Matthew	Proposed	\$1,192.00	\$0.00	\$889.00
04/29/2025	D6010 - Surgical placement of implant body, endosteal implant	30	MKBLAC: Black, Matthew	Proposed	\$2,980.00	\$0.00	\$2,980.00
04/29/2025	D6056 - Prefabricated abutment - includes modification and placement	30	MKBLAC: Black, Matthew	Proposed	\$0.00	\$0.00	\$0.00
04/29/2025	D9222 - deep sedation/general anesthesia - first 15 minutes		MKBLAC: Black, Matthew	Proposed	\$330.00	\$0.00	\$330.00
04/29/2025	D9223 - Deep sedation/general anesthesia - each 15 minute increment		MKBLAC: Black, Matthew	Proposed	\$294.00	\$0.00	\$294.00
04/29/2025	D9223 - Deep sedation/general anesthesia - each 15 minute increment		MKBLAC: Black, Matthew	Proposed	\$294.00	\$0.00	\$294.00
04/29/2025	D9610 - Therapeutic parenteral drug, single administration		MKBLAC: Black, Matthew	Proposed	\$125.00	\$0.00	\$125.00
Phase 2					\$5,650.00	\$0.00	\$5,347.00
FINAL ESTIMATE OF Extraction					\$5,784.00	\$0.00	\$5,516.00

Financial Policy: Our goal is to provide the highest quality of oral surgery care with a comfortable financial arrangement for our patients. The quoted fees above will be honored for a period of 90 days.

Fees for your consultation, x-rays, and any other diagnostic aids obtained during your first appointment are due at that time. If your surgery is not covered by insurance, or if you desire to have your consultation and treatment performed on the same day (ie. emergency patients), we will ask you to provide payment in full by cash, credit card, or check. We reserve the right to collect a deposit or payment in full prior to your scheduled appointment.

Applicable to Implants ONLY: Dental Implant Restoration Consent: Dental implant treatment is a staged, team effort in which your surgeon will work directly with your general dentist. The surgical portion of your dental implant care will be completed by us. The restoration portion of your dental implant care will be completed by your general dentist. The fees listed above reflect ONLY the surgical portion of dental implant care. The fees relating

Proposed Treatment Plan

4/29/2025

Clearwater Dental

Han And Rose PLLC
5000 W. Clearwater Ave

Kennewick, WA 99336-1964
(509)783-5000



ID: 35518

<u>Phase</u>	<u>Date Plan</u>	<u>Appt</u>	<u>Provider</u>	<u>Service</u>	<u>Tth</u>	<u>Surf</u>	<u>Fee</u>	<u>Ins.</u>	<u>Pat.</u>
	2/17/2023		16	06058 Implant Crown Porc.	13		\$1,760.00	\$0.00	\$1,760.00
	2/16/2023		16	06057 Custom Abutment	13		\$1,050.00	\$0.00	\$1,050.00
	2/16/2023		16	CR-ST CROWN SEAT	13		\$0.00	\$0.00	\$0.00
Subtotal:							\$2,810.00	\$0.00	\$2,810.00

Insurance coverage is only an estimation. Guarantor is responsible for all treatment not covered by insurance.

Total Proposed:	\$2,810.00
Total Completed:	\$0.00
Total Accepted:	\$0.00
Proposed Insurance:	\$0.00

I REQUEST AND AUTHORIZE THE DENTIST OR QUALIFIED ASSIGNEE TO PERFORM THE WORK DESCRIBED ABOVE.

Patient or Guarantor's Signature _____ Date _____

5. Please select the long-term care service for which reimbursement is sought:

Home health care ___ Nursing home ___ Custodial care
___ Hospital extended facility ___ Assisted living facility

6. Is the member able to perform the following Activities of Daily Living (ADLs)

Bathing	___ Yes	<input checked="" type="checkbox"/> No
Dressing	___ Yes	<input checked="" type="checkbox"/> No
Feeding	___ Yes	<input checked="" type="checkbox"/> No
Toileting	<input checked="" type="checkbox"/> Yes	___ No
Transferring	___ Yes	<input checked="" type="checkbox"/> No
Continence	<input checked="" type="checkbox"/> Yes	___ No
Cognitive Functionality	___ Yes	<input checked="" type="checkbox"/> No
Other*	___ Yes	___ No

*Describe "other" (i.e., self-medicate) _____

7. Please list specific medical and other assistance this member needs: _____

*Needs assistance in bathing, dressing, feeding, medication management and administration
Requires home oxygen.*

8. Estimated length of time this member will require specialized care: life long

9. Please list any other medical consults this member has received: (include address & phone #) _____

*Neurologist Anil Kumar Raghurath (KRODCC)
Columbia River Home Health*

Dated this 8 day of May, 2025


LEOFF 1 member or Representative (sign/print name)

