CITY OF Vancouver WASHINGTON

Police
Pension Board
Special Meeting Schedule
July 24, 2024

Police Pension Board
4:00pm
Aspen Conference Room, 1st Floor City Hall
Call In: 1 347-941-5324
Phone Conference ID: 234 543 826#
Teams Meeting ID: 280 249 072 02
Passcode: Ztu2Hi

Please contact Caylee Trant at (360) 487-8403 or
Caylee.Trant@cityofvancouver.us
if you are unable to attend.
Thank you!

Police Pension Board

Wednesday, Jul. 24, 2024
4:00p.m.
Vancouver City Hall
Aspen Conference Room, 1st Floor

MEETING ACCESS INFORMATION:
Join the meeting now
Call In: 1-347-941-5324
Phone Conference Number: 234 543 826#

AGENDA

1. Call to Order and Roll Call – McEnerny-Ogle
2. New Business – Trant
    a. Request for Home Health Care – Claimant A

Members

Anne McEnerny-Ogle
Chair

Erik Paulsen, Mayor Pro Tempore
Anthony Glenn, City Treasurer
Natasha Ramras, CFO/Board Secretary
August Lehto, Police Retiree
Kit Abernathy, Police Retiree
Jeffrey Dong, Police Retiree

Human Resources Department

P.O. Box 1995
Vancouver, WA 98668
360-487-8403
TTY: 711
cityofvancouver.us

To request accommodation or other formats, please contact:
Caylee Trant | 360-487-8403 | TTY: 711 | Caylee.Trant@cityofvancouver.us

CITY OF Vancouver WASHINGTON

MEMORANDUM

DATE: July 24, 2024

TO: Police Pension Board

FROM: Caylee Trant, Pension Board Coordinator

RE: **Request for Home Health Care – Claimant A**

Attached for Board review is a ComFor Care assessment and Physician's Statement supporting a request for home health care for Claimant A. The original Application Request and Physician's Statement requesting Long Term Care is attached for reference. Previously, Claimant A was approved for Long Term Care facility at the May 22, 2024, meeting for up to $10,770/month provided by Clearwater Springs.

Section III. 10 of the Board's rules and regulations requires:

"*Explanation of benefits insurance documentation forms showing amounts paid and/or rejected, including proof of submission to Medicare, VA Benefits, and any existing Long Term Care Insurance*."

Claimant A is currently receiving health care services provided by Kaiser twice a week. However, they only provide physical therapy and do not provide the custodial care needs that were outlined in the Physician's Statement.

Section III.10.b of the Board rules state:

"*The member must obtain pre-approval for assisted living care unless at the Board's sole discretion determine that emergency circumstances reasonably prevented prior approval.*"

Claimant A wanted to be closer to his family and receive his care within his home. Claimant A gave his notice to vacate Clearwater Springs and was required to move out on July 12, 2024. After he moved out of Clearwater Springs, Claimant A's family was able to secure medically necessary home health care services from ComFor Care.

Section III.10.a of the Board rules limits:

"*The Board does not provide benefits for the following….* charges for reports or records; transportation*; homemaker or housekeeping services; except by home health aides as ordered in home health plan of treatment;*"

Claimant A's daughter secured ComFor Care with a $1600 deposit and $150 administrative fee, and she is requesting reimbursement for these fees. According to the home services agreement, the deposit will be refunded in full or applied to the final invoice upon discharge of services. The administrative fee is for paperwork processing and keeping their client file in compliance with state regulations. The fee also covers any changes in the care plan or with advanced directives of the claimant.

Section III.10.d of the Board rules for long term care costs:

"Total daily cost allowed shall not exceed the semi-private room rate in a skilled nursing facility. This allowance will be determined using the latest annual Genworth Cost of Care Survey for Nursing Home Care services in the state of Washington."

According to the plan of care documents, Claimant A is currently a level 1 resident which has a care level cost of $40/hour at an estimated 20 hours per week or $3,200/month. The current average daily cost for a semi-private room in Washington State is $359/day or about $10,770/month.

Items for consideration by the Board:

$1600	Deposit
$150	Administrative Fee
$40/hour	Ongoing Home Health Care by ComFor Care

Action Requested
Consider Claimant A's request for medically necessary home health care up to the current daily cost for a semi-private room as presented.

City of Vancouver Human Resources
415 W 6th St – 3rd Floor/P.O. Box 1995
Vancouver, WA 98668-1995
P: 360.487.8403 F: 360.487.8418
Email: Caylee.Trant@cityofvancouver.us

HR No. 83083914

Physician's Statement

LEOFF I Member Name:	SSN:	Birthdate:
[redacted]		[redacted]

*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:
History of left femur fracture HTN Impaired self care Gait Gait abnormality	good.

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 ☐ Assisted Living ☐ Long Term Custodial Care ☐ Skilled Nursing
☒ Other Need caregiver help at home.

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: 24 (#) hours a day; 7 (#) 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:

Need 24 hour assistance & supervision. Required set up of electronic pill organizer and assit for refills. Required SBA for all self care & mobility within home due to hx of fall and cognition affecting safety. Need total assist for meal prep, transportation, housekeeping & laundry

Physician's Signature: _____ Date: 6/12/2024

Typed or Printed Name: Mike Lin, MD Phone: (800) 813-2000

Physical Address, including zipcode:
Mike C. Lin, M.D.
Kaiser Permanente
Salmon Creek Medical Office
14406 N.E. 20th Ave.
Vancouver, WA 98685-1448
(800) 813-2000

Mailing Address, including zip code:

Caylee Trant | 360-487-8403 | caylee.tashiro@cityofvancouver.us
P.O. Box 1995 | Vancouver, WA 98668-1995 | cityofvancouver.us

CLIENT EMERGENCY PLAN

ComForCare
HOME CARE

CLIENT: [redacted]

DATE OPENED: 7-9-2024

TELEPHONE: [redacted]

Physician Name: Dr. Mike Lin, Geriatrician 800-813-2000

Specialists: _____

Preferred Hospital: CIRCLE ONE: PHSW 360.514-2000/~~Legacy SC 360-487-1000~~ / VA PDX 800-949-1004
Kaiser ~~Legacy~~ Preferred

Clinic: _____

Clinic: _____

Pharmacy: Kaiser Salmon Creek Pharmacy. 866-280-2736-Toll free 800-813-2000

Hospice: _____

Emergency Contacts:

Name: [redacted] Home _____

Relationship: daughter Cell [redacted]

Email: [redacted] Work _____

Name: [redacted] Home [redacted]

Relationship: daughter (local) Cell [redacted]

Email: [redacted] Work _____

Name: [redacted] Home _____

Relationship: wife Home Cell [redacted]

Email: [redacted] Work _____

[redacted] Cell - [redacted]

**It is the responsibility of Emergency Contacts noted above to provide numbers that they can be reached 24 hours a day. Further, it is the emergency contact's responsibility to notify ComForcare office when said numbers change and/or alternate contacts should be contacted (e.g. in the event of a vacation for emergency contacts)

Home Services Agreement

Client Name: [redacted]

Consent to Care

I, or my Authorized Representative (hereinafter, together "I"), have asked ComForCare Home Care (hereinafter "**Agency**") and its employees to take care of me at my residence. I understand that any discussions with Agency employees regarding this Home Services Agreement (hereinafter "**Agreement**") or the development of my care plan are not intended to diagnose or treat me for any health condition. Agency and its employees will follow any instructions for my care given by my physicians and/or nurses. I also acknowledge that I have not been convicted of any criminal offense in any court of competent jurisdiction. Acknowledgment of Receipt of Client Rights Policy and Notice of Privacy Practices I acknowledge receipt of Agency's Client Rights Policy as well as Agency's Notice of Privacy Practices.

