City of Longview

1525 Broadway
Longview, WA 98632
www.ci.longview.wa.us

LEOFF-1
Disability Board

Agenda

Wednesday, July 26, 2023 **8:30 AM** **2nd Floor, City Hall**

The City Hall is accessible for persons with disabilities. Special equipment to assist the hearing impaired is also available. Please contact the City Executive Office at 360.442.5004 48 hours in advance if you require special accommodations to attend the meeting.

To attend the meeting virtually use the link or information below:
Click here to join the meeting
Meeting ID: 269 837 824 466
Passcode: 998pKy

Or call in (audio only)
+1 213-631-2692
Phone Conference ID: 315 649 02#

1 CALL TO ORDER

2 FLAG SALUTE

3 ROLL CALL

4 AGENDA APPROVAL

5 PUBLIC COMMENT

6 APPROVAL OF MINUTES

23-001347 June 28, 2023 Regular Meeting Minutes

7 OLD BUSINESS

8 MEDICAL REIMBURSEMENT REQUESTS

9 APPROVAL OF BILLS

23-001348 July 2023 Medical Bills (Regular) - Total $19,355.54

23-001349 July 2023 Medicare B Reimbursement - Total $8,266.30

10 CONTINUED BUSINESS

23-001350 Long Term Care Form
Reimbursement of hearing aids

11 ADJOURNMENT

NEXT REGULAR MEETING
August 30, 2023 at 8:30 a.m.

City of Longview

Agenda Summary

June 28, 2023 Regular Meeting Minutes

Attachments:
1. June 28, 2023 Regular Meeting Minutes

City of Longview

1525 Broadway
Longview, WA 98632
www.ci.longview.wa.us

LEOFF-1
Disability Board

Minutes

Wednesday, June 28, 2023 | **8:30 AM** | **2nd Floor, City Hall, Small Conference Room**

The City Hall is accessible for persons with disabilities. Special equipment to assist the hearing impaired is also available. Please contact the City Executive Office at 360.442.5004 48 hours in advance if you require special accommodations to attend the meeting.

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1 CALL TO ORDER

Chairperson Kendall called the meeting to order at 8:30 a.m.

2 FLAG SALUTE

The flag salute was recited.

3 ROLL CALL

Present: Don Barnd, Police Department Representative
Jim Morkert, Fire Department Representative
Ruth Kendall, City Council Representative
Mike Wallin, City Council Representative
Chet Makinster, Member-at-large - absent/excused

Also Present: Tiffany Ostreim, Board Secretary
Dana Beck, Payroll Specialist
Jim McNamara, City Attorney - via telephone
Kris Swanson, City Manager

4 AGENDA APPROVAL

No changes were made to the agenda.

5 PUBLIC COMMENT

No public comment.

6 APPROVAL OF MINUTES

23-001250 May 31, 2023 Regular Meeting Minutes

A motion was made by Member Barnd, seconded by Member Morkert to approve the minutes of May 31, 2023. The motion carried unanimously.

7 OLD BUSINESS

8 MEDICAL REIMBURSEMENT REQUESTS

9 APPROVAL OF BILLS

23-001251 June 2023 Medical Bills (Regular) - Total $15,586.75

A motion was made by Member Barnd, seconded by Member Wallin to approve the bills as presented, reasonable, and medically necessary. The motion carried unanimously.

23-001252 June 2023 Medicare B Reimbursement - Total $8,266.30

A motion was made by Member Morkert, seconded by Member Wallin to approve the bills as presented, reasonable, and medically necessary. The motion carried unanimously.

10 CONTINUED BUSINESS

23-001253 Update Long-Term Care Form

Update regarding presentation of resources/policies from other jurisdictions for review regarding the reimbursement of hearing aids and eyeglasses

The Board discussed hearing aids and eyeglasses and reviewed polices from City of Olympia, City of Kirkland, Skagit County, City of Vancouver and King County.

A motion was made by Member Morkert, seconded by Member Barnd to direct staff to reach out to someone local in the hearing aid profession and L & I for standards or categories of hearing aids. The motion carried unanimously.

A motion was made by Member Barnd, seconded by Member Morkert to leave eyeglasses as currently stated in policy. The motion carried unanimously.

