8/11/2026

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

11:30 AM

1. **CALL TO ORDER**

2. **TREASURER'S REPORT**
   a. Treasurer's Report: June 2026

3. **CONSENT AGENDA**

   All items included in the Consent Agenda have been provided to each member of the Kennewick Disability Board for review and consideration. These items are deemed routine and will be approved with a single motion, without any separate discussion. A Board Member may remove an item for individual consideration.

   a. **Approval of the Minutes Dated July 7, 2026**
      *Motion to approve the meeting minutes as presented.*
   b. **Fire Member #19 Reimbursement Request: Dental**
      *Motion to approve the claim as presented.*
   c. **Fire Member #19 Reimbursement Request: Medical Injection**
      *Motion to approve the claim as presented.*
   d. **Fire Member #28 Reimbursement Request: RX**
      *Motion to approve the claim as presented.*
   e. **Fire Member #28 Reimbursement Request: Eyeglass Lenses & Exam**
      *Motion to approve the claim as presented.*
   f. **Police Member #4 Reimbursement Request: Eyeglass Lenses**
      *Motion to approve the claim as presented.*
   g. **Police Member #15 Reimbursement Request: RX**
      *Motion to approve the claim as presented.*
   h. **Police Member #25 Reimbursement Request: Massage Therapy**
      *Motion to approve the claim as presented.*

4. **BOARD COMMENTS/DISCUSSION**

5. **ADJOURNMENT**

**NEXT MEETING DATE: September 1, 2026**

# CITY OF KENNEWICK

# OTHER POST EMPLOYMENT BENEFITS

# TRUST FUND

Preliminary Financial Statements

June 30, 2026

# CITY OF KENNEWICK

## Other Post Employment Benefits Trust Fund

Balance Sheet
June 30, 2026

| | Current Year | Prior Year |
|---|---|---|
| **Assets** | | |
| Equity in Pooled Cash & Investments | $ 6,152,061 | $ 5,831,663 |
| Investments | - | $ - |
| Interest Receivable | | |
| Total Assets | $ 6,152,061 | $ 5,831,663 |
| **Liabilities** | | |
| Accounts Payable | $ 16,646 | $ 14,330 |
| Total Liabilities | 16,646 | 14,330 |
| **Fund Balance** | | |
| Committed Fund Balance | 6,135,414 | 5,817,333 |
| Total Fund Balance | 6,135,414 | 5,817,333 |
| Total Liabilities and Fund Balance | $ 6,152,061 | $ 5,831,663 |

# CITY OF KENNEWICK

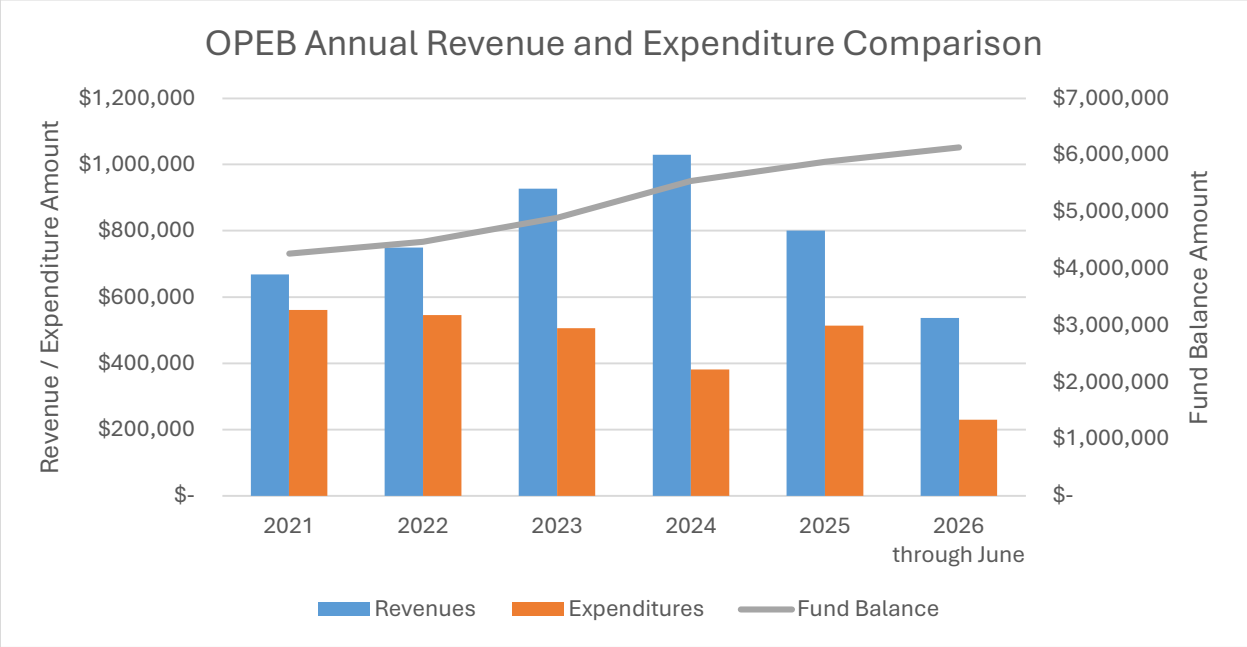
## Other Post Employment Benefits Trust Fund