Health Records

I authorize Agency to release any information, health or otherwise, that Agency determines to be necessary for the delivery of my care including information concerning: HIV, AIDS, ARC (AIDS Related Complex), substance abuse treatment or diagnosis, and social/psychological services. Authorized entities may include, but are not limited to: individuals, third party payor sources, health care facilities & professionals, and/or appropriate federal or state agencies. Such releases may be via unsecured electronic networks.

Insurance/Liability

I will not allow any Agency employee to drive any of my vehicles without filing an automobile waiver slip in advance with Agency. I understand that Agency's insurance does not cover damage to my car or me while Agency's employees drive my vehicle. I accept full responsibility for such damage. I agree to carry a standard homeowner's insurance policy or similar tenant's policy on my residence. Agency is not responsible for property, fixtures, appliances, or other items damaged or broken as the result of normal use by Agency employees. I agree to remove and/or properly secure all personal items including any cash, jewelry, and firearms that I may possess. Agency limits its liability for property loss or damage to claims filed within thirty (30) days of occurrence. All losses require a police report.

Agency Employees

I understand that Agency personnel are employees of Agency. Agency is responsible for the payment or the provision of all employee payroll taxes, liability insurance, and workers' compensation requirements. Money or gifts may not be given directly to any Agency field employee or caregiving staff. I must request any changes to established schedules from Agency's office. I understand that: a) I am not allowed to make private employment arrangements with Agency employees within one (1) year of the discontinuation of my services unless I receive written authorization from the Agency Director, Manager, or Administrator, b) active Agency employees, or their family members, are not allowed to make any sort of alternative employment arrangements (i.e., private, alternative agency, etc.) with me or my family within one (1) year of the discontinuation of services unless I receive written authorization from the Agency Director, Manager, or Administrator, and c) employees who have quit or been terminated by Agency, as well as their family members, are not allowed to make any sort of alternative employment arrangements (i.e., private, alternative agency, etc.) with me or my family within one (1) year of their termination of employment unless I receive written authorization from the Agency Director, Manager, or Administrator. I acknowledge that doing so will cause Agency to incur substantial economic damages and losses of types and in amounts which are difficult to compute and ascertain. Accordingly, in addition to any other relief to which Agency may be entitled (equitable, monetary and otherwise), Agency shall be entitled to liquidated damages the greater of either: a) ten times (10 x's) the largest bi-weekly service charge/bill I received from Agency, or b) $15,000.00, plus all related attorney/court costs Agency incurs in enforcing this Agreement. Such liquidated damages are intended to represent a reasonable approximation of actual Agency damages and is not a penalty. I promise to pay this amount upon Agency's demand. Agency further reserves the right to discontinue my care if I violate this Agreement and to apply my deposit to satisfy any unpaid balance.

[redacted]

Client/Authorized Representative Signature

Home Services Agreement

Stopping Service

If I want to stop the Agency's services, **I must give at least 24 hours advance notice to the office**. I understand that if I fail to give sufficient notice or request during a shift to end my services (excepting situations in which Agency verifies employee incompetence or unsatisfactory duty), I may be required to pay the full shift charge and Agency may assess and collect for this shift charge without my signature on the time or flow sheets. **Agency reserves the right to discharge my care according to my state's discharge policy or with 48 hours' notice, whichever is the greater.** Furthermore, I understand that the Agency can stop its service without notice if Agency's management determines that services related to my care pose a significant risk to Agency or any of its employees or agents. If services are requested by telephone, facsimile, or electronic mail or otherwise provided prior to the date of this Agreement, the terms of this Agreement shall apply back to the initial date of service.

[redacted]

Client/Authorized Representative Initials

Emergency Contact

I understand that the Agency cannot guarantee there will be no unplanned emergency interruptions of service. The Agency Back-Up Policy/Procedure review states, if services are interrupted for reasons outside of Agency's control, the client/authorized representative shall designate an emergency contact person to assist with client emergency needs:

Name: [redacted] Relationship to client, if not client: Daughters

Address: [redacted]

Telephone:(H) [redacted]

(Email) [redacted]

Financial Responsibility

The Agency's minimum shift is 4 hours (contiguous), thereafter Agency bills for services in 15-minute increments. I agree to pay Agency for the services I receive at the following rates:

LEVEL I: $40.00/HR
LEVEL II: $45.00/HR
LEVEL III: Rates can vary depending on the specifics of the care.

Special Shifts/Rates (Short Shifts, QCP, Wellness Checks, etc.): CARE MANAGEMENT $65.00/HR - Minimum 2 hours

I also agree to pay the Agency for any health supplies provided by the Agency during the course of my services including, but not limited to; sterile gloves, gait belts and medical gowns.
In the event of a change in the rates or health supply costs, I will be given 30 days' written notice.
Holiday rates will be billed at a rate of time and one half (150%) for the following holidays (or as required by state law):
New Year's Day, Easter Sunday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Eve Day, Christmas Day and New Year's Eve Day.
Overtime rates will be billed according to the prevailing state and/or federal wage and hour laws. I promise to pay the Agency for all charges and damages in accordance with the deadlines stated on each invoice I receive, including any legal fees associated with collection of these charges.

[redacted]

Client/Authorized Representative Signature

Home Services Agreement

Client Invoicing

Any invoice(s) not paid within 10 days of the invoice(s) due date(s) will be subject to late charges of the maximum rate allowed by law. I further agree that no extenuating circumstance (change in health condition, billing error, change in services, dissatisfaction with services, delayed payments by an insurance company or public agency, or other) will justify delay in my payment. If I wish to dispute any part of my invoice(s), I must notify Agency's billing department prior to the relevant invoice(s) due date(s) otherwise Agency will assume the invoice(s) is accurate and payable in full. If I pay my invoice(s) automatically by credit card or by direct payment authorization, I must notice Agency of any disputes involving such invoice(s) within 30 days of receipt of my paid invoice(s) otherwise Agency will assume the invoice(s) is accurate and payable in full. Agency reserves the right to apply my deposit to any outstanding balance as well as charge any credit card on file if I fail to pay any balance in a timely manner. If I reside in a retirement community, monthly packages are to be prepaid. The individual(s) signing as "Authorized Representative" will jointly assume all legally binding responsibility for all aforementioned financial responsibilities including legal and late fees associated with collection of such balances.