The Board discussed the current Long Term Care form, which is very basic. Long Term Care forms of City of Vancouver, City of Kirkland and King County will be distributed to the Board members for review and discussion next month. The Board discussed the need for specific ADL's and physician statement.

Miscellaneous -
Russian Massage is not covered by Humana or Kaiser. If you have a referral from a physician, a member can get prior approval, otherwise, not covered.

Acupunture is covered by Humana up to 20 visits. Acupunture is not covered by Kaiser.

11 ADJOURNMENT

With no further business to discuss, Chairperson Kendall adjourned the meeting at 9:18 a.m.

Next Meeting
The next regular meeting of the LEOFF-1 Board is scheduled for July 26, 2023 at 8:30 a.m.

_____ _____

Ruth Kendall, Chairperson *Tiffany Ostreim, Board Secretary*

City of Longview

Agenda Summary

July 2023 Medical Bills (Regular) - Total $19,355.54

Attachments:
1. Reimbursment July Spreadsheet

July 2023 MEDICAL BILLS (Regular)			
Member	**Dental**	**Regular**	
R-09	$85.30		
R-36		$630.49	
R-37		$6,800.00	
R-38		$7,392.00	
R-39	$3,640.60		
R-61		$213.42	
R-63		$593.73	
TOTAL	$3,725.90	$15,629.64	$19,355.54

City of Longview

Agenda Summary

July 2023 Medicare B Reimbursement - Total $8,266.30

Attachments:
1. Medicare B July voucher list

Medicare Premiums		July 2023	
Code	Vendor #	Year	RATE
R59	000092	2023	$31.50
R2	000122	2023	$243.00
R5	000233	2023	$361.20
R6	000278	2023	$164.90
R34	000447	2023	$156.90
R8	000465	2023	$164.90
R9	000466	2023	$164.90
R11	000632	2023	$164.90
R36	000634	2023	$164.90
R28	000664	2023	$164.90
R13	000666	2023	$164.90
R37	000701	2023	$164.90
R14	000706	2023	$164.90
R39	000740	2023	$164.90
R40	000744	2023	$164.90
R16	000789	2023	$164.90
R17	000827	2023	$164.90
R64	000883	2023	$164.90
R19	000963	2023	$164.90
R44	001021	2023	$164.90
R51	001106	2023	$164.90
R29	001124	2023	$164.90
R47	001226	2023	$164.90
R21	001245	2023	$164.90
R49	001402	2023	$164.90
R50	001481	2023	$151.90
R23	001511	2023	$164.90
R57	001599	2023	$151.90
R24	001631	2023	$164.90
R25	001644	2022	$134.00
R53	001685	Quarterly	$0.00
R63	001694	2023	$164.90
R55	001714	2023	$164.90
R56	001732	2023	$164.90
R58	001823	2023	$164.90
R26	002066	2023	$164.90
R27	210058	2023	$164.90
R18	210122	2023	$164.90
R42	210489	2023	$0.00
R48	211292	Quarterly	$0.00
R12	211809	2023	$479.30
R43	216727	2023	$164.90
R1	217402	2023	$164.90
R38	217404	2023	$164.90
R31	218105	2023	$141.90
R33	218134	2022	$164.90
R46	218350	2023	$164.90
R41	223804	2023	$164.90
R61	224982	2023	$164.90
R22	225194	2022	$148.50
R15	226325	2023	$164.90
			$8,266.30

City of Longview
Agenda Summary Sheet

1525 Broadway
Longview, WA 98632
www.mylongview.com

Update of Long-Term Care Form

Update on reimbursement of hearing aids

SUMMARY STATEMENT:
Long term Care Form update was requested to clean language and possible conflicts with ADL's.

Review of someone local in the hearing aid profession and L & I for standards or categories of hearing aids because of the many different options available which affect the price.

RECOMMENDED ACTION:
Continue research and place under Continued Business until finalized.

City of Longview Hearing Aids – Prior approval before purchase. Audiology report, a devise recommendation and a cost estimate are required.

City of Olympia Hearing Aids – Prior approval before purchase. Must submit quotes from two audiologists.

City of Kirkland Hearing Aids – Up to max of $2,500 toward the cost of each hearing aid ($5,000 per pair) during any 36-month period when medical necessity and 2-year warranty required.

Skagit County Hearing Aids – Prior approval, case by case

City of Vancouver Hearing Aids – Preapproval required. Quotes from two providers.

