LEOFF DISABILITY BOARD

AGENDA

Wednesday, March 29, 2017 at 2:00 p.m.

Camas City Hall, 616 NE 4th Avenue

SPECIAL MEETING

I. CALL TO ORDER BY CHAIR

II. CLOSED SESSION

III. APPROVAL OF THE MINUTES

IV. CLAIMS SUMMARY REPORT

V. OTHER BUSINESS

A. Review and Approval of Draft Application Request Form

B. Review and Approval of Draft Home Health Provider Information Form

C. Decision Regarding Retiree Coverage Request Discussed During Closed Session

VI. ADJOURNMENT

<u>Agenda Item III</u>

Approval of the Minutes

Discussion:
The minutes from the December 21, 2016 meeting are included in this packet.

Minutes should be reviewed and approved as-is or with necessary changes/edits.

Action requested:

- Motion to approve the minutes from the December 21, 2016 meeting.

  IF CHANGES REQUESTED:

- Motion to approve the minutes from the December 21, 2016 meeting with the discussed changes.

LEOFF DISABILITY Board

MEETING MINUTES - Draft

December 21, 2016, 1:30 p.m.

SPECIAL MEETING

Present: Don Chaney, Joan Durgin, Bob Rhode and Melissa Smith

Excused: Paul Berg

Staff: Leisha Copsey, Jennifer Gorsuch and Shawn MacPherson

I. CALL TO ORDER

Administrative Services Director Jennifer Gorsuch called the meeting to order at 1:00 p.m.

II. APPROVAL OF THE MINUTES

It was moved by Council Member Smith, seconded by Council Member Chaney, to approve the meeting minutes of October 31, 2016. The motion carried unanimously.

III. OTHER BUSINESS

A. Special Meeting Overview

City Attorney Shawn MacPherson gave the Board an overview of the guidelines associated with holding special meetings. MacPherson and Gorsuch responded to questions from the Board.

B. Selection of Chair and Vice-Chair

There was a brief discussion about the selection of Chair and Vice-Chair.

It was moved by Board Member Rhode, seconded by Council Member Chaney, to nominate Council Member Smith for the position of Chairperson and Board Member Durgin for the position of Vice-Chairperson effective January 1, 2017, for a one year term expiring December 31, 2017. The motion carried unanimously.

C. Review and Approval of Draft Rules and Procedures Manual

Gorsuch explained why the City of Camas created a LEOFF Disability Board.

Gorsuch reviewed the Draft Rules and Procedures Manual with the Board. Discussion ensued.

It was moved by Council Member Smith, seconded by Board Member Durgin, to adopt the City of Camas LEOFF Board Rules and Procedures as drafted. The motion carried unanimously.

D. Review and Approval of Draft Reimbursement Form

The Board reviewed the Draft Reimbursement Form and made recommended changes.

It was moved by Council Member Chaney, seconded by Board Member Durgin, to adopt the City of Camas LEOFF Reimbursement Form as drafted with the proposed changes by the Board. The motion carried unanimously.

E. Review and Approval of Draft Medicare Annual Reimbursement Form

Gorsuch reviewed the Draft Medicare Annual Reimbursement Form with the Board.

It was moved by Board Member Durgin, seconded by Council Member Smith, to adopt the City of Camas LEOFF Medicare Annual Reimbursement Form as drafted. The motion carried unanimously.

F. Delegation of Authority

The Board discussed delegating authority for some reimbursement claims to the Administrative Services Director.

It was moved by Council Member Smith, seconded by Board Member Durgin, to delegate authority to the Administrative Services Director to authorize processing and payment of reimbursements claimed under Section VII, subsection 3 as outlined, as well as the Medicare Part B reimbursements. The motion carried unanimously.

G. Open Public Meetings Act (OPMA) Training

Gorsuch gave the Board an overview regarding the Open Public Meetings Act (OPMA) training that is required and explained the various training options available.

H. Meeting Material Dissemination Discussion

After a brief discussion, the Board concluded that receiving the agenda material through an email would be sufficient. A link to the City's website will also be included in the email.

There was also discussion about when future meetings would be held. The Board will normally meet quarterly. If there is business that requires Board approval or a need to meet sooner, then a meeting will be scheduled. There could also be a change to the proposed schedule in the future.

IV. ADJOURNMENT

The meeting adjourned at 2:05 p.m.

Agenda Item IV

Claims Summary Report

Discussion:
A summary of all reimbursement requests processed from January 1, 2017 through March 31, 2017 are included for review in the attached spreadsheet. The total amount of reimbursements is $18,063.81.