Client Billing Information ☐ same as "Emergency Contact"

All invoices should be mailed to the following person:

Name: Vancouver City Hall ATTN Caylee Trant Relationship to client, if not client: City of Vancouver

Address: 415 W 6th St. Vancouver, WA 98660

Telephone:(H)_____ (W) 360-487-8403 Fax 360 487 8418

(Email) _____

Facsimile Signature and Counterparts

This Agreement may be signed and then transmitted by facsimile, or scanned and emailed, and a facsimile or scanned and emailed copy shall have the same force and effect as an original. Further, this Agreement may be executed in counterparts, which when taken together have the same force and effect as if one Agreement were fully executed.

Client Acknowledgment and Signature

I have read this Agreement (or it has been read to me), I have been given a copy (after I sign), and I have asked all my questions and received satisfactory answers to them, and I agree with the statements.

_____ _____

Client Signature **Date**

Authorized Representative Acknowledgment and Signature

Signature is required for any authorized representative, legal guardian, conservator, family member, power of attorney, or other interested third party. I have read this Agreement (or it has been read to me), I have been given a copy (after I sign), I have asked all my questions and received satisfactory answers to them, I understand that I am jointly and severally liable for all amounts due, and I agree to abide by all terms and conditions of this Agreement.

[redacted] Daughter 7/15/24

Authorized Representative's Signature **Relationship to Client** **Date**

Greta Cole 7/9/2024

ComForCare Representative's Signature **Date**

COMFORCARE HOME CARE CAREGIVER CARE PLAN INSTRUCTIONS

Client's Name: [redacted] **Date:** 7-9-2024

Client prefers to be referred to as (i.e.: Mr. Smith, John) [redacted]

Address: [redacted]

☑ Male ☐ Female Medical Alert: ☐ Yes ☑ No Advanced Directive: ☑ Yes ☐ No DNR: ☐ Yes ☐ No

Dress Code: ☑ Scrubs ☐ Street Clothes ☐ Other: _____

Allergies: ☑ NKA ☐ Medication ☐ Food ☐ Environmental

Explain: _____

Living Environment: ☑ Single Family Home ☑ Ranch Style ☐ 2-Story Home ☐ Stairs / Handrail

☐ Ramp ☐ Apartment ☐ Lives Alone ☐ Lives in IL / ALF ☑ Lives with family: Wife - [redacted]

Weight: [redacted] Height: [redacted] Pets: ☐ Yes ☑ No Number: ___ Type: _____

Caregiver Instructions: Reinforce / Support Self-Management Instruction / Skills

NOTE: Only perform the duties / tasks as assigned on your care plan. Notify your supervisor regarding any necessary changes. Observe standard precautions including hand washing techniques.

Mental Status: Cognitive decline - As per Primary Physician

Hearing / Vision / Speech: Hearing Aids - Glasses Speech Clear -

Personal Care (Bathing): Total Assist allowing independence when possible - fall Precautions -

Grooming / Oral Care: SBA

Skin Care / Nails / Shaving: OTC Lotion - SBA

Dressing-Undressing: SBA to Partial Impaired - Bom - Allow Independence when possible

Feeding-Nutrition-Meal Prep: Total Assist Meal Prep -

Toileting-Elimination: Independent for Most part - SBA - Caution landing & waist

Mobility-Activities: Walker @ All times - SBA

Home Safety Checklist: YES

Safety Measures / Devices: Walker, Shower Chair

Medication Reminder: Observe, Record - Electronic Med organizer - Assist as needed with Refills - family oversight -

Light Housekeeping: Total Assist

Transporation-Shopping- Appointments: Family Transporting @ this time - Assist As Needed

Client Phone-Vechicle Information: —

Personal Habits ~~Pets~~: Hearing Aids in Charger every (pm) Hearing loss - Knock on Walls when entering

Special Needs: No Hovering - PTSD - daily wt. Checks Severe Hearing loss

Fall Risk: Yes - Hx of falls -

Client Initials: [redacted] Evaluator Initials: YC

ComForCare
HOME CARE

Medication Assistance

ComForCare Home Care staff members who are Nursing Assistance Certified, NAC, will be following the rules and regulations that apply when providing client medication assistance. Prior to the beginning of service with ComForCare Home Care, this form must be read, dated, and signed.

Our Staff May do the following:

1. Our NAC's may remind their client to take medications as prescribed.
2. Our NAC's may assist the client by reading the medication label and any accompanying documentation.
3. Our NAC's may assist the client by handing them their medication containers and by opening the container.

Our Staff May NOT do the following:

1. Home Care Aide may **NOT** touch, alter, break, crush, or handle any part of the client's medications.
2. Home Care Aide may **NOT** apply prescription topical preparations.

7/15/24

Date

[redacted]

Client Signature or Authorized Representative

ComForCare Home Care

7402 NE St. John's Road Ste. D

Vancouver, Wa. 98665

Phone: 360-718-8276 Fax: 360-605-0616

VancouverWA.ComForCare.com

License #IHS.FS 60203382

ComForCare
HOME CARE

RATE SHEET

Quote for Services: [redacted]

Level I $40.00/Hr

Basic care for IADL's and ADL's

Assistance is provided in 4-hour blocks for each shift.

Totaling up to 4o hrs every 2-weeks.

Our agency will provide services according to the care plan (copy provided).

COMFORCARE NOTIFICATION OF CLIENT DEPOSIT & OTHER FEES

Client Deposit

- Prior to the commencement of services, ComForCare Home Care (hereinafter "Agency"), requires a deposit ("Client Deposit") from the client and/or client representative in the amount of the client's estimated average bi-weekly service charge/bill (calculated below).
- The Client Deposit is **not a payment that will be applied to services rendered.** Rather, the Client Deposit will be **refunded in full or applied to the final invoice upon discharge of services**.

Additional Deposit

- Agency reserves the right to request an increase in the amount of the Client Deposit left on account with the Agency. Such a request may be made for any reason such as, but not exclusively, to account for an increase in the amount of hours that Client receives services from the Agency or to adjust for the client's and/or client representative's payment history.

Admin/ Re-Evaluation Fee

- The Agency charges a $150.00 Administration fee. This Administration fee will be deducted from the Client Deposit before the Agency returns said Client Deposit. Any charges in excess of the Client Deposit will then be re-billed to the client and/or client representative.
- Agency reserves the right to charge a $150.00 Re-evaluation Fee for any re-evaluations requested by the client and/or client representative.