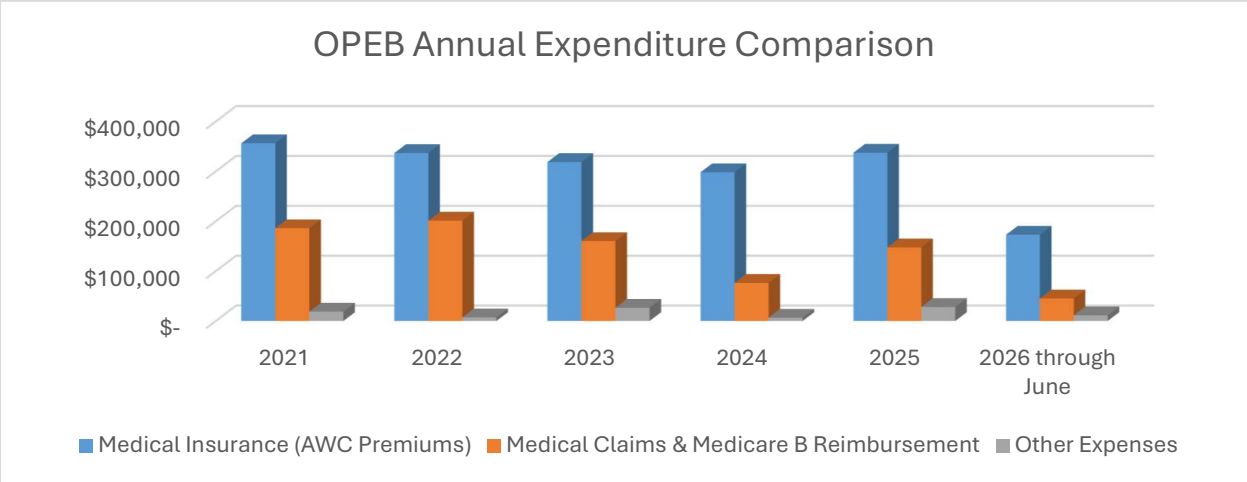
Income Statement
June 30, 2026

| | 2026 Budget | Year To Date | Over (Under) Budget | Prior Year To Date |
|---|---|---|---|---|
| **Revenues:** | | | | |
| Water and Sewer Utility Tax | $ 590,000 | $ 393,621 | $ (196,379) | $ 388,588 |
| Investment Interest | 163,500 | 102,368 | (61,132) | 102,959 |
| Expense Reimbursements | - | 40,687 | 40,687 | - |
| Total Revenues | 753,500 | 536,677 | (216,823) | 491,547 |
| **Expenditures:** | | | | |
| Medical Insurance | 348,500 | 172,934 | (175,566) | 171,958 |
| Medical and Prescriptions | 205,000 | 45,290 | (159,710) | 43,303 |
| Disability Board Secretary | 2,000 | - | (2,000) | - |
| Office Supplies | 50 | - | (50) | - |
| Postage Expense | 300 | 7 | (293) | 31 |
| Travel and Training | 2,000 | 1,430 | (570) | - |
| Contractual/Consulting Services | 12,500 | 10,062 | (2,438) | - |
| Copier Charges | 18 | - | (18) | 59 |
| Total Expenditures | 570,368 | 229,724 | (340,644) | 215,350 |
| Net Income (Loss) | 183,133 | 306,953 | 123,821 | 276,196 |
| Beginning Fund Balance | 5,828,461 | 5,828,461 | - | 5,541,137 |
| Ending Fund Balance | $ 6,011,594 | $ 6,135,414 | $ 123,821 | $ 5,817,333 |

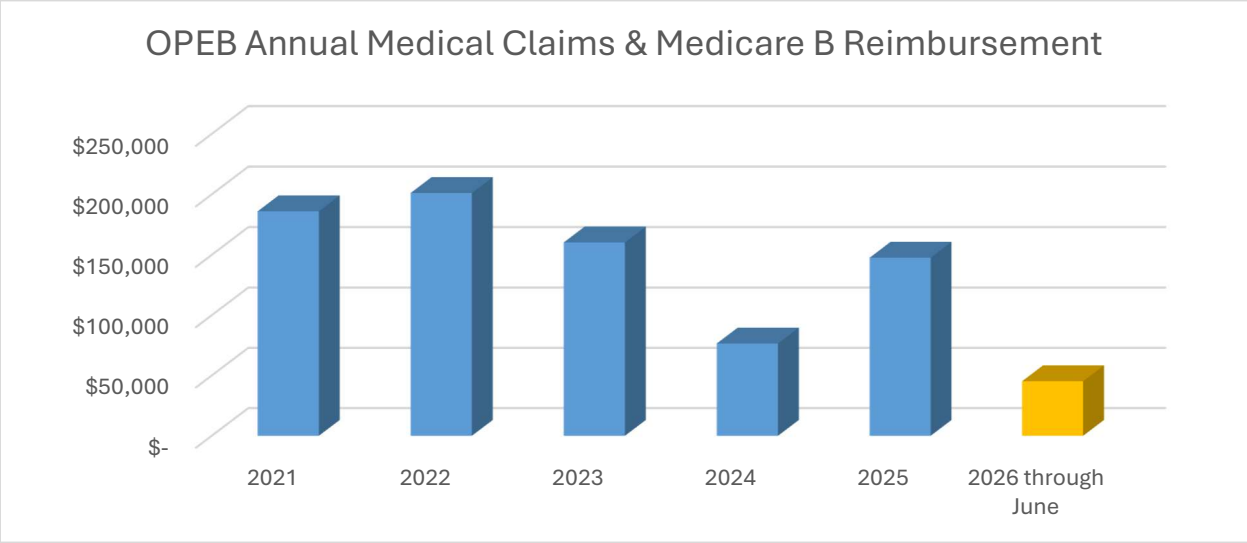
**City of Kennewick**
**Other Post Employment Benefits Trust (OPEB) Fund**
**June 30, 2026**