Board Action _____

Date _____

IN-HOME CARE EVALUATION FORM

The Kennewick Fire/Police Disability Board requires this form to be completed by a certified assessor whenever a member is seeking reimbursement for long-term in-home care, whether it be custodial care, home health care, or any form of long-term medical care provided in the member's home. All completed forms must be submitted to the City of Kennewick Disability Board, 210 W. 6th Avenue, Kennewick, WA 99336. *Note: Failure to complete the necessary forms or submission of incomplete forms will result in denial of a member's request for reimbursement.*

<div style="background-color: black; width: 100%; height: 20px; margin-bottom: 5px;"></div> NAME OF MEMBER	<div style="background-color: black; width: 100%; height: 20px; margin-bottom: 5px;"></div> DOB	<div style="background-color: black; width: 100%; height: 20px; margin-bottom: 5px;"></div> Phone Number
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General Information

Housing Environment – Check all that apply:

- Facility/Accessible
- Senior housing accessible
- House
- Apartment
- One level
- Multi-level
- Mobile home
- Ramp present
- Ramp not present
- Heated storage space available
- Non-heated storage space available
- Pertinent doorways provide access

Comments:

Primary Means of Transportation – Check all:

- Patient drives
- Patient does not drive
- Public Transportation
- Van with lift
- Van without lift
- Car
- Car with lift

Identify year/make/model:

2019 BUICK

Current Activities:

- Retired for age
- Retired due to disability
- Works
- Attends school
- Volunteers in community
- Active member of community organizations
- Other:

Relevant Health Information

Cognition/Mental State:

- Alert
- Oriented to person, place, time
- Disoriented
- Confused
- Lethargic
- Unresponsive
- Follow Commands:
 - Simple Complex
- Attention Span:
 - Adequate Decreased
 - Cooperative Uncooperative
- Behavior:
 - Appropriate Impulsive
 - Restless Distractible
 - Agitated

Comments:

*Dementia diagnosed
in 1992*

Edema:

- None present
- Potential
- Present/Potential in both lower extremities
- Present/Potential in left lower extremity
- Present/Potential in right lower extremity

Comments:

Vision:

- Within functional limits with eye glasses
- Within functional limits without eye glasses
- Visual field defects
- Legally blind

Comments:

Skin Risk:

- Poor general physical condition
- Altered level of consciousness
- Decreased mobility
- Eating <50% of meals
- Incontinent
- Contractures
- Decreased sensation
- Minimum/No Risk; none of the above

Comments:

Decubiti:

- None Present
- Actual (describe):
- Potential (describe):

Comments:

Personal Mobility

Transfers:

- Out of chair -
 - Independently
 - Distant supervision
 - Close supervision
 - Contact guard assistance
 - Minimum assistance
 - Moderate assistance
 - Maximum assistance
 - Total/Mechanical lift
- Out of bed -
 - Independently
 - Distant supervision
 - Close supervision
 - Contact guard assistance
 - Minimum assistance
 - Moderate assistance
 - Maximum assistance
 - Total/Mechanical lift

Comments:

ADL Function:

- Independent
- Supervision
- Assistance (describe):
mobility, self-care + feeding
- Aide service

Comments:

Mobility within home – check all:

- Ambulates without assistive device
- Independent with assistive device
- Non-ambulatory/wheelchair
 - Manual wheelchair
 - Powered wheelchair

Comments:

Walker

Mobility outdoors – check all:

- Ambulates without assistive device
- Independent with assistive device
- Non-ambulatory/wheelchair
 - Manual wheelchair
 - Powered wheelchair

Comments:

Walker

Wheelchair mobility:

- Dependent
- Needs some assistance
- Independent

Is the distance he/she propels manual wheelchair greater than 100 feet? Yes No

Comments:

Mobility aids:

- Cane
- Walker
- Crutches
- Other:

Physical Considerations

Gait:

- Ambulates independently w/o assistive device
 - Independent with assistive device
 - Assisted ambulation with assistive device
- Is the distance he/she ambulates greater than 100 feet? Yes No
- Assisted ambulation without assistive device
- Is the distance he/she ambulates greater than 100 feet? Yes No
- Non-ambulatory/wheelchair

Comments:

Range of Motion:

- UE: WFL Limited
- LE: WFL Limited

Comments:

Gross Muscle Strength:

UE: *normal on upper extremities*

LE: *weakness of both lower extremities*

Comments:

Hand Dominance:

- Right Left Ambidextrous

Hand Function/Sensation:

- WFL
- Impaired

Describe:

Sitting Posture:

Head/Neck:

- Aligned Laterally flexed to: R / L
- Flexed forward Hyperextended

Shoulders:

- Level Right higher Left higher
- Subluxation: R / L

Spine:

- Straight Scoliosis: R / L
- Kyphosis Normal lumbar space
- Flat lumbar space Hyperlordosis

Rib Cage:

- Even Oblique: R higher / L higher
- Rotated forward on: R / L

Pelvis:

- Obliquity: None R higher L higher
- Fixed Flexible
- Rotation: None R higher L higher
- Fixed Flexible

- Tilt: Neutral Anterior Posterior

Comments:

Additional Environmental Considerations

Social Support:

- Patient lives alone; independently functioning
- Patient lives alone; has supportive family/friends
- Patient lives alone; has home health care services
- Patient lives with others; independently functioning
- Patient lives with others; alone at times
- Patient lives with others; always supervised
- Does not go into community alone
- Caregiver present for assistance
- Caregiver not present for assistance

Comments:

Caregiver is wife and her health is failing.

Bathroom Facilities:

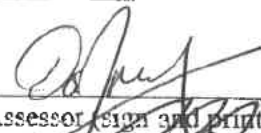
Shower Tub Both

Assistance rails installed? Yes No

Comments:

The information provided in this form may be relied upon by the City of Kennewick Disability Board in making the determination as to whether reimbursement shall be made for physical equipment as requested by a LEOFF 1 member.

Dated this 8 day of May, 2025.

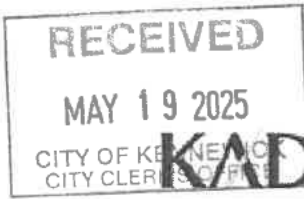


Certified Assessor (sign and print name)

LEOFF 1 Member or Representative (sign and print name)

Board Action _____

Date _____



KADLEC

KADLEC RICHLAND SENIOR CLINIC
560 GAGE BLVD STE 102
RICHLAND, WA 99352-9777
509-942-3135

Patient: [REDACTED] DOB:
[REDACTED]

5/13/25

Dear HH HOME CARE SOLUTIONS

Please contact our patient [REDACTED] to schedule an appointment with your office. We have attached the referral with insurance and demographic information.

If you require additional information, you can contact our office at 509-942-3135.

For continuity of care purposes, please notify us when our patient has been scheduled with your office. You can call 509-942-3135 or fax this letter back to our office at 509-942-2361.

APPT DATE _____
TIME _____
PROVIDER _____

Thank you for participating in the health and wellness of our patient!

<u>Payer/Plan</u>	<u>Subscriber Name</u>	<u>Rel</u>	<u>Member #</u>	<u>Group #</u>
BCBS MEDICARE - BCBS *	[REDACTED]			[REDACTED]
PO BOX 91059, SEATTLE WA 98111-9159				
REGENCE MEDICARE - RE*	[REDACTED]			[REDACTED]
PO BOX 1827, MEDFORD OR 97501-0143				
MEDICARE -	[REDACTED]			

MEDICARE P* [REDACTED]
PO BOX 6720, FARGO ND 58108-6720

KADLEC

KADLEC RICHLAND SENIOR CLINIC
560 GAGE BLVD STE 102
RICHLAND, WA 99352-9777
509-942-3135

Patient: [REDACTED] DOB:
[REDACTED]

KADLEC RICHLAND SENIOR CLINIC
560 GAGE BLVD STE 102
RICHLAND, WA 99352

Patient Demographics

Name: [REDACTED] **DOB:** [REDACTED]
Address: [REDACTED] **Phone #:** Home [REDACTED]
Phone [REDACTED]
Mobile [REDACTED]
Payor/Plan: REGENCE WA MDCR PPO **Eff Date:** 01/01/20
Group #: [REDACTED] **Member ID:** [REDACTED]

Referred To Information

Location: HH HOME CARE SOLUTIONS **Provider:**
Department: **Dept Spec:** N/A
Address: 7401 W HOOD PL SUITE 204
KENNEWICK WA 99336-3400
Phone #: **Fax#:** 509-491-1313

Referred By Information

Provider: David F. Frugone Larrea
Department: KADLEC RICHLAND SENIOR
CLINIC
Address: 560 Gage Blvd Ste 102
Richland Wa 99352-9531
Phone #: 509-942-3135 **Fax #:** 509-567-6018

Referral Details / Authorization Information

Priority: Routine [1] **Reason:** Specialty Services
Required

Diagnoses: J96.11 (ICD-10-CM) - 518.83, 799.02 (ICD-
9-CM) - Chronic respiratory failure with
hypoxia (HCC) **Procedures:**
REF34 (Custom) - AMB REFERRAL TO
HOME HEALTH

Provider Comments: Home Health Solutions

Authorization #:
Auth Start Date: 05/13/2025 **Auth End Date:** 05/13/2026
Visits: 1 **Visits:** 999
Requested: **Authorized:**

Auth Comments:

CHART NOTES:

Progress Notes by David Fernando Frugone Larrea, MD at 05/08/25 1300

Author: David Fernando Frugone Larrea, MD Service: — Author Type: Physician
Filed: 05/13/25 0842 Status: Signed
Editor: David Fernando Frugone Larrea, MD (Physician)
Expand All Collapse All Expand All by Default
☰

Subjective

Patient ID: [REDACTED]

HPI
HOSPITAL BED
HOME HEALTH

89-year-old patient that I am seeing today for a lot of regular follow-up. Worsening shortness of breath and cough and debility. Patient has Alzheimer's disease and he is a poor historian. Most of the history is obtained to patient's family.

