

## Whitman County LEOFF I Board Policy

### Appendix “C”

#### Forms

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**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

**LEOFF I MEMBER**  
**EMPLOYEE'S STATEMENT**

**Please check one:**

- Application for Disability Retirement  
 Application for Disability Leave

Delay in filing statement could result in a shorter disability leave period. Submit this form immediately to the Clerk of the LEOFF I Board, c/o Whitman County Commissioners' Office, 400 N Main Street, Colfax, WA 99111.

**SECTION I:**

Date of Application: \_\_\_\_\_ Date of Hire: \_\_\_\_\_  
Name: \_\_\_\_\_ SSN#: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Position: \_\_\_\_\_ Employer: \_\_\_\_\_

**TO THE WHITMAN COUNTY LEOFF I BOARD:**

In accordance with the provisions of RCW 41.26.120 and/or 41.26.125 and because of physical or mental disability, I hereby apply for retirement from active service as an employee under the Washington Law Enforcement Officers' and Fire Fighters' Retirement System.

**CLAIM INFORMATION**

1. First day of employer's sick leave benefit: \_\_\_\_\_
2. Last day of sick leave: \_\_\_\_\_
3. First day of disability leave: \_\_\_\_\_
4. Last day of disability leave: \_\_\_\_\_

I understand that the dates I have requested above are subject to approval by the LEOFF I BOARD. (Please initial: \_\_\_\_\_).

**SECTION II: (circle one on each line)**

This disability (was, was not) incurred in the line of duty.  
This disability (was, was not) incurred while in other employment.  
This disability (was, was not) incurred through dissipation or abuse.

**SECTION III:**

I herewith submit statements by my physician with respect to my disability. I hereby consent to examination by the Whitman County LEOFF I Board's physician, or any other physicians as the Board may so require.

The information contained herein is true and complete to the best of my knowledge and belief.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
**WCLIB #1**

**WHITMAN COUNTY LEOFF I BOARD**  
**LEOFF I MEMBER**  
**EMPLOYER'S STATEMENT AND REPORT ON**  
**APPLICATION FOR DISABILITY RETIREMENT**

**SECTION I:**

This is to certify that \_\_\_\_\_ Social Security Number \_\_\_\_\_ a member of the Washington Law Enforcement Officers' and Fire Fighters' Retirement System, was an employee of \_\_\_\_\_ and said member's last day of active service was \_\_\_\_\_.

**SECTION II:**

A. Describe employee's position and duties:

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B. In your opinion, is the employee incapacitated for performance of duty: Yes \_\_\_\_\_ No \_\_\_\_\_

C. Give nature of incapacity to the best of your knowledge (Please elaborate):

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D. Was the disability claim sustained as the result of an accident occurring in the actual performance of duty, while in the employ of your agency: Yes \_\_\_\_\_ No \_\_\_\_\_

E. If the answer to "D" above is "Yes", please supply the following information:

1. Date of accident \_\_\_\_\_
2. Place of accident \_\_\_\_\_
3. Give full details (description and result of accident):

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4. Witnesses: \_\_\_\_\_

**SECTION III:**

I hereby certify that the above is true and correct information as regards to this employee and is complete to the best of my knowledge and belief.

Signature: \_\_\_\_\_

Dated: \_\_\_\_\_

**WHITMAN COUNTY LEOFF I BOARD  
LEOFF I MEMBER  
DISABILITY APPLICATION  
LIST OF HEALTH CARE PROVIDERS**

Please list the physicians and therapists who have treated you regarding the condition for which you are filing for disability benefits:

Employee' Name: \_\_\_\_\_  
Health Care Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

SSN#: \_\_\_\_\_  
Date treatment began: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Treatment provided: \_\_\_\_\_

\*\*\*\*\*

Employee' Name: \_\_\_\_\_  
Health Care Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

SSN#: \_\_\_\_\_  
Date treatment began: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Treatment provided: \_\_\_\_\_

\*\*\*\*\*

Employee' Name: \_\_\_\_\_  
Health Care Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

SSN#: \_\_\_\_\_  
Date treatment began: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Treatment provided: \_\_\_\_\_

\*\*\*\*\*

Employee' Name: \_\_\_\_\_  
Health Care Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

SSN#: \_\_\_\_\_  
Date treatment began: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Treatment provided: \_\_\_\_\_

\*\*\*\*\*

Employee' Name: \_\_\_\_\_  
Health Care Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

SSN#: \_\_\_\_\_  
Date treatment began: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Treatment provided: \_\_\_\_\_

\*\*\*\*\*

\_\_\_\_ Additional sheet attached.