Health Supplies

- Health supplies are charged/invoiced by Agency to client and/or client representative per the following schedule:

Item	Price Per Unit	# of Units	Total Charge
Sterile Gloves (Box)			
Gait Belt			
Surgical Masks			
Medical Gowns			

- Supplies may not be returned or refunded.
- Agency will charge/invoice for all ongoing client health supply costs, Agency will provide client and/or client representative 30 days written notice.
- **If deposit is paid by credit card, a 3% Credit Card Convenience Fee will be deducted once the case is closed.**

Calculation of Client Deposit:

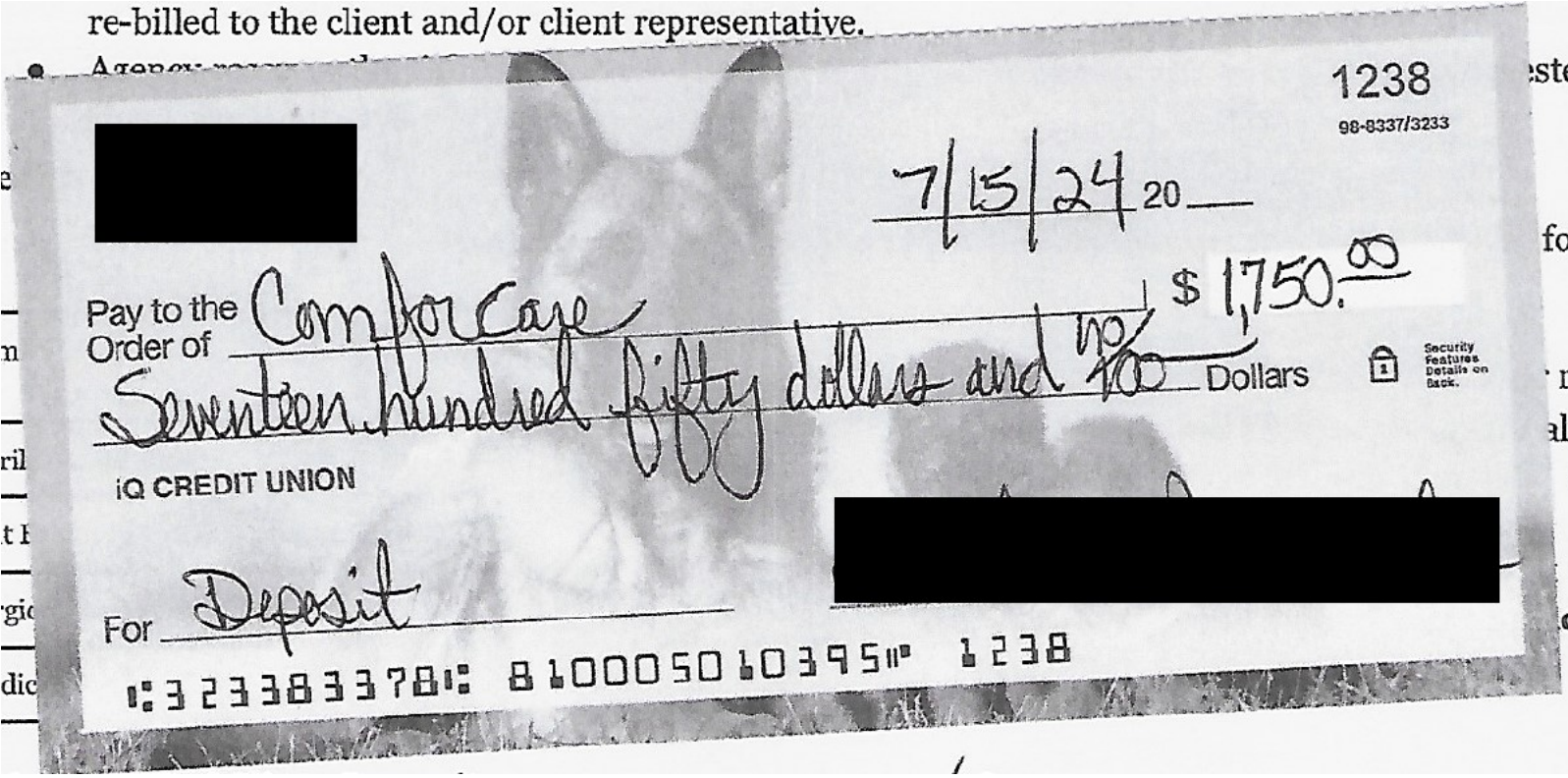
Average Bi-Weekly Hours per Week: 40 X's
Rate per Hour: @ 40.00 = 1,600.00
(Service hrs. & Connected Care Fall Detection pkg. rate)
Initial Medical Supply Order: _____ + _____
Administrative Fee: + 150.00
Total Client Deposit: $ 1,750.00

[redacted]
Client/ Representative Signature **Date** 7/15/24

Greta Cole
Agency Representative Signature **Date** 7/10/2024

License # HIS.FS. 60203382
CLIENT DEPOSIT FORM 01/2024

re-billed to the client and/or client representative.



[redacted]

1238

98-8337/3233

7/15/24 20__

Pay to the Order of ComforCare

$ 1,750.00

Seventeen hundred fifty dollars and no/100 Dollars

Security Features Details on Back.

iQ CREDIT UNION

[redacted]

For Deposit

⑆323383378⑆ 810005010395⑈ 1238

City of Vancouver Human Resources
415 W 6th St – 3rd Floor/P.O. Box 1995
Vancouver, WA 98668-1995
P: 360.487.8403 F: 360.487.8418
Email: Caylee.Trant@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 Long Term Care/Assisted Living

Name: Claimant A	SSN:	Telephone Number:
Complete address including zip code:	Pension Board: ☒ Police ☐ Fire	Status: ☐ Active ☒ Retired
Medical Insurance: ☒ Kaiser Permanente ☐ Blue Cross ☐ Other _____	Veteran? ☒ Yes - Branch of Svc Army ☐ 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.

On 30 March 2024, fell off a ladder and broke/separated left femur. Plus have previous injuries to lower back, right lumbar radiculopathy, sciatic nerve, and scoliosis.

Care at home would be unsafe and inadequate due to the severity of his injury, combined with his previous health issues and age.

Proximity to family members maximizes his support, which improves the speed and quality of his recovery.

This placement would support his mental and emotional well-being by enabling him to focus on his recovery rather than the stress of burdening his wife, who is also elderly.

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: 01 May 2024

Print Name: _____ Relationship to Member: Youngest Daughter

Caylee Trant | 360-487-8403 | caylee.tashiro@cityofvancouver.us
P.O. Box 1995 | Vancouver, WA 98668-1995 | cityofvancouver.us

CITY OF Vancouver WASHINGTON

City of Vancouver Human Resources
415 W 6th St – 3rd Floor/P.O. Box 1995
Vancouver, WA 98668-1995
P: 360.487.8403 F: 360.487.8418
Email: Caylee.Trant@cityofvancouver.us

Physician's Statement

LEOFF I Member Name:	SSN:	
Claimant A	[redacted]	[redacted]

*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: S72.025D

Nondisplaced Fracture of Epiphysis (Seperation) (upper) Left Femur Subsequent Encounter for Closed Fracture with routine Healing.