These reimbursement requests were authorized by the Administrative Services Director, as outlined in the delegation of authority given by the Board.

The documentation submitted will be available at this meeting for review or in the event of questions from the Board.

Action requested:

- Motion to approve the City of Camas LEOFF Disability Board reimbursements as presented.

3/15/2017

LEOFF I Disability Board
Reported Expenses

Expense Type	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	YTD Total
Medicare Premiums			$ 4,410.00										$ 4,410.00
Rx & Office Co-pays		$ 35.00	$ 35.00										$ 70.00
Dental Care (Verde)	$ 290.00	$ 215.72	$ 1,431.00										$ 1,936.72
Eye Care													$ -
Hearing Aids		$ 1,743.34											$ 1,743.34
Medical Equipment													$ -
Assisted Living (pre-approved)	$ 4,845.50	$ 5,058.25											$ 9,903.75
In Home Care (pre-approved)													$ -
Miscellaneous													$ -
Total	$ 5,135.50	$ 7,052.31	$ 5,876.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 18,063.81

Fire 613.00.522.215.21 (3 participants)

Police 613.00.521.201.21 (9 participants)

Descriptions

Medicare Part B
Co-pay & Rx
Dental (FI. Last name)
Eye Care
Hearing Aid
Med. Equip.
Assisted Living (FI. Last name, Month Year)

Agenda Item V

A. Review and Approval of Draft Application Request Form

Discussion:
An application request form for home health care, assisted living and nursing home care services is appropriate and required for proper Board review and approval. This form requires information from both the member as well as the member's health care provider, and also includes an instruction sheet.

This application request form will be distributed to members as requested.

If changes to the form are desired by the Board at the meeting, the second motion below would be appropriate.

Action requested:

- Motion to adopt the City of Camas Application Request Form as drafted.

  OR

- Motion to adopt the City of Camas Application Request Form as drafted with the proposed changes by the Board.

City of Camas LEOFF Disability Board Application Request

Application for: (check one)

_____Home Health Care Services

_____Assisted Living

_____Nursing Home Care Services

Member Name: _____ Telephone Number _____

Under the LEOFF I guidelines, and as stated in RCW 41.26, medical services are allowed whenever:

1. Any active or retired LEOFF I member subject to the jurisdiction of the Disability Board and who is covered under the provisions of RCW 41.26 is sick or disabled.

2. The sickness or disability is not caused by dissipation or abuse, of which the Board shall be judge.

The employer shall pay reasonable charges for such active or retired employee (excluding spouses or survivors) for those necessary medical services listed below, which are not payable from some other source as provided for in Section VII, Subsection B of the Rules and Procedures Manual. Issues regarding reasonableness of charges may be resolved by referring to the maximum fees stipulated in the State Industrial Schedule WAC 296-20 through 23.

- The charges of a health care provider other than a provider who ordinarily resides in the member's home or is a member of a family of either the member or the member's spouse, provided, that continuous care beyond 45 days must be approved in advance by the Board, and required by a physician.

- Nursing home confinement and/or home health care when prescribed by a physician, provided, that any care in excess of 45 days must be approved by the Board. The Board will only approve the cost for such necessary medical services provided outside Clark County to the extent that the cost does not exceed by 10% the average cost for such care in the Clark County Washington area. Members requiring this level of care must be reevaluated by a physician semi-annually.

QUICK PERSONAL ASSESSMENT TOOL

(TO BE COMPLETED BY MEMBER)

Assistance Needed:	Full Assistance	Some Assistance	No Assistance
Taking Medications	☐	☐	☐
Eating	☐	☐	☐
Toileting	☐	☐	☐
Bathing Or Showering	☐	☐	☐
Dressing	☐	☐	☐
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

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

Please complete this section if your condition may cause you to relocate and you may require services in an area other that your home address.

City: State: Zip:

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 of Member: _____ Date: _____

Physician's Statement

LEOFF I Member Name:	SSN:	Birth Date:
Complete address including zip code:		Telephone Number:

Under the LEOFF I guidelines, and as stated in RCW 41.26, medical services are allowed whenever:

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2. The sickness or disability is not caused by dissipation or abuse, of which the Board shall be judge.