I hereby authorize my health care provider, at my cost, to supply the LEOFF I Board with any information they may request regarding my disability. My consent is given only for the purpose of establishing my right to disability benefits.

Employee's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

**HEALTH CARE PROVIDER'S STATEMENT**

(To be completed by physician or primary health care provider during the first or second appointment.) It is the sole responsibility of the employee to turn the form into the LEOFF I Board.

PATIENT: \_\_\_\_\_ SSN: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ INSURANCE/HMO: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

Has insurance been billed by your office?      Yes \_\_\_\_\_      No \_\_\_\_\_

PROVIDER: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_      PHONE: \_\_\_\_\_

Diagnosis: I have examined and treated the above-named LEOFF 1 member/claimant for the following medical condition(s):

\_\_\_\_\_

Etiology: The cause of the condition is:

\_\_\_\_\_

Treatment: I have prescribed or performed the following treatment on the dates indicated. (Note: For mental health, chiropractic and substance abuse treatment exceeding one month, a treatment plan MUST be submitted. Attach WCL1B #5, "Health Care Provider Treatment Plan".)

\_\_\_\_\_

**\*\*Physician please answer the following:**

1. Is patient able to perform his duties of \_\_\_\_\_ with average efficiency?

\_\_\_\_\_ I have received a copy of the job functions.

2. In your opinion, is disability duty or non-duty related? Please elaborate.

\_\_\_\_\_

3. According to medical evidence, will the disability be permanent? Please elaborate.

\_\_\_\_\_

The services rendered by me and the medication, appliances or other therapies, which I prescribed, were necessary medical services in view of the patient's diagnosis and condition.

Signature of Provider: \_\_\_\_\_ Date: \_\_\_\_\_

**WCLIB #4**

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

**HEALTH CARE PROVIDER'S TREATMENT PLAN**

This form to be completed by providers of mental health, chiropractic and substance abuse treatment exceeding one month or in the case of additional medical services continuing more than two (2) visits for the same condition. To be mailed directly to member's employer/employer retired from within two weeks of initiation of treatment.

Patient: \_\_\_\_\_ SSN: \_\_\_\_\_  
Employer/Retired from: \_\_\_\_\_ Physician/Provider: \_\_\_\_\_  
Physician/Provider's Address: \_\_\_\_\_

The treatment plan needs to be designed as an **individualized** plan to meet the unique treatment requirement of the patient while including, but not limited to, the categories suggested below. Please feel free to attach additional sheets as necessary.

**Diagnosis:**

Current medical diagnostic information (for mental health condition DSM III-R 5 digit code plus other axes involved and any relationship to the condition).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Significant History:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Prescribed Medication:**

(Dosage, frequency, side effects, estimated length of treatment).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Description of Treatment or Therapy:**

(Treatment modality, frequency, length of treatment session, estimation of duration, approximate recovery time, criteria indication progress, additional professionals/therapists providing supplemental or alternative treatment services).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ I have attached an additional sheet.

The services rendered by me and the medication, appliances or other therapies, which I prescribed, were necessary medical services in view of the patient's diagnosis and condition.

Signature of Provider: \_\_\_\_\_ Date: \_\_\_\_\_

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

**MEDICAL EXPENSE CLAIM FORM**

LEOFF I MEMBER NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_  
Street City State Zip Code

DAYTIME OR MESSAGE TELEPHONE NUMBER: (\_\_\_\_) \_\_\_\_\_

Please provide the following information about this claim:

Date of Service	
Medical Care Provider	
List Service(s) Provided (attach additional sheet if necessary)	

Diagnosis (attach additional sheet if necessary)	
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Total Charges	\$
Less Amount Medicare Part A & B Paid	\$
Less Amount Medicare Part D Paid	\$
Less Amount Other Insurance(s) Paid	\$
Amount to be Paid by LEOFF I Board	\$
Who Should Check Be Made Payable To?	

Please attach a copy of the invoice and explanation of benefits showing payment from other sources. If your claim was rejected, attach a copy of the rejection notice.