Patient needs to have bed elevated in order for him to breathe better. I have tried this with pillows and wedges but it is not helping. They request a new prescription for a hospital bed.

Family also request help to home health. Patient is required constant supervision. Recently had another ED visit on 5/4/2025 for worsening cough and shortness

of breath. He got another round of corticosteroid this time with a Medrol pack. Which has helped with symptom. He had a repeat the CT of the chest angio due to his recent diagnosis of pulmonary embolism. At this time CT of the chest was cleared. He continues on apixaban. He has an appointment to establish with pulmonology. Patient since last hospitalization has developed chronic respiratory failure needing home oxygen. He was started on nebulizer treatments with Pulmicort and albuterol nebs. Inhalers were not effective due to patient's dementia.

Today's appointment was also to fill some forms for patient regards to services that he could get through insurance due to his previous work as a fire fighter.

Patient has poor mobility. Legs are weak according to family. Requiring more help.

PHQ-2 Depression screening Negative (05/08/25 1321)

Synopsis

1. Little interest/pleasure in doing things? : Not at all (05/08/25 1321)
2. Feeling down, depressed/hopeless?: Not at all (05/08/25 1321)

The following elements of the patient's history were reviewed and updated as appropriate. They are available elsewhere in the patient record. allergies, current medications, past family history, past medical history, past social history, past surgical history, and problem list

Review of Systems

Comprehensive review of system performed. Important listed in HPI

Objective

BP 122/78 | Pulse 89 | Temp 36.7 °C (98.1 °F) (Oral) | Resp 18 | Ht 1.676 m (5' 6") | Wt 67.9 kg (149 lb 11.2 oz) | SpO2 92% | BMI 24.16 kg/m²

Physical Exam

General: No acute distress and pleasantly confused

Eyes: Anicteric and moist

Skin: No pallor

Psych: Normal mood and affect

Lungs: Distant breath sounds

Heart: Regular S1-S2

Extremity no edema

Results for orders placed or performed during the hospital encounter of 05/04/25

B Type Natriuretic Peptide

Result	Value	Ref Range
BNP	33	0 - 100 pg/mL

CBC with Differential

Result	Value	Ref Range
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White Blood Cells	8.94	3.8 - 11.0 K/uL
Red Blood Cells	4.69	4.20 - 5.70 M/uL
Hemoglobin	15.0	13.2 - 17.0 g/dL
Hematocrit	45.8	39.0 - 50.0 %
MCV	97.7	80.0 - 100.0 fL
MCH	32.0	27.0 - 34.0 pg
MCHC	32.8	32.0 - 35.5 g/dL
RDW-CV	13.2	11.6 - 14.4 %
RDW-SD	46.7	fL
Platelet Count	328	150 - 400 K/uL
MPV	9.4	Reference Range Not Established fL
% Neutrophils	65.0	%
% Lymphocytes	13.4	%
% Monocytes	12.0	%
% Eosinophils	8.4	%
% Basophils	0.8	%
% Immature Granulocytes	0.4	%
Absolute Neutrophils	5.81	1.90 - 7.40 K/uL
Absolute Lymphocytes	1.20	1.00 - 3.90 K/uL
Absolute Monocytes	1.07 (H)	0.00 - 0.80 K/uL
Absolute Eosinophils	0.75 (H)	0.00 - 0.50 K/uL
Absolute Basophils	0.07	0.00 - 0.10 K/uL
Absolute Immature Granulocytes	0.04	0.00 - 0.07 K/uL
% nRBC	0.0	0 per 100 WBCs
Absolute nRBC	<0.01 (H)	<=0.00 K/uL
Comprehensive Metabolic Panel		
Result	Value	Ref Range
Na	140	135 - 145 mmol/L
K	4.2	3.5 - 4.9 mmol/L
Cl	103	99 - 109 mmol/L
CO2	30	23 - 32 mmol/L
Anion Gap	11	5 - 20 mmol/L
Glucose	101 (H)	65 - 99 mg/dL
BUN	20	8 - 25 mg/dL
Creatinine	0.82	0.70 - 1.30 mg/dL
Calcium	9.7	8.5 - 10.5 mg/dL
Albumin	4.5	3.3 - 4.8 g/dL
Bilirubin Total	0.3	0.1 - 1.5 mg/dL
Total Protein	7.3	6.3 - 8.2 g/dL
AST	20	10 - 45 U/L
ALT	16	10 - 65 U/L
Alkaline Phosphatase	77	35 - 115 U/L
Globulin	2.8	1.3 - 4.9 g/dL
Albumin/Globulin Ratio	1.6	1.0 - 2.4
BUN/Creatinine Ratio	24.4	
eGFR	84	>=60 mL/min/1.73m2
Troponin I		
Result	Value	Ref Range
Troponin I, High Sensitivity	6	<=45 ng/L
ECG 12 lead		