The employer shall pay reasonable charges for such active or retired employee (excluding spouses or survivors) for those necessary medical services listed below, which are not payable from some other source as provided for in Section VII, Subsection B of the Rules and Procedures Manual. Issues regarding reasonableness of charges may be resolved by referring to the maximum fees stipulated in the State Industrial Schedule WAC 296-20 through 23.

- The charges of a health care provider other than a provider who ordinarily resides in the member's home or is a member of a family of either the member or the member's spouse, provided, that continuous care beyond 45 days must be approved in advance by the Board, and required by a physician.

- Nursing home confinement and/or home health care when prescribed by a physician, provided, that any care in excess of 45 days must be approved by the Board. The Board will only approve the cost for such necessary medical services provided outside Clark County to the extent that the cost does not exceed by 10% the average cost for such care in the Clark County Washington area. Members requiring this level of care must be reevaluated by a physician semi-annually.

PLEASE COMPLETE AND SIGN SECTION ON OTHER SIDE.

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

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Patient Name:	Patient BD:

Diagnosis:	Prognosis:

Assistance Needed:	Full Assistance	Some Assistance	No Assistance
Taking Medications	☐	☐	☐
Eating	☐	☐	☐
Toileting	☐	☐	☐
Bathing or Showering	☐	☐	☐
Dressing	☐	☐	☐
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

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

Based on the needs of this patient, I would recommend the following type of service (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.

Physician's Signature: _____ Date: _____

Specialty: _____ Phone: _____

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

Please return this form to: City of Camas LEOFF Disability Board, Attn: Leisha Copsey
616 NE 4th Avenue, Camas, WA 98607 **OR** Fax: (360)817-1574

PLEASE READ CAREFULLY:

The application to request medical services (home health care, assisted living, and nursing home care) consists of two forms; a member request/assessment and a physician's statement.

1) Please fill out every space on the form(s) to avoid delays in processing your application.

2) If a section does not apply, or information is not available, please write "NONE" or "N/A" in the space provided.

3) If an incomplete form is received by you or your physician, it will be returned for completion.

Application Request:

1) This form should be completed by the LEOFF I member or legal representative.

Physician's Statement:

1) This form should be completed by the LEOFF I member and the LEOFF I member's physician.
2) The *front page* of the form is to be completed by the LEOFF member. This page identifies you as the patient to your physician.
3) The *back page* of the form entitled "Physician's Statement" is to be completed, in full, by your physician.

Please make sure all required forms are completed and returned to the City of Camas.

Forms may be sent to:

City of Camas LEOFF Disability Board
Attn: Leisha Copsey
616 NE 4th Avenue, Camas, WA 98607
OR
Fax: (360) 817-1574

Please contact Jennifer Gorsuch, Administrative Services Director,
at (360) 817-7013 with any questions.

Agenda Item V

B. Review and Approval of Draft Home Health Provider Information Form

Discussion:
An information form for Home Health Providers is appropriate and required for proper processing of member application requests. This form requires basic information about the provider, a copy of the care plan and a copy of current licensure/certification as a caregiver.

This information form will be distributed to members as needed.

If changes to the form are desired by the Board at the meeting, the second motion below would be appropriate.

Action requested:

- Motion to adopt the City of Camas Home Health Provider Information Form as drafted.

  OR

- Motion to adopt the City of Camas Home Health Provider Information Form as drafted with the proposed changes by the Board.

City of Camas LEOFF Disability Board
Home Health Provider Information Form

Service Provider: _____ Telephone Number _____

Agency Street Address: _____

City: _____ State: _____ Zip: _____

Hourly rate(s): _____

Current level of care required **(copy of care plan is attached)**

_____

_____

_____

Medical treatments provided:

_____

_____

_____

Signature: _____ Date: _____
Home health care supervisor

<u>Please attach a copy of current licensure/certification of caregiver(s)</u>

City of Camas LEOFF Disability Board
Attn: Leisha Copsey
616 NE 4th Avenue, Camas, WA 98607
OR
Fax: (360) 817-1574

Please contact Jennifer Gorsuch, Administrative Services Director,
at (360) 817-7013 with any questions.

Agenda Item V

C. Decision Regarding Retiree Coverage Request Discussed During Closed Session

Discussion:
Board members were provided with the following documents during the closed session:

- Staff Report summarizing member request
- Application Request for Personal Caregiver Services
- Glenwood Place Service Agreement dated 2/15/2017
- Home Health Provider Information Form

Action requested:

- Motion to approve Personal Caregiver/Companion Services for member Deloy Little

  OR

- Motion to deny Personal Caregiver/Companion Services for member Deloy Little