King County Hearing Aids – Cost must include 2-year warranty.

Allied Hearing Pricing

Make	Tech Level	Warranty	Price Each	Price Per Set
Unitron	3	1-year	$1,250	$2,500
Unitron	5	2-years	$1,600	$3,200
Unitron	7	2-years	$2,100	$4,200
Unitron	9	3-years	$3,150	$6,300

L & I –
When L & I has accepted a hearing loss condition either as a result of industrial injury or occupational exposure, they will authorize hearing aids when prescribed or recommended by a physician. L&I will pay for the cost of repairs or replacement due to normal wear and the cost of battery replacement for the life of the hearing aid. Hearing aids require prior authorization.

L & I will pay for hearings aids of appropriate technology to meet the worker's needs.
The decision will be based on recommendations from:
Physicians,
ARNPS
Licensed audiologists
fitter/dispensers.

L & I will cover the following types of hearing aids:
Behinds the ear
digital or programmable in the ear
In the canal
Completely in the canal
Receiver in canal

Considerations when choosing a hearing aid:
Which features will I need most?
Do I care about the appearance of the device?
What is the total cost of the hearing aid?
Will the benefits of newer technology outweigh the higher costs?
Is there a trial period to test the hearing aids?
How long is the warranty, and what does it cover?

Kaiser Permanente
Offers hearing aid coverage that employer groups can purchase and add to their medical policy. The cost for adding the coverage varies based on the benefit chosen and the group.

Additionally, to comply with WA House Bill 1222, Kaiser will be adding a new benefit for hearing aids and bone conduction hearing services to their Washington Large group plans starting 1/1/2024. With the new benefit, Kaiser will cover up to $3,000 per ear, every 36 months, at $0 cost share for non-HSA qualified plans. For HSA-qualified HDHPs, the $0 cost share applies after meeting the minimum deductible.

AWC Trust currently offers Medicare-eligible LEOFF I Retirees:

Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	**In- and out-of-network:** $0 copay per provider per day
In addition to the Medicare-covered hearing services, we also cover: **Routine hearing exam *** 1 routine hearing exam every calendar year *See Section 3.1 for exclusions*	**In-network:** $0 copay **Out-of-network:** $150 copay TruHearing providers must be used to receive the in-network benefit.

Services that are covered for you	What you must pay when you get these services:
Hearing services (continued) **Routine hearing aids *** Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors and are available in rechargeable style options for an additional $50 per aid. Call **1-855-542-1711** to schedule an appointment (TTY: dial 711). Hearing aid purchase includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models Benefit does not include or cover any of the following: • Additional cost for optional hearing aid rechargeability • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries, batteries when a rechargeable hearing aid is purchased • Hearing aids that are not TruHearing-branded hearing aids • Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan. *See Section 3.1 for exclusions*	**In-network benefits only:** Hearing aids: $599 copay per aid for Advanced aids $899 copay per aid for Premium aids $50 additional cost per aid for optional hearing aid rechargeability Fitting and evaluation: $0 copay Unlimited visits for the first 12 months. TruHearing provider must be used to receive hearing aid benefits.

* Copays, coinsurance and amounts beyond the benefit limits do not apply to any out-of-pocket maximum.

HB 1222 was passed during this last legislative session and requires that fully insured plans cover prescription hearing devices at $3,000 per ear every three years.

The mandate does not apply to self-insured plans. HB 1222 is effective 1-1-24.

City of Longview

LEOFF-1

Medical Report and Request for Long-Term In-Home Nursing Assistance, Confinement in a Nursing Home or Similar Facility, or in a Hospital Extended Care Facility

Name of Member: _____

1. Name and address of attending physician: _____

_____

_____

2. The following are the dates on which the member was examined relative to his/her present condition, including the most recent examination: _____

_____

_____

3. The following is a summary of the relevant medical, mental, functional, neurological history of this member as known to me: _____

_____

_____

_____

_____

4. The following are my findings as to the medical condition of this member, including diagnosis and prognosis. _____

_____

_____

_____

		Yes	No
5.	Home health care is necessary due to the foregoing diagnosis:	☐	☐
6.	Nursing home confinement is necessary due to the foregoing diagnosis:	☐	☐
7.	Hospital extended facility confinement is necessary due to the foregoing diagnosis:	☐	☐