Result	Value	Ref Range
VENTRICULAR RATE EKG	106	BPM
ATRIAL RATE	106	BPM
P-R INTERVAL	210	ms
QRS DURATION	134	ms
Q-T INTERVAL	362	ms
Q-T INTERVAL (CORRECTED)	480	ms
P WAVE AXIS	9	degrees
QRS AXIS	-85	degrees
T AXIS	14	degrees
INTERPRETATION TEXT		
This ECG contains Unconfirmed Interpretation Statements. See ED Record for Physician Interpretation.		
Sinus tachycardia with 1st degree A-V block		
Left axis deviation		
Right bundle branch block		
Abnormal ECG		
When compared with ECG of 03-May-2025 18:58,		
Premature atrial complexes are no longer Present		
Confirmed by MUSE READ ONLY, -COMPUTER (500), editor BURNS, MADALYN (5115) on 5/5/2025 7:57:27 PM		

Assessment

/

Plan

1. Chronic respiratory failure with hypoxia (HCC) (Primary)

Continue with home oxygen.

He is now on Pulmicort and albuterol for possible COPD. No history of previous diagnosis of COPD or asthma. Unable to do a pulmonary function test due to patient's dementia. He was not able to coordinate his breathing effort for the test. On today's appointment, I also filled out paperwork indicating the limitations patient's mobility.

For details, check scanned section for filled paperwork.

- Referral to Home Health

2. Late onset Alzheimer's disease without behavioral disturbance (HCC)

Progressively worsening.

On today's appointment, I also filled out paperwork indicating the limitations patient's mobility.

For details, check scanned section for filled paperwork.

Worsening: Treatment plan in place, continue to monitor, discussed medication plan of care, and risk factors. Follow up as directed.

3. Congestion of nasal sinus

- fluticasone (FLONASE) 50 mcg/nasal spray; Use 1 spray into the nostril Daily.
Dispense: 16 g; Refill: 3

Hospital Bed Evaluation:

Patient is unable to safely transfer to a chair, wheelchair or standing position and manage chronic pulmonary disease most of the time after an unsuccessful trial of upper torso props at greater than 30 degrees when in bed. Based on my evaluation, this patient medically requires a hospital bed.

Bed Order:

Patient requires a semi-electric (foot/head), manually adjusted variable height to permit frequent changes in body position and/or has an immediate need for a change in body position for management of respiratory condition. Further, the patient does not require a heavy duty extra wide hospital bed. Patient does not require trapeze equipment.

Return if symptoms worsen or fail to improve.

Total time (in minutes) face to face 25 min; Total time (in minutes reviewing records, documentation, etc.) non face to face 15 min.

Parts of this note were prepared using Dragon dictation voice recognition technology. There may be sound-alike errors even though every effort has been made to ensure accuracy

Current Outpatient Medications

Medication	Sig	Dispense	Refill
• albuterol 2.5 mg/3 mL nebulizer solution	Take 3 mLs by nebulization every 3 hours as needed for Wheezing or Shortness of Breath.	1350 mL	3
• amLODIPine (NORVASC) 10 MG tablet	TAKE 1 TABLET BY MOUTH DAILY	90 tablet	3
• apixaban (ELIQUIS) 5 mg tablet	Take 1 tablet by mouth 2 times daily.	180 tablet	3
• azithromycin (ZITHROMAX)	You received your	4 tablet	0