I certify that these statements are correct and that the services were provided as indicated. I authorize any Provider, Plan Administrator, or Third Party Administrator to disclose any information regarding my benefit coverage that is necessary to process this claim. I attest that the injury/illness, which prompted this claim, was not a result of criminal conduct by the Member, dissipation or abuse. I authorize payment of any LEOFF I medical benefits to the physician or supplier of medical services listed on the attached invoice.\*

\_\_\_\_\_  
Member's Signature Date

**This completed form and all supporting documentation (invoices, insurance rejections, statement of benefits) should be submitted TO YOUR EMPLOYER (OR FORMER EMPLOYER IN THE CASE OF RETIREES) FOR PAYMENT.** Your employer or former employer may submit this claim to the **LEOFF I BOARD FOR REVIEW.** If you have any questions regarding the claims process, please contact your employer or the Clerk of the Whitman County LEOFF I BOARD at (509) 397-6202.

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

**MEDICAL EXPENSE CLAIMS PROCEDURE**

**INSTRUCTIONS FOR FILING A CLAIM FOR MEDICAL EXPENSES**

1. **All claims must first be submitted to Medicare and all available medical benefits plans, group policies, or prepayment plans for payment.** After the insurance(s) payment or rejection, the member must submit a Medical Expense Claim Form accompanied by itemized billings indicating the balance due after insurance coverage, explanation of benefits statements for all insurance plans, and any rejection notices to the employer for payment. **The completed Medical Claim Form will also include information regarding the type of medical services or supplies, diagnosis of the attending health care provider, and the date of service. Please note that a separate Medical Claim Form is required for each service provider.**
2. If the employer is uncertain as to whether a claim is payable under the provisions of LEOFF I and the policies of the Whitman County LEOFF I Board, the claim and accompanying employer statement may be submitted by the employer to the Board for review.
3. It is the responsibility of the member to ensure that the claim is complete before forwarding it to the employer. The employee must submit all invoices, correspondence and documentation regarding a **claim to their current/employer retired from by the third Tuesday of each month.** Any claims submitted after that date will be held until the next regular or special LEOFF I Board meeting. The Board will not review claims that are incomplete or have not been submitted to the employer for payment first.
4. All claims, except prescription drug claims must be submitted to the employer within ninety (90) days of the treatment date. Failure to comply may result in rejection of the claim.
5. Prescription drug claims shall be submitted to the employer within twelve (12) months from the date of purchase. This policy shall apply to all prescription drug claims purchased on or after January 1, 2004.
6. If a member has received or is eligible to receive payment toward a claim from any other source including Medicare, medical benefit plans, group policies, or prepayment plans, the amount of these payments from other sources will be deducted from the claim amount approved by the Board.
7. Payment of any claim approved by the Board will be made by the member's employer, or former employer in the case of retired members.
8. All medical expenses/co-pays are the member's initial responsibility to pay. Claims for necessary medical services submitted to the Board shall be reimbursed to the member in the amount approved by the Board.

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

**EMPLOYER STATEMENT**  
**REGARDING MEDICAL EXPENSE CLAIM**

LEOFF I MEMBER NAME: \_\_\_\_\_ SSN: \_\_\_\_\_  
EMPLOYER (or former employer in the case of retirees): \_\_\_\_\_  
CONTACT PERSON: \_\_\_\_\_ TITLE: \_\_\_\_\_  
The Claimant is (check one): ACTIVE DUTY \_\_\_\_\_ or RETIRED \_\_\_\_\_

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**FOR ACTIVE DUTY employees, please complete the following:**

Date Hired: \_\_\_\_\_ Currently on Disability Leave? \_\_\_\_\_ If yes, date leave began: \_\_\_\_\_  
To your knowledge, is this claim related to the disabling condition for which leave was taken? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please comment: \_\_\_\_\_

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To the best of my knowledge and information, the injury/illness, which prompted this claim, (circle one) **was / was not** incurred on the job and/or in the line of duty. Please attach all pertinent information such as reports and investigation results indicating the situation and circumstances surrounding the incident.

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**FOR RETIRED employees, please complete the following:**

Date Retired: \_\_\_\_\_ Service Retirement? \_\_\_\_\_ Disability Retirement? \_\_\_\_\_

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**FOR ALL CLAIMS, please respond to the following:**

Date claim was received: \_\_\_\_\_  
Do you have any reason to believe that the injury/illness, which prompted this claim, was the result of criminal conduct, dissipation, or abuse on the part of the member? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

I attest that the attached billing and related documentation has been reviewed for accuracy and completeness, and to the best of my knowledge this is a valid claim for necessary medical services for submission to the Whitman County LEOFF I Board.