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

	Yes	No
Bathing	☐	☐
Dressing	☐	☐
Feeding	☐	☐
Toileting	☐	☐
Transferring	☐	☐
Continence	☐	☐
Cognitive Impairment	☐	☐
Other*	☐	☐

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

_____

9. The following are my opinions on the specific medical and other assistance this member needs: _____

_____

_____

_____

_____

10. The following is my opinion regarding the estimated length of time this member will require the care identified in 5, 6, or 7, above: _____

_____

_____

_____

11. I have also met, spoken with or consulted the following persons regarding this member:

_____

_____

_____

Dated this _____ day of _____.

_____ _____

Physician's Signature Phone Number

_____

Physician's Name (Please type or print clearly)

CITY OF VANCOUVER HUMAN RESOURCES
415 W Sixth St – 3rd Floor/P.O. Box 1995
Vancouver WA 98668-1995
360.487.8403 phone 360.487.8418 fax
E-Mail - Julie.moore@cityofvancouver.us

Application Request

(To Be Completed by Member, Family Member or Legal Rep – please check one)

☐ Home Health Care ☐ Skilled Nursing Home Care Services ☐ Other_____

Name:	SSN:	Telephone Number:

Complete address including zip code:	Pension Board: ☐ Police ☐ Fire	Status: ☐ Active ☐ Retired

Medical Insurance: ☐ Medicare ☐ Kaiser Permanente ☐ Blue Cross ☐ Other _____	Veteran? ☐ Yes - Branch of Svc _____ ☐ No

QUICK PERSONAL ASSESSMENT TOOL

(TO BE COMPLETED BY MEMBER, FAMILY MEMBER OR LEGAL REPRESENTATIVE)

Assistance Needed:	Full Assistance	Some Assistance	No Assistance
Taking Medications	☐	☐	☐
Eating	☐	☐	☐
Toileting	☐	☐	☐
Bathing or Showering	☐	☐	☐
Dressing	☐	☐	☐
Transferring	☐	☐	☐
Continence	☐	☐	☐
Shaving, Hair Care	☐	☐	☐
Preparing Meals	☐	☐	☐
Transportation	☐	☐	☐
Housekeeping	☐	☐	☐
Personal Laundry	☐	☐	☐

Current Living Situation: ☐ Home (alone) ☐ Home (with services) ☐ Lives with family
☐ Hospital ☐ Other _____

Walking Ability: ☐ Independent ☐ Walker ☐ Cane ☐ Wheelchair ☐ Not Mobile

Memory Loss: ☐ Frequent loss ☐ Occasional loss ☐ No memory loss
☐ Dementia Diagnosis ☐ Alzheimer's Diagnosis

ADDITIONAL INFORMATION

What recent conditions or events have occurred causing you to consider a change in your circumstance? Please be specific.

I hereby certify, under the penalty of perjury in the State of Washington, that this application contains no willful misrepresentation and that the information is true and complete to the best of my knowledge and belief.

Signature: _____ Date: _____

Print Name: _____ Relationship to Member: _____

CITY OF VANCOUVER HUMAN RESOURCES
415 W Sixth St – 3rd Floor/P.O. Box 1995
Vancouver WA 98668-1995
360.487.8403 phone 360.487.8418 fax
E-Mail - Julie.moore@cityofvancouver.us

Physician's Statement

LEOFF I Member Name:	SSN:	Birth Date:

*The LEOFF I member, as listed above, has applied to the City of Vancouver Pension Board for approval of medical services. Please complete and sign the **PHYSICIAN** section of the form as listed below.*

Diagnosis:	Prognosis:

Assistance Needed:	Full Assistance	Some Assistance	No Assistance
Taking Medications	☐	☐	☐
Eating	☐	☐	☐
Toileting	☐	☐	☐
Bathing or Showering	☐	☐	☐
Dressing	☐	☐	☐
Transferring	☐	☐	☐
Continence	☐	☐	☐
Shaving, Hair Care	☐	☐	☐
Preparing Meals	☐	☐	☐
Transportation	☐	☐	☐
Housekeeping	☐	☐	☐
Personal Laundry	☐	☐	☐

Walking Ability: ☐ Independent ☐ Walker ☐ Cane ☐ Wheelchair ☐ Not Mobile

Memory Loss: ☐ Frequent loss ☐ Occasional loss ☐ No memory loss
☐ Dementia Diagnosis ☐ Alzheimer's Diagnosis

Based on the needs of this patient, I would recommend the following type of service (please check one):

☐ Home Health Care ☐ Skilled Nursing Home Care Services ☐ Other_____

Based on the needs of this patient, I would recommend the following level of care (please check one):

☐ Skilled Care: nursing care performed under the orders of a doctor, supervised by a licensed registered nurse or practical nurse available around the clock on a daily basis. A person with professional training or skills must perform most daily procedures.