## Revenues and Expenditures

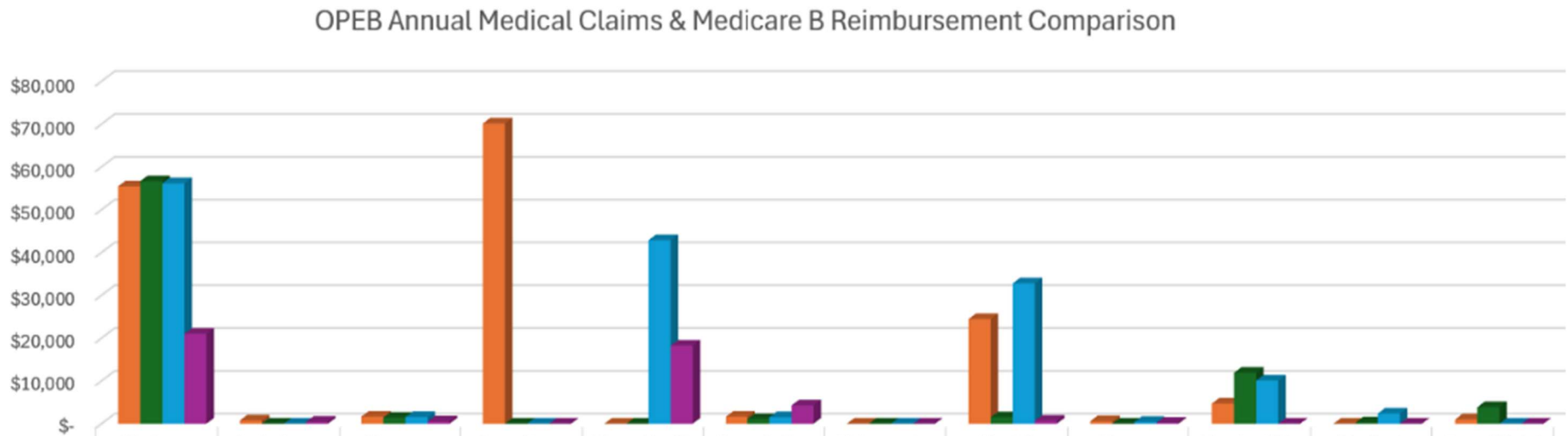


**Medical Claims & Medicare B Reimbursement**



**City of Kennewick**
**Other Post Employment Benefits Trust (OPEB) Fund**
**June 30, 2026**




| | Medicare Part B | Ambulance | Massage | Long-Term Care | Home Health | Prescription Medication / Other | Chiropractor | Dental | Glasses (Frames/Lenses) | Hearing Aids | Medical Supplies | Travel/Hotel Reimbursement |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2023 | $55,447 | $735 | $1,625 | $70,136 | $- | $1,641 | $- | $24,430 | $564 | $4,699 | $- | $997 |
| 2024 | $56,655 | $- | $1,382 | $- | $- | $1,040 | $- | $1,477 | $- | $11,880 | $275 | $3,864 |
| 2025 | $56,141 | $- | $1,550 | $- | $42,884 | $1,513 | $- | $32,790 | $382 | $10,045 | $2,368 | $- |
| 2026 through June | $21,001 | $415 | $500 | $- | $18,226 | $4,279 | $- | $681 | $187 | $- | $- | $- |

# Disability Board

**Meeting Date:** 8/11/2026
**Agenda Item #:** 3.a.
**Subject:** Approval of the minutes dated July 7, 2026

## RECOMMENDATION

Staff recommends approving the minutes as presented.

## MOTION FOR CONSIDERATION

Motion to approve the meeting minutes as presented.

## SUMMARY

Staff has prepared action-format minutes for the meeting.

## ALTERNATIVES

The Board may correct factual errors and approve the minutes as amended.

## ATTACHMENTS

1. 07.07.2026 Minutes - DRAFT

# DISABILITY BOARD
# REGULAR MEETING
# July 7, 2026 - DRAFT

**ATTENDANCE:** The at-large position is vacant.

| Board Members Present: | City Staff Present: |
|---|---|
| **Chuck Torelli,** *Mayor Pro Tem* | **Jessica Platt,** *Finance Director* |
| **Jim Kraft,** *Police Representative* | **Liz D'Hondt,** *Accounting Specialist, Board Secretary* |
| **Dennis Waters,** *Fire Representative* | **Kristi Smith**, *Disability Board Benefits Administrator* |
| **Brad Klippert,** *Councilmember* | |

1. **CALL TO ORDER:** Police Representative Jim Kraft called the regular meeting of the Kennewick Disability Board to order at 11:30 a.m.

2. **APPROVAL OF AGENDA:** Agenda was approved as presented.