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Signature of Employer Representative

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Date

**Please return the completed statement, claim, and all supporting documentation to:**

Whitman County LEOFF I Board, 400 N Main Street, Colfax, WA 99111. Claims must be received by the fourth Tuesday of each month. Any claims submitted after that date will be held until the next regular or special LEOFF I Board meeting. If you have any questions regarding the claims form or procedures, please contact your employer or the Clerk of the Whitman County LEOFF I Board at (509) 397-6202.

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

**MEDICAL REQUEST FOR HOME HEALTH CARE**

This form to be completed by the LEOFF I member's health care provider and mailed directly to member's employer/employer retired from prior to the commencement of any home health care.

Patient: \_\_\_\_\_ Patient's SSN: \_\_\_\_\_  
Employer/Retired from: \_\_\_\_\_  
Health Care Provider: \_\_\_\_\_  
Health Care Provider Address: \_\_\_\_\_  
Health Care Provider Phone: \_\_\_\_\_

**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).**

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**Provide the Board with a description of work to be performed by the home health care provider. This description is to be as detailed as possible.**

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\_\_\_\_\_  
Signature of Member's Health Care Provider

\_\_\_\_\_  
Date

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

DATE:

TO: LEOFF I RETIREE

FROM: LEOFF I BOARD

RE: \_\_\_\_\_ PRESCRIPTION REIMBURSEMENT  
\_\_\_\_\_ MEDICAL REIMBURSEMENT  
\_\_\_\_\_ PAYMENT OF MEDICAL SERVICES  
\_\_\_\_\_ REQUEST FOR MEDICAL SERVICES  
\_\_\_\_\_ REQUEST FOR MEDICAL EQUIPMENT  
\_\_\_\_\_ MEDICARE PREMIUM  
\_\_\_\_\_ OTHER

Dear Retiree:

The Whitman County LEOFF I Board has considered your request for \_\_\_\_\_.

Your request has been:

\_\_\_\_\_ **Approved**

\_\_\_\_\_ **Pending**

\_\_\_\_\_ **Rejected based on** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This action was taken by the Board on \_\_\_\_\_.

In accordance with Whitman County LEOFF I BOARD policy you have 30 days from the denial of the claim/request by the Board to appeal their decision. The Board will set a date and time for reconsideration at which time you may present such evidence deemed relevant. If the Board sustains denial of the claim/request, you have the right of judicial review.

\_\_\_\_\_  
Secretary or Clerk of the LEOFF I Board

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

DATE:

TO: LEOFF I RETIREE

FROM: LEOFF I BOARD

RE: REQUEST FOR MEDICAL PAYMENT/REIMBURSEMENT

Dear Retiree:

It is very important that you or your provider submit your bills directly to Medicare and the insurance company to reduce the chance for loss, error, or additional waiting time for payments and/or reimbursements. The County will not process your medical requests for reimbursement or pay any medical claims until **you** have fulfilled these processing obligations.

**\*\*Please read carefully and follow all instructions.\*\***

**Since you are enrolled in Medicare Part B:**

1. Submit the attached medical bill to Medicare as your Primary Insurance.
2. Submit any balance(s) to other insurance company(ies) you have.
3. Submit any balance(s) to Whitman County's insurance company.
4. Submit any remaining balance(s) to:

**Retired Whitman County Members**  
ATTN: Officer Bolyard/Officer Auvil  
Whitman County Sheriff's Office  
PO Box 470  
Colfax, WA 99111

**Retired City of Colfax Members**  
ATTN: Carol Larson  
City of Colfax  
PO Box 229  
Colfax, WA 99111

**Retired City of Tekoa Members**  
ATTN: Peggy Hagan  
City of Tekoa  
PO Box 927  
Tekoa, WA 99033

Only after items #1, #2, and #3 above have been met will the LEOFF I Board review your remaining balance(s) to determine the appropriate reimbursement or payment level.

Should you have any questions, please call Maribeth Becker at (509) 397-6202.

**WCLIB #11**

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

DATE:

TO: LEOFF I RETIREE

FROM: LEOFF I BOARD

RE: REQUEST FOR MEDICAL PAYMENT/REIMBURSEMENT

Dear Retiree:

It is very important that you or your provider submit your bills directly to the insurance company to reduce the chance for loss, error, or additional waiting time for payments and/or reimbursements. The County/City will not process your medical requests for reimbursement or pay any medical claims until **you** have fulfilled these processing obligations.