☐ Intermediate Care: nursing care performed under the orders of a doctor and under supervision of a licensed registered nurse or practical nurse. The patient is provided with skilled care on a periodic basis. These periodic procedures cannot be done without professional training or skill.

☐ Custodial Care: primarily meets the personal needs of the patient and can be provided by a person without professional training or skill.

Frequency of Need: _____ (#) hours a day, _____ (#) days a week

Duration (how long do you anticipate need): ☐ Less than 2 weeks ☐ 3 – 4 weeks
☐ 1 – 3 months ☐ 4 – 6 months ☐ over 6 months ☐ not sure ☐ other_____

ADDITIONAL INFORMATION

Please provide any additional opinions on the specific medical and other assistance this patient needs:

Physician's Signature: _____ Date: _____

Typed or Printed Name_____ Phone: _____

Physical Address, including zip code:	Mailing Address, including zip code:

Please **SEND** this form to: City of Vancouver Human Resources/Pension Board, Attn: Julie Moore
P.O. Box 1995, Vancouver, WA 98668-1995 **OR** Fax: (360) 487-8418

		Vendor Number _____

CITY OF KIRKLAND FINANCE DEPARTMENT ACCOUNTING DIVISION

LEOFF I MEMBER CLAIM FOR EXPENSES

Budget Accounts		Amount
_____		_____

City Purpose for Expenditures: LEOFF I MEDICAL EXPENSES

Claim of: _____

Address: _____

Department: ☐ Police ☐ Fire

Claim will not be allowed unless all information requested on reverse side of this vouchers shown in detail

EXPENSE BREAKDOWN

For Medical Expenses During the Period of _____ to _____

as shown in detail by attached bills, receipts, and insurance statements.

Medical Services AHR0007005	$	Total from Below
Prescriptions AHR0007001	$	Total from Below
Dental AHR0007002	$	Total from Below
Long-term Care AHR0007003	$	Total from Below
Medicare AHR0007004	$	Total from Below
TOTAL EXPENSES	$	
TOTAL DUE EMPLOYEE	$	

Expenses have been reviewed and claim should be made

Disability Board Staff Assistant DATE:

STATE OF WASHINGTON)
) SS.
CITY OF KIRKLAND)

I, the undersigned applicant, do hereby certify under penalty of perjury that the information contained in the foregoing claim for reimbursement of expenses is true and correct; that the expenses were actually incurred by me as a LEOFF I employee and in a manner consistent with the policies established by Resolution R-3344 relating to reimbursement of employee expenses; that I have not previously been paid or reimbursed for any of said expense.

Signature of Applicant Date

The attention of the applicant is called to RCW Section 9A.72.030, which provides that any person swearing falsely in an affidavit or certifying under penalty of perjury shall be guilty of perjury in the second degree, a class C felony.

PAID TO	FOR	AMOUNT
	LEOFF I MEDICAL	
	LEOFF I MEDICAL	
	LEOFF I MEDICAL	
	TOTAL	$

CITY OF KIRKLAND FINANCE DEPARTMENT ACCOUNTING DIVISION

LEOFF I MEMBER CLAIM FOR EXPENSES

GLASSES 1st PAIR	PAID	ALLOWED		GLASSES 2nd PAIR	PAID	ALLOWED
Frames	$			Frames	$	
Lenses ☐ single ☐ bi ☐ tri	$			Lenses ☐ single ☐ bi ☐ tri	$	
Hardcote	$			Hardcote	$	
Contacts	$			Contacts	$	

DON'T FORGET TO ATTACH THE FOLLOWING:

☐ **Copy of receipt from doctor showing payment or copy of check reflecting payment to doctor**