Prognosis: Skilled nursing care/ Nursing home care.

Physical Therapy and Occupational Therapy.

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 ☐ Assisted Living ☐ Long Term Custodial Care ☐ Skilled Nursing

☐ 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: As a result of Claimant A's left hip fracture & prior right hip fracture, he is unable to transfer or ambulate independently. He requires physical assistance with use of a walker to prevent falls, as he is at a very high risk.

Physician's Signature: (RILEY) MD Date: 4/30/24

Typed or Printed Name_____ Phone: _____

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

Caylee Trant | 360-487-8403 | caylee.tashiro@cityofvancouver.us
P.O. Box 1995 | Vancouver, WA 98668-1995 | cityofvancouver.us

Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

Kepro

5/2/2024

Case ID: 20240430 1110_

MA Organization Name: Kaiser Permanente
Provider Name: The Oaks At Timberline
Provider ID#: 505206
Patient Name: Claimant A
Patient MBI/HIC#: 1VQ9R64GP32
Admission Date: 5/8/2024 - 5/5/2024
Physician Name: Dr Craig Riley

Dear Claimant A:

Kepro is the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) authorized by the Medicare program to review skilled services provided to Medicare patients in your area. By law, we review Medicare cases to determine if the services meet acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

You asked for an immediate appeal of your Medicare Advantage (MA) plan's decision to end skilled services provided by The Oaks At Timberline.

According to the Kepro physician's review of the medical record and the Medicare Benefit Policy Manual, ending skilled nursing services **is not appropriate** based on the findings noted below:

You have been in a skilled nursing facility (SNF) because of a left femur fracture. Before your time in the SNF, you lived with others.

A physician reviewed your medical records. The physician looks at multiple activities to determine your ability to move around. The information about a few of your important movement activities is listed below.

Before your stay at the SNF:

· You could move from the bed to a chair independently, meaning you needed no help from others. You were able to move without any equipment to help you.
· You were able to walk greater than 100 feet. You were able to walk without anything to help you. You were able to walk independently, meaning you needed no help from others.

According to the most recent therapy notes in your medical record:

· You can move from the bed to a chair with moderate assistance, meaning someone needs to help you with approximately half of the work to do this activity. You need a walker to help you to move.
· You are able to walk approximately 40 feet. You need a walker to help you to walk. You are able to walk modified independently, meaning you need no help from others, but you need to use something to help you.

According to the most recent nursing and/or physician notes:
· You do not have any signs or symptoms that need to be watched and/or treated seven days a week.

The plan once you leave the SNF is to go home with your family and or caregivers.

You need therapy five days a week to learn how to keep up your ability to move. Kepro disagrees with the Notice of Medicare Non-Coverage. Medicare will pay for continued care in the skilled nursing facility.

Based on this documentation, the independent physician has decided that you require skilled services.

You do not have to pay for any services except for deductible and coinsurance amounts that apply and convenience services and items normally not covered by Medicare.

You have the right to review the complete medical record and other information that we used to make the decision about the medical necessity of your care. The provider is responsible for keeping the official medical record of the care received, but we can provide a copy at a reasonable cost. Kepro will tell you the cost for a medical record copy. We must receive your payment before we can send the record.

We would also like to make you aware of a feature on our website that allows you to check the status of your appeal (www.Keproqio.com/casestatus) if you are in need of our services in the future.

Sincerely,

cc: MA Organization: Kaiser Permanente
Provider: The Oaks At Timberline

This document (letter) contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

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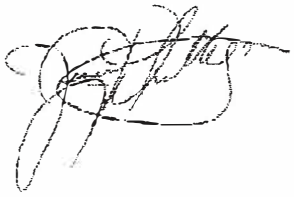
Kepro



Jessica Whitley, MD, MBA
Chief Medical Officer

Information and questions about quality of care or appeals?
Contact Kepro at 888-305-6759

Complaints or concerns about Kepro's work?
Let CMS know at QIOCONCERNS@cms.hhs.gov

5201 W. Kennedy Blvd., Suite 900 · Tampa, FL 33609
Phone: 888-305-6759 · Fax: 844-878-7921 · www.Keproqio.com

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Kepro

5/9/2024

Case ID: 20240508_855_
MA Organization Name: Kaiser Permanente
Provider Name: The Oaks At Timberline
Provider ID: 505206
Patient Name: Claimant A
Patient MBI/HIC#: 1VQ9R64GP32
Admission Date: 4/8/2024 - 5/12/2024
Physician Name: Dr Craig Riley

Dear Claimant A:

Kepro is the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) approved by the Medicare program to review skilled services for Medicare patients in this state. The process includes a medical record review from an independent, actively-practicing doctor (physician reviewer). This Kepro physician decides if services meet acceptable standards of care, are medically necessary, and are provided in the most appropriate setting.

You requested an immediate appeal of your Medicare Advantage (MA) plan's decision to end skilled services provided by The Oaks At Timberline. Based on a review of your medical record and the information provided, the Kepro physician has determined that the MA plan's decision was medically appropriate.

According to the independent physician's review of the medical record and the Medicare Benefit Policy Manual, the ending of skilled services is appropriate as noted below.

Your need for skilled services has been reviewed, and it was noted that:

You have been in a skilled nursing facility (SNF) because of functional decline after discharge from an acute care hospitalization where he was treated for a fall that caused a fracture of the epiphysis of his left femur. Before your time in the SNF, you lived with others.

A physician reviewed your medical records. The physician looks at multiple activities to determine your ability to move around. The information about a few of your important movement activities is listed below.

Before your stay at the SNF:

- You could move from the bed to a chair independently, meaning you needed no help from others. You needed a cane to help you to move.
- You were able to walk approximately 10 feet. You needed a cane to help you to walk. You were able to walk independently, meaning you needed no help from others.

- You were not using a wheelchair. Because you were not using a wheelchair before, there is no information about assistance needed with wheelchair use.

According to the most recent therapy notes in your medical record:

- You can move from the bed to a chair with contact guard assistance, meaning someone should place a hand on you to help if needed. You need a walker to help you to move.
- You are able to walk greater than 100 feet. You need a walker to help you to walk. You are able to walk with contact guard assistance, meaning someone should place a hand on you to help if needed.
- You are not using a wheelchair. Information about the amount of help that you need to use a wheelchair was not found in the medical record.

According to the most recent nursing and/or physician notes:

- You do not have any signs or symptoms that need to be watched and/or treated seven days a week.

The plan once you leave the SNF is to go home with your family and or caregivers.

You may still need skilled services, but you no longer need therapy five days a week and/or nursing care seven days a week. Getting therapy or nursing care less often should not cause your health or ability to move to worsen. Kepro agrees with the Notice of Medicare Non-Coverage. Medicare probably will not pay for continued care in the skilled nursing facility.