250 mg tablet	first dose in the Emergency Dept. Take your next dose starting tomorrow. Take one daily until gone..			
• benzonatate (TESSALON) 100 mg capsule	Take 1 capsule by mouth 3 times daily as needed for Cough.	30 capsule	3	
• budesonide (PULMICORT) 0.5 mg/2 mL nebulizer solution	USE 1 VIAL IN NEBULIZER ONCE DAILY	60 mL	3	
• clobetasol (TEMOVATE) 0.05 % external solution	Apply to affected areas on scalp wet skin twice a day as needed for itching..	50 mL	5	
• fluticasone (FLONASE) 50 mcg/nasal spray	Use 1 spray into the nostril Daily.	16 g	3	
• hydrocortisone 2.5% cream	APPLY TO AFFECTED AREAS ON FACE AND EARS 1 TO 2 TIMES DAILY. DO NOT USE FOR MORE THAN 15 DAYS PER MONTH.			
• magnesium, as oxide, 250 MG tablet	Take 1 tablet by mouth Daily 250 mg daily .			
• methylPREDNISolone (MEDROL DOSEPAK) 4 mg tablet	Follow package directions..	21 tablet	0	
• potassium 99 mg tablet	Take 1 tablet by mouth Daily.			
• rivastigmine (EXELON) 13.3 mg/24 hr patch	APPLY 1 PATCH TOPICALLY TO CLEAN AND DRY SKIN EVERY DAY	90 patch	3	
• sodium chloride (OCEAN, AYR) 0.65% nasal spray	2 sprays by Each Nare route every hour as needed for Nasal Dryness.	15 mL	3	
• Spacer/Aero-Holding Chambers DEVI	Use spacer with metered dose inhaler.	1 each	0	
• UNCODED DME	Please dispense a Hospital Bed. HT: 5' 6" WT: 149 lb	1 each	0	

LON: 99.

No current facility-administered medications for this visit.

Kennewick Area, WA

Monthly cost

2024

Home Health Care

Homemaker Services	\$7,436
Homemaker Health Aide	\$7,436

Based on annual rate divided by 12 months (assumes 44 hours per week).

Adult Day Health Care

Adult Day Health Care	\$1,874
-----------------------	---------

Based on annual rate divided by 12 months.

Assisted Living Community*

Private, One Bedroom	\$8,484
----------------------	---------

As reported, monthly rate, private, one bedroom.

Nursing Home Care

Semi-Private Room	\$11,072
Private Room	\$11,954

Based on annual rate divided by 12 months.

* Referred to as Residential Care Facility in California.

The information shown above is based on a specific scenario generated by the 2024 Cost of Care. Future years are calculated by assuming an annual 3% growth rate. For more information and location comparison, visit carescout.com/cost-of-care.

Kennewick Area, WA

Daily cost

2024

Home Health Care

Homemaker Services	\$245
Homemaker Health Aide	\$245

Based on annual rate divided by 365 days (assumes 44 hours per week).

Adult Day Health Care

Adult Day Health Care	\$87
-----------------------	------

As reported, daily rate.

Assisted Living Community*

Private, One Bedroom	\$279
----------------------	-------

Based on annual rate divided by 365 days, private, one bedroom.

Nursing Home Care

Semi-Private Room	\$364
Private Room	\$393

As reported, daily rate.

* Referred to as Residential Care Facility in California.

The information shown above is based on a specific scenario generated by the 2024 Cost of Care. Future years are calculated by assuming an annual 3% growth rate. For more information and location comparison, visit carescout.com/cost-of-care.

#23

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
-----------------	---	---------------------	--------------	---------------

2/21/25	HEARING	HEARING HEALTH ASSOC	\$3798. ⁰⁰	0

TOTAL: \$ 3798.00

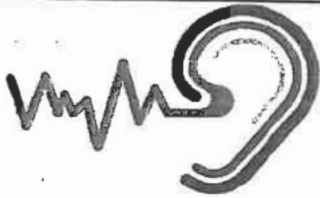


2/28/25
Date

Board Use Only

RECEIVED
FEB 28 2025
CITY OF KENNEWICK
CITY CLERK'S OFFICE

5/2/2025: Member # 23 has submitted documentation requesting reimbursement for hearing aids from Costco in the amount of \$1,599.99.



Hearing Healthcare Associates

PLATINUM CARE PLAN
 Bilateral Platinum Devices
 5 Year Hearing Healthcare Plan
 4 Year Device Warranty
 5 Years Batteries Or 6 rechargeable

PLUS CARE PLAN
 Bilateral Plus Devices
 4 Year Hearing Healthcare Plan
 3 Year Device Warranty
 4 Years Batteries Or 4 rechargeable

PREFERRED CARE PLAN
 Bilateral Preferred Devices
 3 Year Hearing Healthcare Plan
 3 Year Device Warranty
 3 Years Batteries Or 4 rechargeable

PRIMARY CARE PLAN
 Bilateral Primary Devices
 2 Year Hearing Healthcare Plan
 2 Year Device Warranty
 2 Years Batteries Or 2 rechargeable

DEVICE STYLES

<input checked="" type="checkbox"/> Receiver in Canal ^P	<input type="checkbox"/> In the Canal (ITC)
<input type="checkbox"/> Custom Earmold	<input type="checkbox"/> Mini Canal
<input type="checkbox"/> ITE	<input type="checkbox"/> Micro Canal (CIC)
<input type="checkbox"/> Half-Shell	<input type="checkbox"/> Invisible ITC (Nano)
<input type="checkbox"/> BTE	
<input type="checkbox"/> Open Fit	
<input type="checkbox"/> Earmold Non-refundable \$ _____	