☐ **Copy of insurance paperwork showing amount patient owes doctor**

☐ **Copy of bill from doctor**

☐ **For Medicare reimbursements, copy of monthly withdrawal statement or year-end statement is all that is needed**

If you have questions, please call Xin (Shinna) at 425.587.3241

MEDICAL CLAIM FORM
KCDRB Form 9A
LEOFF-1 Assessment of Need for Assisted Living Care: Claimant or Power of Attorney

Form 9A to be completed by Claimant or POA; Form 9B to be completed by the Director of Nursing or Assisted Living; Form 9C to be completed by facility medical director physician or resident's primary health care provider. Submit all three forms directly to your LEOFF-1 employer. If you have questions call your employer or the King County Disability Retirement Board at 206-684-1556

This section to be completed by Claimant or Power of Attorney.

LEOFF-1 member/claimant's name: _____ Date of Birth: _____

Power of Attorney: _____ Phone: _____

POA address: _____

City: _____ State: _____ ZIP: _____

Type of accommodation (e.g. one bedroom, other): _____

Long-term care insurance? ☐ Yes ☐ No

Attach itemized statement showing each service, cost and date provided (**required**).

Name of insurance carrier: _____ Policy No.: _____

Signature: _____ Date: _____
LEOFF-I claimant or power of attorney

The King County Disability Retirement Board for LEOFF-1 will only accept original signed and dated claim forms. If you are concerned about privacy, do not e-mail personal information or a copy of this completed form to the Board – your privacy over the Internet cannot be guaranteed.

Revised 3/2020

MEDICAL CLAIM FORM
KCDRB Form 9B
LEOFF-1 Assessment of Need for Assisted Living Care: Director of Nursing or Assisted Living

Form 9A to be completed by Claimant or POA; Form 9B to be completed by the Director of Nursing or Assisted Living; Form 9C to be completed by facility medical director physician or resident's primary health care provider. Submit all three forms directly to your LEOFF-1 employer. If you have questions call the employer or the King County Disability Retirement Board at 206-684-1556

This section to be completed by director of nursing or assisted living.

Director of nursing: _____ Phone: _____

Name of assisted living care facility: _____

Street address of facility: _____

City: _____ State: _____ ZIP: _____

Date of admittance to facility: _____

Level of care required at admittance: _____

Current level of care required (copy of care plan **required**): _____

Signed: _____ Date: _____
Director of Nursing or Assisted Living

_____
Print Name

The King County Disability Retirement Board for LEOFF-1 will only accept original signed and dated claim forms. If you are concerned about privacy, do not e-mail personal information or a copy of this completed form to the Board – your privacy over the Internet cannot be guaranteed.

Revised 3/2020

MEDICAL CLAIM FORM
KCDRB Form 9C
LEOFF-1 Assessment of Need for Assisted Living Care: Facility Medical Director Physician or Resident's Primary Health Care Provider

Form 9A to be completed by Claimant or POA; Form 9B to be completed by the Director of Nursing or Assisted Living; Form 9C to be completed by facility medical director physician or resident's primary health care provider. Submit all three forms directly to your LEOFF-1 employer. If you have questions call the employer or the King County Disability Retirement Board at 206-684-1556

This section to be completed by facility medical director physician or resident's primary health care provider.

(Dictate for typing or print ONLY.)

Name of resident: _____

Medical director physician or primary health care provider: _____ Phone: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Diagnosis upon admission to facility: _____

_____

History of illness/condition leading up to placement: _____

_____

Patient's prognosis for recovery: _____

_____

Current level of functioning: _____

_____

Current medication (please attach printed list to include name, dosage, frequency): _____

_____

Other providers involved in patient's care since admission: _____

_____

What treatment services have been prescribed (physical therapy, speech therapy, etc.)? Attach treatment plans for ***each*** service **(required).** _____

_____

What treatment services have been prescribed (physical therapy, speech therapy, etc.)? Attach treatment plans for ***each*** service **(required).** _____

_____

Signed: _____ Date: _____

Medical director physician/primary health care provider

_____

Printed Name

The King County Disability Retirement Board for LEOFF-1 will only accept original signed and dated claim forms. If you are concerned about privacy, do not e-mail personal information or a copy of this completed form to the Board – your privacy over the Internet cannot be guaranteed.

Revised 3/2020