3. **PUBLIC COMMENT:** NONE

4. **TREASURER'S REPORT:**
    a. **Treasurer's Report: May 2026:** Ms. Platt presented the Treasurer's Report and financial analytics for May 2026. Medical expense payouts are higher than the previous year, primarily due to Medicare reimbursements. Revenue is above projections but remains lower than the same period last year. Water consumption continues to be lower than last year. The Board noted that once there are no remaining members, any remaining funds will be returned to the City Council for review and determination of their disposition.
5. **CONSENT AGENDA:** Consent agenda was approved as presented. Staff provided an update on the dental insurance discussion from the previous meeting. The necessary calculations are still being reviewed, and no final determination has been made.
6. **NEW BUSINESS:**
    a. Elizabeth D'Hondt announced she is stepping down from her staff position. Recruitment is underway to fill the vacancy. Krystal Johnston will serve as secretary beginning with the next meeting until position is filled.
7. **UNFINISHED BUSINESS**
    a. **Fire Member #21 Hospice Claim Status:** Staff reported there is no update at this time. Communication with the family continues, and staff are working with the insurance provider regarding the claim.
8. **BOARD COMMENTS/DISCUSSION:**
    a. The Board discussed scheduling the Fire Pension Board meeting in relation to the Disability Board meeting. Since most members serve on both boards, members indicated they were comfortable with either meeting order.
    b. Due to the anticipated absence of some members, the August 4 meeting was canceled and rescheduled for **August 11 at 11:30 a.m.** Jessica will be absent, and a staff member will present the Treasurer's Report. Kristi will also be absent but plans to participate by phone.
    c. It was reported that Police Member #8 passed away in June.
    d. Staff reported that Member #18 has not returned the required SSA documentation. Additional efforts will be made to contact the member.
    e. Staff reported that mail sent to Member #10 was returned, and they have been unable to establish contact. Further attempts to reach the member will continue.

9. **ADJOURNMENT:** Police Representative Kraft concluded the meeting concluded at 11:59 a.m.

**NEXT MEETING DATE: August 11th, 2026**

Draft
Elizabeth D'Hondt
Disability Board Secretary

# Disability Board

**Meeting Date:** 8/11/2026
**Agenda Item #:** 3.b.
**Subject:** Fire Member #19 Reimbursement Request: Dental

## RECOMMENDATION

Staff recommends approving the claim as presented.

## MOTION FOR CONSIDERATION

Motion to approve the claim as presented.

## SUMMARY

A reimbursement claim and supporting documentation were submitted for the Board's consideration. The claim is consistent with the policy and standards set by the Board.

## ALTERNATIVES

The alternative is to deny the reimbursement and provide follow up steps to staff.

## ATTACHMENTS

1. FIRE MEMBER #19_Redacted

## 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] City Fire pension

| Date of Service | Condtion or Illness Or Prescription Name | Provider of Service | Bill Charged | Co-pay Amount |
|---|---|---|---|---|
| 6-26-26 | Broken Tooth | DesRet Dental | $ 310. | ? |

**TOTAL:** $ 310-

[redacted] Jun 22, 2026
**Print Name** **Signature** **Date**

**Board Use Only**

Member #19

RECEIVED 6/22/26 ED

Brook tooth Late 1968 once Lator? once 2 weeks ag

## STATEMENT OF SERVICES RENDERED

Chart # [redacted]

Desert Sage Dental
4303 W. 24th Ave. Suite A
Kennewick, WA 99338-1963

**NEXT APPOINTMENT** 06/29/2026 11:00 AM

GUARANTOR / RESPONSIBLE PARTY

[redacted]

| PLEASE PAY THIS AMOUNT | AMOUNT ENCLOSED |
|---|---|
| $0.00 | |

| BILLING DATE | DUE DATE |
|---|---|
| 05/26/2026 | 06/25/2026 |

To ensure proper recording of your payment, please detach and return this portion of the statement with your payment

Please retain this portion of the statement for your own records

| DATE | DESCRIPTION | PATIENT NAME | AMOUNT | BALANCE |
|---|---|---|---|---|
| 05/25/2026 | **Balance Forward** | | | 0.00 |
| 05/26/2026 | D0350 - 2D Oral/Facial Photo Images | [redacted] | 0.00 | |
| | D0140 - Limited Evaluation | | 138.00 | |
| | D2331 - Anterior Resin Composite 2s Th: 8(MF) | | 388.00 | 526.00 |
| 05/26/2026 | Discount $28.00 | | -28.00 | |
| 05/26/2026 | Discount $78.00 | | -78.00 | |
| 05/26/2026 | In-office Write-off $110.00 | | -110.00 | |
| 05/26/2026 | Credit Card Payment $310.00 | | -310.00 | 0.00 |

(*) = Payments have been split between more than one visit. (**) = Pending insurance payment.

| BALANCE 0-30 DAYS | BALANCE 31-60 DAYS | BALANCE 61-90 DAYS | BALANCE 90+ DAYS | TOTAL BALANCE | - | ESTIMATED INSURANCE | = | PATIENT PORTION |
|---|---|---|---|---|---|---|---|---|
| 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | 0.00 | | 0.00 |

### Statement Message

Reminder: We bill your insurance as a courtesy to you. It is YOUR responsibility to be familiar with your plan coverage, limitations and copays, etc. We advise that you follow-up with your insurance carrier on any claims unpaid after 60 days from date of service. As consistent with applicable laws and the terms of your insurance or other plan coverage, CLAIMS THAT ARE NOT PAID FOLLOWING 90 DAYS FROM DATE OF SERVICE will become patient responsibility for payment AT TIME OF VISIT.

# Disability Board

**Meeting Date:** 8/11/2026
**Agenda Item #:** 3.c.
**Subject:** Fire Member #19 Reimbursement Request: Medical Injection

## RECOMMENDATION

Staff recommends approving the claim as presented.