Device Manufacturer: PHONAK
 Model: AUDIO 130 - RIC
 Color: _____

ACCESSORIES

<u>incl.</u> Bluetooth _____	Remote Microphone
_____ TV Adapter _____	Dry & Store Unit
_____ FM System _____	Remote Control
<u>incl.</u> Charger _____	Advanced Remote

Your Hearing Healthcare Plan Includes:

- _____ Initial Hearing Aid Selection Assessment
- _____ Initial Electroacoustic Analysis
- _____ Hearing Aid Fitting and Orientation
- _____ Speech Mapping
- _____ Post-fitting Aided Processing Assessment
- _____ 3 Month Follow-up and Adjustment

- _____ Annual Electroacoustic Analysis
- _____ Annual Aided Processing Assessment
- _____ Annual Hearing Evaluation
- _____ Life-Time Programming Adjustments
- _____ Life-Time Quality Control Checks
- _____ Unlimited Office Visits

Hearing Healthcare Plan Total: \$3798
 (Price valid 30 days)

Seneca Ben
 Audfologist/Specialist
 Date 2/28/25

 Patient Name

License #LD00000983, LD60384234, HA60018339
 LD61509934, LD61584134



Hearing Healthcare Associates

8102 W. Grandridge Boulevard, Suite A
Kennewick, WA 99336

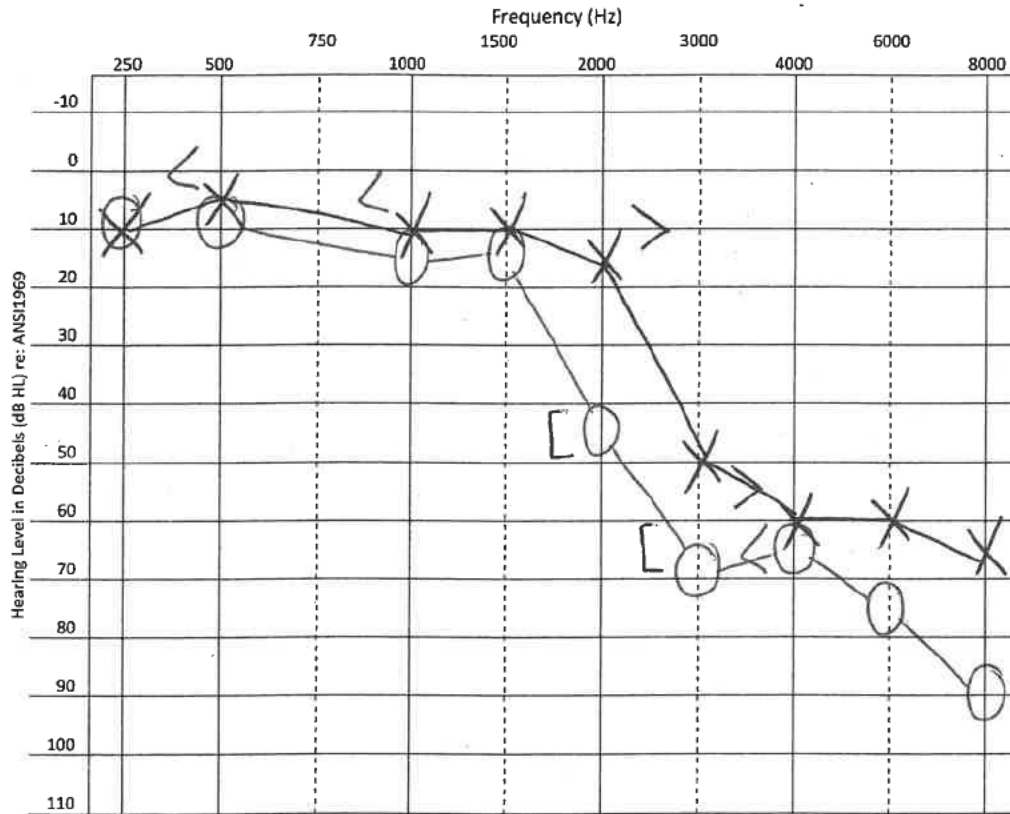
509-735-7461

Name [REDACTED] Age [REDACTED] DOB [REDACTED]

Date 02/21/2025 Referred by [REDACTED] Tested by Seneca Baller

Audiometer GSI-61 Reliability G F P Headphones Insert-Phones [REDACTED]

AUDIOGRAM



SPEECH AUDIOMETRY

Test	R	L	Sound Field
SRT (dB HL)	25	10	
Discrimination (SRT + 40)	80	100	
Discrimination (SRT +)			
Most Comfortable Level (MCL)			
Loudness Discomfort Level (LDL)			
Stimuli: LV REC W22 MAY PBK OTHER			

