AUTHORIZATION FOR RELEASE OF MEDICAL REPORTS AND RECORDS AND HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

SSN: _____

To Whom It May Concern:

You are hereby authorized to furnish to:

Pierce County
LEOFF 1 Disability Board
950 Fawcett Ave, Suite 200
Tacoma, WA 98402
(253) 798-2727

any reports or information whatsoever they may be requesting regarding the medical history and physical condition of and treatment rendered to me, and if requested, to permit them, or any person appointed by them, to examine any and all x-ray pictures or records regarding said physical condition or treatment rendered. I understand that my consent is given only for the purpose of establishing my right to benefits provided under the LEOFF 1 Retirement System. A photocopy of this authorization may serve as an original.

_____ _____
(Signature) (Date)

_____ _____
(Witness) (Date)

PIERCE COUNTY LEOFF 1 DISABILITY BOARD
SKILLED NURSING FACILITY CARE REIMBURSEMENT POLICY
FOR LEOFF 1 MEMBERS

1. The Pierce County LEOFF 1 Disability Board shall provide approval for reimbursement for the reasonable expenses incurred by a LEOFF 1 member needing the services of a skilled nursing facility.

   Expenses which shall be approved for reimbursement may include:

   a. An amount not to exceed the average rate* charged by skilled nursing facilities for semi-private room and board. This rate shall be reviewed on a semi-annual basis at the April and October meetings. A survey of nursing home rates shall be made on skilled nursing facilities in Pierce County. A survey of nursing home policies shall also be made of the Disability Boards of other counties in Washington State. Upon receiving the survey results, the Board shall review and act to update the reasonable reimbursement rate.

      For members residing outside Pierce County, the maximum approved reimbursement shall be an amount not greater than the current Board approved rate.

   b. The semi-private room and board rate plus the “level of care” charge, where charged separately by a skilled nursing facility, so long as the total does not exceed the Board allowed rate.

   c. Charges for medically necessary physician prescribed medications, medical services (i.e., x-rays), and other medically necessary physician prescribed supplies. Regence, or other available insurance, participating pharmacies are to be used whenever possible.

2. Members shall be encouraged to use the services and facilities of participating providers through their medical insurance carrier. Use of a participating provider facility is not mandatory.

3. Non-medical charges, including but not limited to, hair care, personal toiletries and sundries, bed holds, and recreational events organized by the skilled nursing facility shall not be approved for reimbursement.

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* 2013 rate:
Semi-private - $ 268.00 per day, plus applicable taxes

4. Before any skilled nursing facility charges may be approved for reimbursement, the Board must be provided with a letter from the member's attending physician stating medical necessity for and estimated duration of skilled nursing facility care. The question of medical necessity for skilled nursing facility care shall be subject to annual, or more frequent, review by the Board.

5. The Board may approve a reduction in the amount of reimbursement for skilled nursing facility care by the amount received from another source as reimbursement for the services, (i.e., Medicare, Medicaid, or other insurance).

6. All charges must be submitted to Regence BlueShield (or employer provided insurance carrier), Medicare, and any other available insurance before submission to the Board. (Note: The present Regence Blue Shield plan provides for payment of up to 90 days skilled nursing facility care per year. Therefore, each January, members may be required to submit nursing home care charges to Regence, or other available insurance.)

7. The Board shall only approve reimbursement for services rendered by the skilled nursing care facility.

8. The Board shall approve reimbursement to the member, or payment to the member and the agency, for services rendered.

MEDICAL REQUEST FOR SKILLED NURSING FACILITY CARE

Pierce County
LEOFF 1 Disability Board
950 Fawcett Ave, Suite 200
Tacoma, WA 98402
(253) 798-2727

Medical Report for: _____

(To be completed by MD only. Please type or print clearly.)