## MOTION FOR CONSIDERATION

Motion to approve the claim as presented.

## SUMMARY

A reimbursement claim and supporting documentation were submitted for the Board's consideration. The claim is consistent with the policy and standards set by the Board.

## ALTERNATIVES

The alternative is to deny the reimbursement and provide follow up steps to staff.

## ATTACHMENTS

1. FIRE MEMBER #19_2_Redacted

## 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 ⋈ City fire pension

| Date of Service | Condtion or Illness Or Prescription Name | Provider of Service | Bill Charged | Co-pay Amount |
|---|---|---|---|---|
| April 4 2026 | bad knees | DR J Morgan | $1,192.00 | ~~0~~ |

**TOTAL:** $1,192.00 ~~0~~

[redacted] June 16 2026

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

**Board Use Only**

Received: 06/16/2026
ED

Member #19

KADLEC

Patient: [redacted]
Guarantor ID #:

Itemized receipt

# You paid $1,978.00 on Apr 15, 2026

## Visit Details

| Visit info | Service | Qty | Total billed |
|---|---|---|---|
| **06/09/25**<br>KC NW OSM<br>SPAULDING<br>Joshua Israel<br>Morgan | DRAIN/INJ JOINT/BURSA W/O US<br>CPT code: 20610 | 1 | **$786.00** |
| | HC PR RX HYALURONAN OR DERIVATIVE (GEL-ONE) INJ 1 EA<br>CPT code: J7326 | 2 | **$1,192.00** |

| | |
|---|---|
| Total billed: | $1,978.00 |
| Ins adjusted: | -$0.00 |
| Ins paid: | -$0.00 |
| Amount due: | $1,978.00 |
| Paid Apr 15, 2026<br>Confirmation #: [redacted]<br>Payment method: [redacted] | -$1,978.00 |
| **Total Due** | **$0.00** |

Thank you for your payment.

# Disability Board

**Meeting Date:** 8/11/2026
**Agenda Item #:** 3.d.
**Subject:** Fire Member #28 Reimbursement Request: RX

## RECOMMENDATION

Staff recommends approving the claim as presented.

## MOTION FOR CONSIDERATION

Motion to approve the claim as presented.

## SUMMARY

A reimbursement claim and supporting documentation were submitted for the Board's consideration. The claim is consistent with the policy and standards set by the Board.

## ALTERNATIVES

The alternative is to deny the reimbursement and provide follow up steps to staff.

## ATTACHMENTS

1. FIRE MEMBER #28_Redacted

## 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 |
|---|---|---|---|---|
| 6-16-26 | Heart Disease | Lilly Direct | Saba Raz; | $ 304.00/10 |

**TOTAL:** $ 304.00

[redacted] [redacted] 7-16-26

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

Board Use Only

FIRE MEMBER #28
RECEIVED
7.16.2026

7-14-26

# Order Summary

[redacted]

Created 06/16/26 10:23:55 AM
Prescribed by Saba Razi
NPI: 1891675724

| | |
|---|---|
| ZEPBOUND 2.5MG/DOSE (10MG/2.4ML) KWIKPEN (2.5MG) | $299.00 |
| NDC: [redacted] | |
| Rx# [redacted] | |
| Fill Date: June 17th, 2026 08:22 | |
| INJECTION SUPPLIES - PEN NEEDLES | $5.00 |

Fill Date: June 17th,
2026 08:22

| | |
|---|---|
| INJECTION SUPPLIES - PEN NEEDLES | $5.00 |
| Tax | $0.00 |
| Subtotal | $304.00 |
| **Total Paid** | $304.00 |

Card ending in [redacted]

## Shipping Information

[redacted]

Reply Reply all Forward Delete More

7-17-26

# Disability Board

**Meeting Date:** 8/11/2026
**Agenda Item #:** 3.e.
**Subject:** Fire Member #28 Reimbursement Request: Eyeglass Lenses & Exam

## RECOMMENDATION

Staff recommends approving the claim as presented.

## MOTION FOR CONSIDERATION

Motion to approve the claim as presented.

## SUMMARY

A reimbursement claim and supporting documentation were submitted for the Board's consideration. The claim is consistent with the policy and standards set by the Board.

## ALTERNATIVES

The alternative is to deny the reimbursement and provide follow up steps to staff.

## ATTACHMENTS

1. FIRE MEMBER #28_2_Redacted

## 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 |
|---|---|---|---|---|
| 7-16-26 | Optical / Dr Perdue | Post Surgery Exam | $ 70.00 | |
| | | Glasses - Frame | - 0 - | |
| | | Glasses - Lenses | $ 392.00 | - $ 195.00 - |

**TOTAL:** $ 265.00

[redacted] [redacted] 7-16-26

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

Board Use Only

Fire Member #28

POD 7-16-26

579

# Mid-Columbia Eyecare Center, Inc PS

Treatment & Management of Eye Disease & Injury/Contact Lens Center - Surgical Co-Management

4403 West Court Street, Suite J - Pasco, WA 99301 - (509) 547-9695 - www.mideyecare.com

Dr. Daniel C. Perdue, OD — NPI 1508733116 State License #: 3345

Dr. Nicholas Gubler, OD — NPI 1700222180 State License #: OD00378271

Patient: [redacted] DOB: [redacted] DATE OF SERVICE: 7-16-26

INSURANCE: None (Medicare) Medlnl Premera/BCBS Kaiser Regence/Asuris 1st Choice VSP CHPW Molina UHC DSHS Other ____