Based on this documentation, the Kepro physician has determined that a different level of care would be appropriate.

You were notified by telephone on 5/9/2024, at 2:37:54 PM of the determination that the decision made by the MA plan to terminate skilled services was correct. Beginning 5/13/2024, Medicare will no longer pay for the skilled services. If you decide to remain in The Oaks At Timberline beginning 5/13/2024, you must pay for all costs of services except those covered by Medicare Part B.

Medicare will help pay for medically necessary and appropriate medical care or services, but please be aware that you may have to pay for denied services occurring in the future that involve reasonably comparable conditions.

If you disagree with this decision, you may ask Kepro to reconsider the decision to uphold your MA plan's ending of covered services. Your request may be made by telephone or in writing no later than **60 calendar days** from the date of this notice.

cc: MA Organization Name: Kaiser Permanente
Provider: The Oaks At Timberline

This document (letter) contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

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Kepro

You have the right to review the complete medical record and other information that we used to make the decision about the medical necessity of your care. The provider is responsible for keeping the official medical record of the care received, but we can provide a copy at a reasonable cost. Kepro will tell you the cost for a medical record copy. We must receive your payment before we can send the record.

We would also like to make you aware of a feature on our website that allows you to check the status of your appeal (www.Keproqio.com/casestatus) if you are in need of our services in the future.

Sincerely,

Jessica Whitley, MD, MBA
Chief Medical Officer

Information and questions about quality of care or appeals?
Contact Kepro at 888-305-6759

Complaints or concerns about Kepro's work?
Let CMS know at QIOCONCERNS@cms.hhs.gov

Resident Service Plan
Clearwater Springs

Pre-Admission Evaluation on 5/1/2024 | Next Evaluation Due Date: 5/31/2024 | Moved-In: 5/10/2024

Resident: Claimant A | Apartment #: 0 | Care Type: ALF

Life History

Service Needs	Service Notes	Resp. Party
Resident Date of Birth	03/16/1941	
What was the Residents Occupation (Duties and Position(s) Held):	Claimant A was a police officer.	
Who were former employers of the Resident (# of Years):	30 years in law enforcement	
Is the Resident currently Married or been Married in the past?	Current	
Is spouse living?	Yes	
Does the Resident have Biological/Step or Adopted Children?	Yes -Biological	

Cognitive Impairment/Dementia

Service Needs	Service Notes	Resp. Party
Does Resident have Cognitive Impairment/Dementia Diagnosis?	No	

General Information

Service Needs	Service Notes	Resp. Party
What is the Resident's Primany Language	English	
How does the Resident currently identify their gender to self and/or others?	Male	
Where was Resident living prior to moving into current location?	Resident was at rehab.	
What is the name of the previous place of residency?	Oaks at Timberline	
Does Resident have family and/or close friends that are involved in care or visit frequently?	Yes	

Mobility

Service Needs	Service Notes	Resp. Party
Does Resident require full staff assistance with will all the task segments or for the duration of the task? (For escort for the total duration around community by staff with or without a mobility device (wheelchair/walker, cane). Additionally, the Resident may require full assistance with completing mobility tasks such as bed mobility and repositioning.)	Resident in one person assist at this time. Resident will use wheelchair in room. Staff to walk to meals with gait belt and other staff member having wheelchair behind.	Caregiver
Does the Resident have a history of falls with injury prior to admission?	Resident fell off ladder resulting in left hip fracture.	
Did the fall(s) result in Significant injury (Fracture or Required ER/Hospitalization from injury)?	Yes	

Transfers

Service Needs	Service Notes	Resp. Party
Does Resident require full staff assistance with will all of the task segments or for the duration of the task? (For example: transfers to/from chair and bed. Resident is able to move or step feet for pivot with staff assistance. Resident may benefit from a sit-to-stand lift (one team member, this does include on/off toilet and in/out of shower).	Resident is one person assist with transfers at this time. Staff to cue resident "nose over toes" before transferring and remind to push up off wheelchair. Resident tends to grab walker to try to push on to stand.	Caregiver

Dressing

Service Needs	Service Notes	Resp. Party
Does Resident require full staff assistance with all of the task segments or for the duration of the task? (For example: for putting on/ taking off clothes, undergarments, socks, and shoes).	Resident able to dress upper body. Staff to assist with lower body dressing.	Caregiver
Does Resident requires assistance with putting on and/or removing shoes/socks:	Yes	Caregiver
Does Resident requires assistance with fastening, buttoning, snapping or tying clothing or undergarments?	No	Caregiver
Does Resident require assistance with dressing and/or undressing upper body?	No	Caregiver
Does Resident require assistance with dressing and/or undressing lower body?	Yes	Caregiver

Grooming

Service Needs	Service Notes	Resp. Party
Is Resident able to complete all grooming tasks independently without hands-on help or reminders from staff to include but not limited to brushing hair and teeth, shaving, applying makeup.	Yes-Independent	Caregiver
Nail Care (Non-Diabetic, Diabetic, Podiatry Visits, Manicure/Pediure)	Non-Diabetic	Caregiver

Bathing

Service Needs	Service Notes	Resp. Party
Does Resident require full staff assistance with all of the task segments or for the duration of the task? (For example (For example once in the shower, washing body and hair, drying off, applying lotion). Staff must be present during the entire shower for safety purposes.	Yes-Full_Assist	Caregiver
Does Resident have a preferred bathing method such as a whirlpool/tub bath/shower/bed bath/sponge bath?	Shower	Caregiver
Does Resident have time of day they prefer to bathe?	No	Caregiver

Toileting

Service Needs	Service Notes	Resp. Party
Does Resident require full staff assistance with will all of the task segments or for the duration of the task? (For example: hands-on assistance with perineal and personal care (hand hygiene (associated with toileting), changing and removal of incontinent product). This includes the need for staff presence during toileting for safety purposes. Routine assistance with indwelling catheter to be included here.	Yes-Full_Assist	Caregiver

Bladder Continence

Service Needs	Service Notes	Resp. Party
What is the Resident's current level of bladder continency?	Occasionally_Incontinent(2_or_More Episodes/Week_But_Not Daily)	

Bowel Continence

Service Needs	Service Notes	Resp. Party
What is the Resident's current level of bowel continency?	Continent(0_Episodes_of_Incontinency)	Caregiver

Dining

Service Needs	Service Notes	Resp. Party
Is Resident able to complete all tasks related to dining without hands-on help or reminders from the staff? (For example: find dining room at correct time and make all meal choices. Additionally, the Resident is able to complete meal prep with items such as opening packages, cutting food, etc.)	Yes-Independent	Caregiver

Diet and Nutrition

Service Needs	Service Notes	Resp. Party
Does Resident have any specific food preferences (Likes)	Claimant A has a sweet tooth. Likes fried potatoes, apple fritters.	Caregiver