**\*\*Please read carefully and follow all instructions.\*\***

**Since you are not enrolled in Medicare Part B:**

1. Submit the bill to insurances you have privately as your **Primary Insurance**.
2. Submit any balance(s) to Whitman County's insurance company as your **Secondary Insurance**.
3. Submit any remaining balance(s) and explanation of benefits (paid/rejected) to:

**Retired Whitman County Members**

ATTN: Officer Bolyard/Officer Auvil  
Whitman County Sheriff's Office  
PO Box 470  
Colfax, WA 99111

**Retired City of Colfax Members**

ATTN: Carol Larson  
City of Colfax  
PO Box 229  
Colfax, WA 99111

**Retired City of Tekoa Members**

ATTN: Peggy Hagan  
City of Tekoa  
PO Box 927  
Tekoa, WA 99033

Only after items #1 and #2 above have been met will the LEOFF I Board review your remaining balance(s) to determine the appropriate reimbursement or payment level.

Should you have any questions, please contact Maribeth Becker at (509) 397-6202.

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

**MEMBER INSURANCE COVERAGES**

This form is to be completed by the LEOFF I member annually and mailed directly to member's employer/employer member is retired from. List all sources of medical insurance coverages, i.e. Medicare, medical benefits plans, group policies, or prepayment plans.

LEOFF I Member Name: \_\_\_\_\_  
LEOFF I Member SSN: \_\_\_\_\_  
Employed By/Retired From: \_\_\_\_\_

Insurance Provider Name: \_\_\_\_\_  
Insurance Provider Address: \_\_\_\_\_  
Insurance Provider Phone: \_\_\_\_\_  
Insurance Provider Fax: \_\_\_\_\_  
Insurance Provider Email: \_\_\_\_\_  
Insurance Policy Number: \_\_\_\_\_

Insurance Provider Name: \_\_\_\_\_  
Insurance Provider Address: \_\_\_\_\_  
Insurance Provider Phone: \_\_\_\_\_  
Insurance Provider Fax: \_\_\_\_\_  
Insurance Provider Email: \_\_\_\_\_  
Insurance Policy Number: \_\_\_\_\_

Insurance Provider Name: \_\_\_\_\_  
Insurance Provider Address: \_\_\_\_\_  
Insurance Provider Phone: \_\_\_\_\_  
Insurance Provider Fax: \_\_\_\_\_  
Insurance Provider Email: \_\_\_\_\_  
Insurance Policy Number: \_\_\_\_\_

Insurance Provider Name: \_\_\_\_\_  
Insurance Provider Address: \_\_\_\_\_  
Insurance Provider Phone: \_\_\_\_\_  
Insurance Provider Fax: \_\_\_\_\_  
Insurance Provider Email: \_\_\_\_\_  
Insurance Policy Number: \_\_\_\_\_

**I certify that I have answered truthfully and have not knowingly withheld any information relative to my medical insurance coverages.**

\_\_\_\_\_  
**MEMBER NAME**  
**WCLIB #13**

\_\_\_\_\_  
**DATE**

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

DATE: \_\_\_\_\_

TO: LEOFF I and LEOFF II Active/Retired Fire Fighter Members

FROM: Maribeth Becker, Clerk  
Whitman County LEOFF I Board

RE: Self-Nomination for Fire Fighter Representative on the LEOFF I Board

The Whitman County LEOFF I (Law Enforcement Officers and Fire Fighters) Board is seeking nominations for a fire fighter representative.

Current fire fighter or emergency medical technician members of the LEOFF retirement system (LEOFF I and LEOFF II) are **eligible to nominate only themselves** to the LEOFF I Board provided they are elected by only those LEOFF I members who are subject to the jurisdiction of the Board. The individual will be elected for a two-year or unexpired term.

If you are interested in serving on the LEOFF I Board, please forward your **self-nomination** by return mail to the Whitman County LEOFF I Board, 400 N. Main Street, Colfax, WA 99111, Attn: Maribeth Becker, Clerk. Nominations will be accepted through \_\_\_\_\_. The nominees will be verified as LEOFF I or II members and a ballot will be returned to only LEOFF I members as soon as possible. LEOFF I members wishing to vote for one of the nominees appearing on the ballot will then have until \_\_\_\_\_ to return their one candidate choice to the above address.