EXAM TYPE: VISION / (MEDICAL): OPC REFRACTION: (YES) / NO PHOTOS: YES / NO EXAM TOTAL: 70.00

HARDWARE ALLOWANCE: (YES) / NO VSP AMOUNT: ____ HARDWARE TOTAL: ____

| EVAL/MGMT | NEW | EST | FEE |
|---|---|---|---|
| Evl/Mg Srv Lvl | 99201 | 99211 | |
| Evl/Mg Srv Lv2 | 99202 | 99212 | |
| Evl/Mg Srv Lv3 | 99203 | 99213 | |
| Evl/Mg Srv Lv4 | 99204 | 99214 | |
| Evl/Mg Srv Lv5 | 99205 | 99215 | |
| Intermediate | 92002 | 92012 | |
| Comprehensive | 92004 | 92014 | |

| ADDITIONAL SERVICES | | |
|---|---|---|
| Emergency Services | 99058 | |
| Report Fee | 99080 | |
| L&I Report | 1040M | |
| Est/Continued Care | G2211 | |
| Post-Op: Cataract | 66984-55 | RT LT |
| Post-Op: YAG | 66821-55 | RT LT |
| Refraction | 92015 | |

PRODUCTS/OTHER SERVICES: 70 Exam; 305 glasses

| SALES TAX | |
|---|---|
| TOTAL FEE | 375.37 |
| PAYMENT | 392.37 Fee |
| BALANCE DUE | 0 17.37 |
| CA CK CC | |

| SURGICAL PROCEDURES | | FEE |
|---|---|---|
| Dilation of Lacrimal Puncta | 68801-50 | |
| Punctal Plugs-Insertion | 68761-E1 | |
| | 68761-E2 | |
| | 68761-E3 | |
| | 68761-E4 | |
| Removal of Corneal Epithelium | 65435 | |
| Foreign Body Removal Corneal | 65222 | |
| Foreign Body Removal Conjunct. | 65210 | |
| Foreign Body Embedded, Eyelid | 67938 | |
| Epilation by Forceps | 67820 | |
| Placement of Amniotic Membrane | 65778 RT | |
| | 65778 LT | |
| Supplies for Amniotic Membrane | V2790 | |

| MEDICAL PROCEDURES | | FEE |
|---|---|---|
| Visual Fields | 92083 | |
| Gonioscopy | 92020 | |
| Ext. Ophthalmoscopy, initial | 92225 RT | |
| | 92225 LT | |
| Ext. Ophthalmoscopy, Subsequent | 92226 RT | |
| | 92226 LT | |
| Fundus Photography | 92250 | |
| Screening Photos | 92250-52 | |
| Ant. Segment Photos | 92285 | |
| OCT Anterior | 92132 | |
| OCT-Nerve Fiber | 92133 | |
| OCT-Macular Analysis | 92134 | |
| Color Test | 92283 | |
| Pachymetry | 76514 | |
| Dark Adaptation | 92284 | |
| OCT-Angiography | 92137 | |

| | | FEE |
|---|---|---|
| Electroretinogr | 92273 | |
| Visual Evoked | | |
| MPOD | | |
| Tear Lab | | |
| Inflamma Dry | | |
| Adenoplus | | |
| Blephex | | |
| Lipiflow | | |
| CTL for Diseas | | |
| Scleral Fit RT/ | | |
| Scleral Fit RT/ | | |
| Both Eyes | | |
| CL Fitting Fee | | |
| Single Vision | | |
| Bifocal | | |
| Trifocal | | |

| RGP Lenses | |
|---|---|
| Spherical | V2510 |
| | V2511 |

Est. Patient

New Patient

Mid Columbia Eyecare
4403 W Court St Ste J
Pasco, WA 99301
509-547-9695

07/16/2026 09:44:00
Merchant Number: 556002774900

Credit Sale

Transaction #: 7
Card Type: MasterCard
Account: ********[redacted]
Entry: Manual
Invoice #: [redacted]
Amount: USD$579.00
Processing Fee: USD$17.37

Total: USD$596.37

Ref. Number: [redacted]
HREF :
Global UID: 124013922720260716094400511 9
Auth. Code: [redacted]
Batch #: 326
Response: Success

CUSTOMER COPY
Thank You!
All Sales Final

## Optical Questions

1) How old are your current everyday glasses? 3 years

Type: SVD SVN (PAL) BF/TF Computer Neuroiens Other:

2) Did we make them for you last time? (Y) / N → Why not? Cost / Frame Selection

3) What do you wish your glasses did better? distance OS

4) Do they darken in the sun when you go outside? (Y) / N

5) Do you also have prescription sunglasses? Y / (N)

If yes → How old are they? ____

If no → How do you protect your eyes from sun damage?

## Does patient wear CL's

Yes / No / Interest

Doctor Rx Recommendation

SV BF TF PAL Oth

High index / Transition

XR / Eyezen / Neuro

Kodak

## RECALL

Next Visit: ___ Days 1 2 3 4 5 6 Weeks 1 2 (3) 4 5 6 9 12 Months

OVI OCT/MAC ffERG OCT/NFS Color Vision CMEF / CME/MAC

VISION EXAM OCY DRY EYE OTHER: ____

## Doctor Recommendatio

Vitamins: Restore / EZ Tears / D

Mask / Teatree / Pure & Clean

OD: ____ mmHg

OS: ____ mmHg

## REFERRAL

NW EYELID / PCLI / SOUND RETINA / SPOKANE EYE CLINIC

REASON: ____

URGENCY OF REFERRAL: ASAP / ROUTINE / OTHER: ____

## PREVIOUS RX HISTORY

OD: +1.50 -1.50 x 085

OS: +0.25 -0.75 x 087
+2.50 ADD

+2.50 -1.00 x 095
+2.50 -1.00 x 090

2024 RX Glasses

# Disability Board

**Meeting Date:** 8/11/2026
**Agenda Item #:** 3.f.
**Subject:** Police Member #4 Reimbursement Request: Eyeglass Lenses

## RECOMMENDATION

Staff recommends approving the claim as presented.