Redirection

Service Needs	Service Notes	Resp. Party
Resident requires no redirection. Is Resident aware of time of day, location of his/her apartment, activities without reminders or hands-on help. Resident exhibits socially appropriate interactions with other residents and staff activities, bedtime without reminders or hands on help.	Yes-Independent	Caregiver

MOOD/BEHAVIOR/THOUGHT DISORDER

Service Needs	Service Notes	Resp. Party

Does Resident have any Depression/Thought Disorders/Behavior or Mood Problems such as: tearfulness, voicing being sad, Withdrawal from activities of previous interest, anger or aggressive outburst at staff or other residents, acts of harm toward self, refusal to eat or drink, eating non-stop or increased snacking, excessive sleeping, not sleeping or up at unusual hours of night, other noted changes in mood or behavior?	Claimant A has PTSD from career as a police officer. Staff to approach always from the front. Staff to make sure presence known by resident before entering room. If resident mumbling or grimacing. Staff to ask resident what is wrong. Resident able to determine if his PTSD is triggered or he is in pain.	

Sleep

Service Needs	Service Notes	Resp. Party
Is the Resident currently taking any Medications or Herbal/Homeopathic Supplements for sleep?	No	Caregiver

Medications

Service Needs	Service Notes	Resp. Party
Does Resident require enhanced care services due to the complexity and/or frequency of the medication regimen and/or administration techniques. The regimen may consist of medications that require staff that are administering the medications to have specialized training or skills to provide the proper oversight of the medication and observation of the resident. This could be based on the number of medications, the route of the medication is administered, Complexity of medications examples may consist of but not limited to medications that have physician ordered parameters for administration, Medications with lab and notification requirements associated. Additional medications or conditions that would be considered enhanced care services may include Insulin Dependent Diabetics, Anti-coagulants, Anti-hypertensives with v/s orders, other delegated injections to unlicensed staff in states this allowed under the regulations.	Yes-Enhanced_Care	Medication Tech
Does the Resident utilize the communities preferred pharmacy?	Yes	
Does Resident wish to Self-Administer Medications?	If No, Next 6 questions should not be answered.	
Is the Resident able to self-administer medications?	Document Justification for decision.	

Psychotropic Drugs

Service Needs	Service Notes	Resp. Party
Is the Resident currently receiving Antidepressant medication(s)?	Duloxetine 30mg. Med prescribed to treat nerve pain.	Medication Tech

Antidepressants

Service Needs	Service Notes	Resp. Party
What is the expected outcomes from the use of this medication?	Relief from hereditary and idiopathic neuropathy.	

Other Medications

Service Needs	Service Notes	Resp. Party

Is the Resident receiving any Anti-hypertensive Medications?	Metoprolol 50mg once a day; Losartan 12.5mg once a day	Medication Tech

NON-ORAL ROUTES

Service Needs	Service Notes	Resp. Party
Does Resident receive medications via any non-oral routes?	Yes	Medication Tech
Does the Resident receive Cutaneous (cream, ointment, lotion, solution, powder or gel) medications?	Voltaren Gel every 4 hours as needed for pain. Miralax 17 gram as needed if no BM in 3 days.	Medication Tech
Does the Resident receive Transdermal patches?	Lidocaine Patch every 12 hours as needed for pain	Medication Tech

Pain Management

Service Needs	Service Notes	Resp. Party
Is the Resident receiving medication analgesic (pain) medications?	Yes	Medication Tech
Does Resident have physician orders for Nonopioid medications(examples: Tylenol, Ibuprofen, Naproxen)?	Tylenol-SEE MAR	Medication Tech
Does Resident have physician orders for Opioid medications : (examples: Morphine, Oxycodone, Fentanyl, other Narcotics)?	Oxycodone 5mg every 4 hours as needed for severe pain.	Medication Tech
Where does the Resident indicate the pain is located?	Claimant A has chronic back pain	Caregiver
How Does Resident Express Pain (verbally or non-verbally)?	Claimant A is able to verbalize pain and the severity of pain.	Caregiver

AntiCoagulation Therapy

Service Needs	Service Notes	Resp. Party
Is Resident receiving any Anticoagulation Medication(s)?	Apixaban	Medication Tech
Are Residents Labs monitored Routinely?	No	Medication Tech

Nursing Assessment

Service Needs	Service Notes	Resp. Party
Is Resident currently receiving services from any outside providers such as: Dialysis/Therapy/Home Health/Hospice/MCO (PACE/HCBS/Medicaid Caseworker)/ISNP/IESNP Plans	Home Health PT/OT	Caregiver
Name of Residents Primary Care Physician:	Mike Lin Kaiser Permanente Phone: 813-2000 Fax: 503-571-2624	

Hearing

Service Needs	Service Notes	Resp. Party
Hearing: Does the Resident have a Hearing Aide?	Yes	Caregiver
Hearing: Does the Resident use the Hearing Aide?	Yes	Caregiver

Hearing: Is the Resident able to hear adequately with or without the use of a hearing aide to include: normal talk, TV, phone without difficulty?	Claimant A has only ten percent of his hearing. Staff to face Claimant A and speak slowly. Using gestures helps as well.	Caregiver

Vision: Ability to see in adequate light (with glasses, contacts, etc.):

Service Needs	Service Notes	Resp. Party
Vision: Ability to see in adequate light (with glasses, contacts, etc.): Does the Resident wear corrective lens/eye wear?	Claimant A wears reading glasses.	Caregiver

General Skin Condition

Service Needs	Service Notes	Resp. Party
General Skin Condition: Does the Resident have any open areas on skin to include: Pressure wounds, Diabetic wounds, Vascular Wounds, Other Skin Conditions?	No	Medication - Licensed Nurse

REVIEW OF RESIDENT HEALTH STATUS SINCE LAST EVALUATION

Service Needs	Service Notes	Resp. Party
Has the Resident had any changes to their medication regiment since the last evaluation to include but not limited the following classes of drugs : Antipsychotics, Antidepressants, Anti-anxieties, Hypnotics, Blood Pressure Medications, Pain Medications, etc?	No	Medication - Licensed Nurse
Hospitalization	Claimant A was hospitalized when he fractured his femur.	Medication - Licensed Nurse

Acknowledgement and Acceptance

Agreement

This document reflects the agreement of the parties regarding the needs of Resident, regarding who will be responsible for providing the services to fill those needs, and regarding payment for services to be provided by Community. The parties enter into this agreement for services to be provided to Resident by Community or to be provided by Resident for themselves. All parties acknowledge that the needs identified above are to be fulfilled by the Resident, either directly or indirectly through arrangements made by the Resident, unless Community agrees herein to provide services to meet the identified need. Resident understands and acknowledges that independently providing services needed can entail risks, including serious health risks. Resident agrees to release and hold Community harmless against any claims or harm suffered by Resident's decision to provide for the identified needs either directly by Resident or indirectly by arrangements made with anyone other than Community. This is a release. Resident understands and agrees that the Community will charge for the services it agrees to provide, until both parties mutually agree otherwise pursuant to a new Service Agreement.
Resident agrees to pay for the services indicated above to be provided by Community. Resident agrees to comply with the terms of this Services Agreement, and to provide prompt, timely, and effective services either directly or through others to meet those needs which are not to be met through Community services. A breach of this Services Agreement may be grounds for declaring a default under the Servcies Agreement and the lease agreement.