In accordance with Whitman County LEOFF I Board Policy Section 1.05(11), "In the event that there is only one person nominated for the police or fire representative, balloting will not be required and the individual will be considered elected".

Thank you for your prompt response to this request.

Maribeth Becker, Clerk  
LEOFF I Board



**NOMINATION CERTIFICATION**

**For**

**Firefighter Representative**

**For**

**The term of January 1, \_\_\_\_\_ – December 31, \_\_\_\_\_**

Nominations opened on \_\_\_\_\_, \_\_\_\_\_ by the LEOFF I Board Chairman and Clerk as follows:

Nominee: \_\_\_\_\_

Nominee: \_\_\_\_\_

Nominee: \_\_\_\_\_

\_\_\_\_\_  
Maribeth Becker, CMC  
Clerk of the Board

\_\_\_\_\_  
Jerome "Jug" Daubert  
Chairman

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

**BALLOT**

**DATE:**

**TO: LEOFF I Retirement System Members**

**FROM: Maribeth Becker, CMC, Clerk of the LEOFF I Board**

**RE: Ballot for Firefighter Representative on the LEOFF I Board**

Please return the following ballot by \_\_\_\_\_ to:

Maribeth Becker, CMC  
Whitman County LEOFF I Board  
400 N Main Street  
Colfax, WA 99111

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**DATE BALLOT WAS VOTED:** \_\_\_\_\_

**LEOFF I DISABILITY BOARD – Firefighter Representative**

**Nominated for the position:**

\_\_\_\_\_  
Name of Nominee

\_\_\_\_\_  
Name of Nominee

**CAST YOUR BALLOT AND RETURN TO THE ABOVE ADDRESS**

**- Thank you -**

**CERTIFICATION OF ELECTION RESULTS**

**FOR WHITMAN COUNTY LEOFF I BOARD**

Term will commence January 1, \_\_\_\_\_.

**Firefighter Representative**

**Totals**

\_\_\_\_\_  
Maribeth Becker, CMC  
Clerk of the Board

\_\_\_\_\_  
Jerome "Jug" Daubert  
Chairman

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

DATE: \_\_\_\_\_

TO: LEOFF I and LEOFF II Active/Retired Law Enforcement Members

FROM: Maribeth Becker, Clerk  
Whitman County LEOFF I Board

RE: Self-Nomination for Law Enforcement Representative on the LEOFF I Board

The Whitman County LEOFF I (Law Enforcement Officers and Fire Fighters) Board is seeking nominations for a law enforcement representative.

Current law enforcement or Fish and Wildlife members of the LEOFF retirement system (LEOFF I and LEOFF II) are **eligible to nominate only themselves** to the LEOFF I Board provided they are elected by only those LEOFF I members who are subject to the jurisdiction of the Board. The individual will be elected for a two-year or unexpired term.

If you are interested in serving on the LEOFF I Board, please forward your **self-nomination** by return mail to the Whitman County LEOFF I Board, 400 N. Main Street, Colfax, WA 99111, Attn: Maribeth Becker, Clerk. Nominations will be accepted through \_\_\_\_\_. The nominees will be verified as LEOFF I or II members and a ballot will be returned to only LEOFF I members as soon as possible. LEOFF I members wishing to vote for one of the nominees appearing on the ballot will then have until \_\_\_\_\_ to return their one candidate choice to the above address.

In accordance with Whitman County LEOFF I Board Policy Section 1.05(11), "In the event that there is only one person nominated for the police or fire representative, balloting will not be required and the individual will be considered elected".

Thank you for your prompt response to this request.

Maribeth Becker, Clerk  
LEOFF I Board



**NOMINATION CERTIFICATION**

**For**

**Law Enforcement Representative**

**For**

**The term of January 1, \_\_\_\_\_ – December 31, \_\_\_\_\_**

Nominations opened on \_\_\_\_\_, \_\_\_\_\_ by the LEOFF I Board Chairman and Clerk as follows:

Nominee: \_\_\_\_\_

Nominee: \_\_\_\_\_

Nominee: \_\_\_\_\_

\_\_\_\_\_  
Maribeth Becker, CMC  
Clerk of the Board

\_\_\_\_\_  
Jerome "Jug" Daubert  
Chairman

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**WHITMAN COUNTY LEOFF I BOARD  
400 N Main Street, Colfax, WA 99111  
(509) 397-5246  
FAX (509) 397-2099**