## MOTION FOR CONSIDERATION

Motion to approve the claim as presented.

## SUMMARY

A reimbursement claim and supporting documentation were submitted for the Board's consideration. The claim is consistent with the policy and standards set by the Board.

## ALTERNATIVES

The alternative is to deny the reimbursement and provide follow up steps to staff.

## ATTACHMENTS

1. POLICE MEMBER #4_Redacted

## 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 |
|---|---|---|---|---|
| 6-18-2026 | NEW LENSES FOR GLASSES | CENTER VISION CLINIC | $101.00 | $101.00 |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**TOTAL:** $101.00

[redacted]
**Print Name**

6-22-26
**Signature** **Date**

**Board Use Only**

RECEIVED 6/22/26 Member #4 CO

**Center Vision Clinic**
**8127 W Grandridge Blvd, Ste 11**
**Kennewick WA 99336-7166**

Center Vision Clinic

**Phone (509) 783-8383**
**Fax (509) 735-2592**
**admin@centervisionclinic.org**

Date of Service: 06/18/2026

[redacted]

Invoice: [redacted]
Patient:
Provider: Dr. Gomez, Guadalupe

| Bill Code | Proc Code | Description | Insurance | Amount | Insur | Patient |
|---|---|---|---|---|---|---|
| POF | V2020 | Patient Owned Frame - Handling/Pr... | | 25.00 | 0.00 | 25.00 |
| TF-7x28 | V2303 | Qnt 2: Trifocal - Flat Top 7x28 | Eyefinity | 186.00 | 186.00 | 0.00 |
| VSP Poly... | V2784 | Qnt 2: (AD) VSP Polycarbonate MF... | Eyefinity | 44.00 | 9.00 | 35.00 |
| VSP AR A | V2750 | Qnt 2: (QM) VSP A/R - A SV & MF | Eyefinity | 59.00 | 18.00 | 41.00 |
| 06/18/2026 | | Patient - Check Payment [redacted] | | -101.00 | 0.00 | -101.00 |
| **Balance** | | Invoice Balance: | | $213.00 | 213.00 | 0.00 |
| | | Previous Balance: | | | $70.00 | $0.00 |
| | | **Overall Balance:** | | | **$283.00** | **$0.00** |

If we are billing your insurance, plan benefits are not a guarantee of payment. You will be responsible for any overages after your claim processes.

# Disability Board

**Meeting Date:** 8/11/2026
**Agenda Item #:** 3.g.
**Subject:** Police Member #15 Reimbursement Request: RX

## RECOMMENDATION

Staff recommends approving the claim as presented.

## MOTION FOR CONSIDERATION

Motion to approve the claim as presented.

## SUMMARY

A reimbursement claim and supporting documentation were submitted for the Board's consideration. The claim is consistent with the policy and standards set by the Board.

## ALTERNATIVES

The alternative is to deny the reimbursement and provide follow up steps to staff.

## ATTACHMENTS

1. POLICE MEMBER #15_Redacted

## LEOFF I – CERTIFICATION CLAIM FORM – Police

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Asuris [ ] Medicare [ ] Other [ ] _____

| Date of Service | Condition or Illness Or Prescription Name | Provider of Service | Bill Charged | Co-pay Amount |
|---|---|---|---|---|
| 5-29-2026 | Pill Pack | Elk Drug | 10.84 | 10.84 |
| 6-12-2026 | Pill Pack | Elk Drug | 10.84 | 10.84 |
| 6-26-2026 | Pill Pack | Elk Drug | 10.84 | 10.80 |

**TOTAL:** 32.82

[redacted] July 1-2026
Print Name Signature Date

**Board Use Only**

RECEIVED 7/1/2026 BD #15

## Sale

**Elk Drug**
176 E. Main Street
Dayton, WA 99328
Ph : 509-382-2536

Receipt: [redacted]
Date: 06/26/26 12:33PM
Cashier: LISA
Register: POS Lane2
Customer: [redacted]

| Item | Flags | Qty | Price | Value |
|---|---|---|---|---|
| Bubble PK 2 WK | T | 1x | $10.00 | $10.00 |
| Rx [redacted] | RF | | | $0.00 |
| Rx [redacted] | RF | | | $0.00 |
| Rx [redacted] | RF | | | $0.00 |

Flags: T=Taxable F=FSA R=Rx P=Promo A=Auto Refill

Rx count:3
Retail count:1
Total count:4

Rx Total:$0.00
Retail Total:$10.00

| | |
|---|---|
| Subtotal | $10.00 |
| Standard Tax on $10.00 | $0.84 |
| **Total** | **$10.84** |
| Tender Credit [redacted] | $10.84 |

***Mastercard Card - Approved***
Amount:$10.84
Mastercard:********[redacted]
Transaction:CREDIT
Approval [redacted]
Response Code:0
Entry Method:Contactlessicc
MASTERCARD
Trace Code [redacted]