1. Name, address, and phone number of attending physician:

   _____

   _____

   _____

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

   _____

   _____

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

   _____

   _____

   _____

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

   _____

   _____

   _____

   _____

5. Skilled nursing facility care is necessary due to the diagnosis in item #4:
   _____ Yes ____ No

6. Is the patient **<u>able to perform</u>** the following Activities of Daily Living (ADL's):

Bathing	____ Yes	____ No
Dressing	____ Yes	____ No
Feeding	____ Yes	____ No
Toileting	____ Yes	____ No
Transferring	____ Yes	____ No
Continence	____ Yes	____ No
Cognitive Impairment	____ Yes	____ No
Other	____ Yes	____ No

(Describe other, i.e., self-medicate, etc.)

_____

_____

7. The following are my opinions on the specific medical and other assistance this patient needs:

_____

_____

_____

_____

8. The following is my opinion regarding the estimated length of time this patient will require skilled nursing facility care:

_____

9. I have also met, or spoken with, the following individuals regarding this patient:

_____

_____

Date of completion of form: _____

Signature: _____

Typed or printed name: _____

PIERCE COUNTY LEOFF 1 DISABILITY BOARD
HOME HEALTH CARE REIMBURSEMENT POLICY
FOR LEOFF 1 MEMBER

The Pierce County LEOFF 1 Disability Board may provide approval of reimbursement for the reasonable expenses incurred by a LEOFF 1 member needing the services of home health care.

1. Before any home health care charges may be approved for reimbursement, the Board must be provided with a "Medical Request For Home Health Care" form filled out by the member's attending physician. The physician shall state the medical necessity and the estimated length of time during which home health care will be required and the type of care required (medical, daily living, and/or other). This form may be obtained from the Pierce County LEOFF 1 Disability Board office. The attending physician must provide to the Board a description of the work to be performed by the home health care provider. This description is to be as detailed as possible. The question of medical necessity for home health care shall be subject to annual, or more frequent, review by the Board.

2. The Board will allow an average rate* per day. This amount is determined by assessing skilled nursing care facilities. Any amount over the current amount allowed by the Board must be the responsibility of the LEOFF 1 member.

3. The total amount allowed shall not exceed the current Board allowed rate for skilled nursing facility care as provided for in the Skilled Nursing Facility Care Reimbursement Policy.

4. All charges must be submitted to Medicare, Regence Blue Shield, and any other available insurance before submission to the Board.

5. The Board shall approve reimbursement to the member, or payment to the member and the agency, for services rendered.

6. The Board reserves the right to have an assessment agency evaluate the member's home health care needs.

7. The Board will not approve reimbursement for home health care provided by an individual who ordinarily resides in the member's home or is a member of the family of either the member or the member's spouse. The Board will only approve reimbursement for home health care provided by a certified provider or agency.

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* 2013 rate:
Semi-private - $ 268.00 per day, plus applicable taxes

MEDICAL REQUEST FOR HOME HEALTH CARE

Pierce County
LEOFF 1 Disability Board
950 Fawcett Ave, Suite 200
Tacoma, WA 98402
(253) 798-2727

Medical Report for: _____

(To be completed by MD only. Please type or print clearly.)

1. Name, address, and phone number of attending physician:

   _____

   _____

   _____

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

   _____

   _____

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

   _____

   _____

   _____

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

   _____

   _____

   _____

   _____

5. Home health care is necessary due to the diagnosis in item #4:
   _____ Yes ____ No

6. Is the patient **<u>able to perform</u>** the following Activities of Daily Living (ADL's):

Bathing	____ Yes	____ No
Dressing	____ Yes	____ No
Feeding	____ Yes	____ No
Toileting	____ Yes	____ No
Transferring	____ Yes	____ No
Continence	____ Yes	____ No
Cognitive Impairment	____ Yes	____ No
Other	____ Yes	____ No

(Describe other, i.e., self-medicate, etc.)

_____

_____

7. The following are my opinions on the specific medical and other assistance this patient needs:

_____

_____

_____

8. The following are my recommendations as to the specific number of hours and days per week the paid services of a caregiver are required:

_____

9. The following is my opinion regarding the estimated length of time this patient will require home health care:

_____

10. I have also met, or spoken with, the following individuals regarding this patient:

_____

_____

Date of completion of form: _____

Signature: _____

Typed or printed name: _____