Community Staff: _____ (Print Name) Signature: _____ Date: _____

Community Staff: _____ (Print Name) Signature: _____ Date: _____

Resident: _____ (Print Name) Signature: _____ Date: _____

Family Member: _____ (Print Name) Signature: _____ Date: _____

Responsible Party: _____ (Print Name) Signature: _____ Date: _____

Other Provider: _____ (Print Name) Signature: _____ Date: _____

Trant, Caylee

From:
Sent: Friday, May 3, 2024 3:29 PM
To: Trant, Caylee
Subject: Fwd: Requested Care Plan
Attachments: WWEP.pdf; WWCP.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Hi Caylee

Attached is both the Care Plan & Evaluation Plan from the Clearwater Springs Assisted Living.

Care Plan: Level 4, Cost $2400 a month.
Plus Rent: $2900 a month.

Please let me know if you need anything else from them.

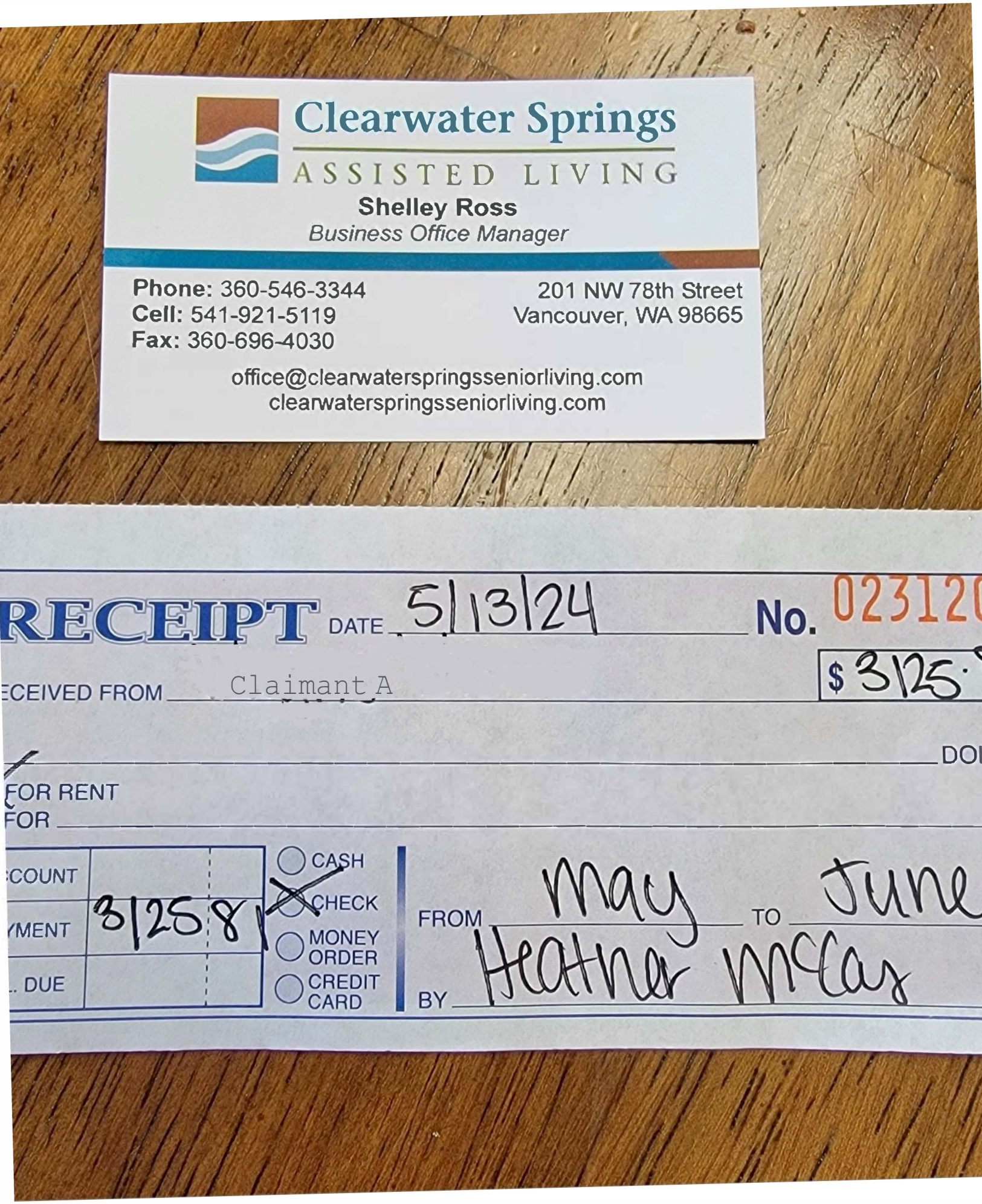
Thx,
Sent from my iPhone

Begin forwarded message:

> **From:** Clearwater Springs RCC <RCC@clearwaterspringsseniorliving.com>
> **Date:** May 3, 2024 at 11:26:51 PDT
> **To:**
> **Subject: Requested Care Plan**
>
> I have attached your dad's care plan and Eval Plan which breaks down points of care at the end of report. I tried everything to get his points down. He is very close to being level three. His points are at 248. Once he gets down to 225 he will qualify for Level 3. I feel that after a month and his 30 day review he will have improved enough that we can change to a level 3 at that point. Please let me know if you have any more questions. It was a pleasure getting to know you and your dad and all his comedic quirks.
>
> Level 4 Cost-$2,400

Heather McCoy
Resident Care Coordinator
Clearwater Springs Assisted Living
RCC@clearwaterspringsseniorliving.com

Cell: 360-947-1445
Tel: 360-546-3344
201 NW 78th St. Vancouver, WA 98665



Clearwater Springs
ASSISTED LIVING

Shelley Ross
Business Office Manager

Phone: 360-546-3344
Cell: 541-921-5119
Fax: 360-696-4030

201 NW 78th Street
Vancouver, WA 98665

office@clearwaterspringssenior living.com
clearwaterspringsseniorliving.com

RECEIPT DATE 5/13/24 No. 023120

RECEIVED FROM Claimant A $ 3125.

DOL

FOR RENT
FOR

COUNT	
YMENT	3125
. DUE	

○ CASH
○ CHECK
○ MONEY ORDER
○ CREDIT CARD

FROM May TO June

BY Heather McCas