## Sale

**Elk Drug**
176 E. Main Street
Dayton, WA 99328
Ph : 509-382-2536

Receipt: [redacted]
Date: 06/[redacted]/26 04:58PM
Cashier: LACY
Register: POS Lane2
Customer: [redacted]

| Item | Flags | Qty | Price | Value |
|---|---|---|---|---|
| Rx [redacted] | RF | | | $0.00 |
| Rx [redacted] | RF | | | $0.00 |
| Rx [redacted] | RF | | | $0.00 |
| Bubble PK 2 WK | T | 1x | $10.00 | $10.00 |

Flags: T=Taxable F=FSA R=Rx P=Promo A=Auto Refill

Rx count:3
Retail count:1
Total count:4

Rx Total:$0.00
Retail Total:$10.00

| | |
|---|---|
| Subtotal | $10.00 |
| Standard Tax on $10.00 | $0.84 |
| **Total** | **$10.84** |
| Tender Credit [redacted] | $10.84 |

***Mastercard Card - Approved***
Amount:$10.84
Mastercard:********[redacted]
Transaction:CREDIT
Approval: [redacted]
Response Code:0
Entry Method:Contacticc
MASTERCARD [redacted]
Trace Code:

## Sale

**Elk Drug**
176 E Main Street
Dayton, WA 99328
Ph : 509-382-2536

Receipt: [redacted]
Date: 05/29/26 11:19AM
Cashier: LACY
Register: POS Lane2
Customer: [redacted]

| Item | Flags | Qty | Price | Value |
|---|---|---|---|---|
| Rx [redacted] | RF | | | $0.00 |
| Rx [redacted] | RF | | | $0.00 |
| Bubble PK 2 WK | T | 1x | $10.00 | $10.00 |
| Rx [redacted] | RF | | | $0.00 |

Flags: T=Taxable F=FSA R=Rx P=Promo A=Auto Refill

Rx count:3
Retail count:1
Total count:4

Rx Total:$0.00
Retail Total:$10.00

| | |
|---|---|
| Subtotal | $10.00 |
| Standard Tax on $10.00 | $0.84 |
| **Total** | **$10.84** |
| Tender Credit [redacted] | $10.84 |

***Mastercard Card - Approved***
Amount:$10.84
Mastercard:********[redacted]
Transaction:CREDIT
Approval [redacted]
Response Code:0
Entry Method:Contactlessicc
MASTERCARD
Trace Code [redacted]

# Disability Board

**Meeting Date:** 8/11/2026
**Agenda Item #:** 3.h.
**Subject:** Police Member #25 Reimbursement Request: Massage Therapy

## RECOMMENDATION

Staff recommends approving the claim as presented.

## MOTION FOR CONSIDERATION

Motion to approve the claim as presented.

## SUMMARY

A reimbursement claim and supporting documentation were submitted for the Board's consideration. The claim is consistent with the policy and standards set by the Board.

## ALTERNATIVES

The alternative is to deny the reimbursement and provide follow up steps to staff.

## ATTACHMENTS

1. POLICE MEMBER #25_Redacted

## 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.
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Asuris [ ] Medicare [ ] Other [ ] LEOFF 1

| Date of Service | Condition or Illness Or Prescription Name | Provider of Service | Bill Charged | Co-pay Amount |
|---|---|---|---|---|
| 6/11/26 | SORE BACK | MASSAGE TRI CITIES | $100 | $100 |
| 6/24/26 | SORE BACK | MASSAGE TRI CITIES | $100 | $100 |

TOTAL: $200

[redacted] 6/30/26

Print Name Signature Date

**Board Use Only**

POLICE MEMBER #25
RECEIVED 6.30.2026

Massage Tri-Cities
4206 West 24th Avenue Suite A101
Kennewick, WA 99338 United States
nancy_hisaw@live.com | (509) 845-6722

[redacted]

Issue date
Jun 11, 2026

# Invoice [redacted]

WA state License # MA00024917. NPI - 1144467895. CPT Code - 97140.

**Customer**
[redacted]

**Invoice Details**
PDF created June 11, 2026
$100.00

**Payment**
Due June 11, 2026
$100.00

| Items | Quantity | Price | Amount |
|---|---|---|---|
| 60 Min Massage with Nancy Hisaw LMT | 1 | $100.00 | $100.00 |
| Subtotal | | | $100.00 |

## Total Paid $100.00

**Payments**
Jun 11, 2026 [redacted] $100.00

[redacted]

**View online**

To view your invoice go to https://squareup.com/u/Fpv8g42l
Or open the camera on your mobile device and place the QR code in the camera's view.

Massage Tri-Cities
4206 West 24th Avenue Suite A101
Kennewick, WA 99338 United States
nancy_hisaw@live.com | (509) 845-6722

Invoice [redacted]

Issue date
Jun 24, 2026

# Invoice [redacted]

WA state License # MA00024917. NPI - 1144467895. CPT Code - 97140.

**Customer**
[redacted]

**Invoice Details**
PDF created June 24, 2026
$100.00

**Payment**
Due June 24, 2026
$100.00

| Items | Quantity | Price | Amount |
|---|---|---|---|
| 60 Min Massage with Nancy Hisaw LMT | 1 | $100.00 | $100.00 |
| Subtotal | | | $100.00 |
| **Total Paid** | | | **$100.00** |

**Payments**
Jun 24, 2026 [redacted] $100.00

[redacted] View online