TYMPANOMETRY

Ear	Type	Pressure	Compliance	Volume
R				
L				

LEGEND

Ear	Air	Air Mask	Bone	Bone Mask	No Response
Right Red	O	△	<	[↙
Left Blue	X	□	>]	↘

Masking	BC	AC

COMMENTS: Bilat QSIN 6.5 dB SNR LOSS

[REDACTED] was seen for an audiometric assessment on February 21, 2025. Patient reports significant history of hazardous noise exposure in the workplace. Pure tone air and bone conduction tests revealed moderate to severe sensorineural hearing loss in the right ear from 2000-8000 Hz and moderate to severe sensorineural hearing loss in the left ear from 3000-8000 Hz. Speech reception thresholds, obtained at 25 dB HL in the right ear and 10 dB HL in the left ear, were in agreement with pure tones. Word recognition scores, presenting CID W-22 word lists, were 80% in the right ear and 100% in the left ear. Tympanometry revealed normal, type A tympanograms in each ear. Speech in noise testing, presenting QuickSIN bilaterally, revealed a mild signal to noise ratio of 6.5 dB. Testing today indicates sensorineural hearing loss bilaterally. Bilateral, prescriptive wide dynamic range compression hearing aids are recommended. Thank you for referring [REDACTED]

to us.

Seneca R. Baller
Seneca R. Baller, Au.D., CCC-A
Audiologist



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

5-10-25
 10:00
 F. HAINY

Member Copy
 Do Not Slip Print



PRINT NAME OF USER _____ MEMBERSHIP NO. _____
 ADDRESS _____
 PATIENT ID _____ TELEPHONE NO. _____
 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	1891069	Sennheiser Sonite Pair with Charger & Streamer		1599.99	1599.99
<i>Left Hearing Aid</i>		<i>Sennheiser Sonite R RIC Digital Loss & Damage Warranty Battery Size Rechargeable</i>	36 mths 36 mths		
<i>Right Hearing Aid</i>		<i>Sennheiser Sonite R RIC Digital Loss & Damage Warranty Battery Size Rechargeable</i>	36 mths 36 mths		
<i>Accessory</i>		<i>Sennheiser Sonite R-Li Standard Charger</i>	36 mths		
<i>Accessory</i>		<i>Phonak TV Connector</i>	12 mths		
Left Receiver		Sonova M Receiver 5, 2	36 mths	0.00	0.00
Right Receiver		Sonova M Receiver 5, 2	36 mths	0.00	0.00
				Tax (if applicable)	_____
				Total	_____

Manufacturer warranty periods are noted above.

180-DAY-RETURN POLICY: During the 180-day return policy 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 return policy 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.**

All hearing aids are new on initial sale.

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

- ❖ Scheduled a follow-up appointment to take place at the Costco Hearing Aid Center where the hearing aid was purchased.
Follow-up Appt.: _____
- ❖ Reviewed with me the 180-Day Return policy, Manufacturer Warranty, Loss Policy and Damage Policy, as they apply to my purchase.

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.

SALES RECEIPT

Buyer: _____ **Purchase Date:** 05/02/2025

Signature _____



Print Name _____

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

Signature _____

Print Name _____

Sold by: _____ **License No:** _____

Signature _____

Cody Cameron

Print Name and License Type _____

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

Signature _____

DELIVERY RECEIPT

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

Signature _____



Print Name _____

Dispensed by: _____ **License No:** _____

Signature _____

Cody Cameron

Print Name and License Type _____

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

Signature _____

Manufacturer's Name and Reg. No: Sennheiser Sennheiser

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.



Kennewick #486
8505 West Gage Blvd
Kennewick, WA 99336
NPI: 1063806859

HEARING AID

US Member [REDACTED]
E 1891069 SON PR+STRM 1,599.99
KIOSK ORDER# 4720071
SUBTOTAL 1,599.99
TAX 0.00
*** TOTAL 1,599.99

XXXXXXXXXXXX4988 H
AID: A0000000031010
Seq# 79511 App#: 002496
Visa Resp: APPROVED
Tran ID#: 512200079511....

APPROVED - Purchase
AMOUNT: \$1,599.99
05/02/2025 10:14 486 79 2 4

Visa 1,599.99
CHANGE 0.00

TOTAL NUMBER OF ITEMS SOLD = 1
~~05/02/2025~~ 10:14 486 79 2 4

FSA N/TAX AMT(F) = 1,599.99
FSA TOTAL = 1,599.99



21048607900022505021014

OP#: 4 Name: Cody C (HA)
Thank You!
Please Come Again
Whse:486 Trm:79 Trn:2 OP:4

Items Sold: 1
U5 05/02/2025 10:14