



8/12/2025

DISABILITY BOARD AGENDA

4:30 PM

SPECIAL MEETING

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

1. CALL TO ORDER

2. REQUEST FOR PRE-APPROVAL FOR IN-HOME CARE

- a. Pre-Approval: Police member # 20 requesting pre-approval for in-home care
- b. Pre-Approval: Fire member # 22 requesting pre-approval for in-home care

3. CONCLUSION

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

*Describe "other" (i.e., self-medicate) Needs someone to fix meals and bring to him where he is sitting. He can take his medicine independently but needs assistance filling pill box.

7. Please list specific medical and other assistance this member needs: Meals made, change clothing,, light housekeeping, showering, at doctor appointments needs to be pushed inside in wheelchair and back out when done, Person to assist with daily functions of living at home.

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

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

Dae Y Lee MD, Vascular surgery, 1100 Goethals, Richland, 509.942.2479 • Iylad Jamali MD, Internal medicine, & cardiovascular disease, 1100 Goethals, Richland, 942.3272 • Praveen Korimeria MD, Cardiology, 1100 Goethals, Richland, 509.942.3135 • Julie Holgado NP, Gerontology, 580 Gage, Richland, 509.942.3135, Dr David Frugone Larrea MD, Kadlec Richland Senior Clinic, 800 Gage STE 102, Richland, 509.942.3135

Dated this 30 day of July, 2015.


LEOFF 1 member or Representative (sign/print name)

Board Action _____

Date _____

Health Issues

Current Health Issues

Please review your health issues, and verify that the list is up to date.

CAD (coronary artery disease) Started 11/19/2013	Atrial fibrillation, chronic Started 11/19/2013	Hypertension Started 11/19/2013
Hyperlipidemia Started 11/19/2013	PAD (peripheral artery disease) Started 11/19/2013	COPD (chronic obstructive pulmonary disease) Started 11/19/2013
Raynaud disease Started 11/19/2013	Gout Started 3/3/2014	Chronic hepatitis B without delta agent with hepatic coma Started 6/21/2016
Liver disease	S/P PTCA (percutaneous transluminal coronary angioplasty)	OSA (obstructive sleep apnea) Started 8/16/2017

Acute renal failure superimposed on chronic kidney disease, unspecified CKD stage, unspecified acute renal failure type
Started 12/5/2019

Nephrolithiasis
Started 12/8/2019

Pneumonia
Started 12/9/2020

CKD (chronic kidney disease) stage 3, GFR 30-59 ml/min
Started 12/9/2020

Lymphedema of both lower extremities
Started 1/29/2021

Stage 3 chronic kidney disease
Started 7/16/2021

Chronic systolic heart failure
Started 7/16/2021

Shortness of breath
Started 7/22/2021

Left renal atrophy
Started 7/23/2021

Hypercoagulable state due to atrial fibrillation
Started 11/22/2021

Class 3 severe obesity in adult
Started 3/28/2022

Prediabetes
Started 6/6/2022

Lab test positive for detection of COVID-19 virus
Started 3/28/2023

Chronic respiratory failure with hypoxia, on home O2 therapy
Started 3/29/2023

Arterial leg ulcer
Started 5/28/2025

**Venous ulcer of
left leg**
Started 5/28/2025

**Venous
insufficiency**
Started 5/28/2025

**Skin ulcer of left
pretibial region
limited to
breakdown of
skin**
Started 5/28/2025

Anemia
Started 7/21/2025

**Acute on chronic
HFrEF (heart
failure with
reduced ejection
fraction)**
Started 7/22/2025

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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.*

NAME OF MEMBER	DOB	Phone Number

please call her as I can't hear well on phone.

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:

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

RECEIVED

8/4/25

member #20

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:

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:

Left lower leg - cellulitis
w/ open areas present

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: Client steps in his recliner chair.

ADL Function:

- Independent
- Supervision
- Assistance (describe):
Partial Assist with bathing, dressing, skin care.
- Aide service

Comments:

Client is unable to cook for himself.

Mobility within home – check all:

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

Comments:

Mobility outdoors – check all:

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

Comments:

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: Walking stick

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:
- LE:

Comments: *Unable to assist*

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:

Bathroom Facilities:

- Shower
- Tub
- Both

Assistance rails installed? Yes No

Comments: Tight quarters in the restroom. Grab bar installed securely.

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 9th day of August, 2025

Per my assessment, it seems [redacted] needs 24-hour care due to his significant physical limitations + inability to complete ADL's without support.

← Kimberly Farrell Limbury Jamell
Certified Assessor (sign and print name)
Visiting Angels (509) 582-7800

LEOFF 1 Member or Representative (sign and print name)

Kimberly Jamell

Board Action _____

Date _____

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.

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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
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As reported, daily rate.

Assisted Living Community*

Private, One Bedroom	\$279
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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.

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

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 Hospital extended facility Assisted living facility

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

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

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

7. Please list specific medical and other assistance this member needs: 24 hr care

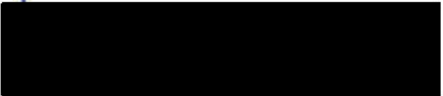
PT / OT / social worker (responder) / SLP / nutrition

8. Estimated length of time this member will require specialized care: 1 + yrs.

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

ortho & spine / home health / assist speech

Dated this 31st day of July, 2025


LEOFF 1 member or Representative (sign/print name)

Board Action _____

Date _____

IN-HOME CARE EVALUATION FORM

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- Mobile home
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- Ramp not present
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- 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:

2014 Fusion

Current Activities:

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

member #22

RECEIVED
8/4/25

Relevant Health Information

Cognition/Mental State:

- Alert
- Oriented to person, place, time
- Disoriented
- Confused
- Lethargic
- Unresponsive
- Follow Commands:
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- Behavior:
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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: *unable to eat much of anything at all.*

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
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 - Total/Mechanical lift

- Out of bed -
 - Independently
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 - Total/Mechanical lift

Comments:

ADL Function:

- Independent
- Supervision
- Assistance (describe): *dh pain*

Aide service

Comments:

Mobility within home – check all:

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

Comments: *uses walker indoors because wheel chair is too difficult to operate inside*

Mobility outdoors – check all:

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

Comments: *uses wheelchair when out + about*

Wheelchair mobility:

- Dependent
- Needs some assistance
- Independent

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

Comments: *weathers*

Mobility aids:

- Cane
- Walker
- Crutches
- Other: *wheelchair*

Kennewick Area, WA

Monthly cost

2024

Home Health Care

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