**BALLOT**

**DATE:**

**TO:** LEOFF I Retirement System Members

**FROM:** Maribeth Becker, CMC, Clerk of the LEOFF I Board

**RE:** Ballot for Law Enforcement Officer Representative on the LEOFF I Board

Please return the following ballot by \_\_\_\_\_ to:

Maribeth Becker, CMC  
Whitman County LEOFF I Board  
400 N Main Street  
Colfax, WA 99111

-----  
**DATE BALLOT WAS VOTED:** \_\_\_\_\_

**LEOFF I DISABILITY BOARD – Law Enforcement Officer Representative**

**Nominated for the position:**

\_\_\_\_\_  
**Name of Nominee**

\_\_\_\_\_  
**Name of Nominee**

**CAST YOUR BALLOT AND RETURN TO THE ABOVE ADDRESS**

**- Thank you -**

**CERTIFICATION OF ELECTION RESULTS**

**FOR WHITMAN COUNTY LEOFF I BOARD**

Term will commence January 1, \_\_\_\_\_.

**Law Enforcement Representative**

**Totals**

\_\_\_\_\_  
Maribeth Becker, CMC  
Clerk of the Board

\_\_\_\_\_  
Jerome "Jug" Daubert  
Chairman

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

[DATE]

[NAME]

[ADDRESS]

[CITY], [STATE] [ZIP]

Dear [NAME]:

We received and reviewed your request to access your health information record. Unfortunately, we cannot honor your request because:

- We do not maintain this information. Contact **[NAME AND ADDRESS OF THE ENTITY THAT DOES MAINTAIN THE INFORMATION]**.
- Due to federal and state laws this health information is not available.
- The record no longer exists or cannot be found.

Under certain circumstances you have the right to have this decision reviewed by another health care professional. If you wish to make this request, please sign on the line given below. After signing the form, please check one of the options offered and return the form to Kelli Campbell or John Peterson at the address above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Select one of the following options:**

- Please have the following licensed health care professional review the decision (include name, address, phone number)

- \_\_\_\_\_  
\_\_\_\_\_
- Please find a licensed health care professional to review the decision (someone not involved in the original decision).

If you have questions, need further information or believe your privacy rights have been violated, you may contact Kelli Campbell at (509) 397-6200. We respect your right to file a complaint with us or the Secretary of Health and Human Services.

Sincerely,

[NAME]

**WCLIB #17**

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

REVOCAION OF AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

Client's Name: \_\_\_\_\_

Previous Name: \_\_\_\_\_

\_\_\_\_\_ (**Initial**) Please revoke my authorization dated: \_\_\_\_\_

Disclose no further information to: \_\_\_\_\_

Address: \_\_\_\_\_

**I understand that this request does not apply to any uses or disclosures required by law and/or made before this revocation is received by the appropriate organization.**

\_\_\_\_\_  
Client or Legal Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name if Signed on Behalf of the Client

\_\_\_\_\_  
Relationship to Client

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
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**FAX (509) 397-2099**

**REQUEST FOR CORRECTED/AMENDED  
HEALTH INFORMATION**

Client Name: \_\_\_\_\_ Previous Names: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Record to Be Changed: \_\_\_\_\_

Explanation of Why and How the Record Should be Changed: \_\_\_\_\_

\_\_\_\_\_  
Client or Legally Authorized Representative Date

\_\_\_\_\_  
Relationship to client if signed on behalf of the client by parent, legal guardian, personal representative, etc.

Whitman County will review your request and respond within 10 days of its receipt. A copy of your request will be added to your record. Any changes to your record will be forwarded to individuals identified by you and/or anyone who received the information in the past and who needs to know about the change.

**This Page to be Completed by Whitman County**

**Date Received:** \_\_\_\_\_ **Change has been:**    **Accepted**        **Denied**

The review of your request has been delayed. Your request will be processed by the following date: \_\_\_\_\_  
(not later than 21 days after the request date).

Your request has been denied for the following reasons (attach further information to back of this form if needed):

- The existing health information is accurate and complete.
- This request does not pertain to the patient's medical and financial records.
- Due to federal and state laws this health information is not available.
- The health information was not created by this organization.
- The record no longer exists or cannot be found.
- The record is not maintained by this organization.

Comments:

\_\_\_\_\_  
**Reviewed By**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Position Title

\_\_\_\_\_  
Department

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
**(509) 397-5246**  
**FAX (509) 397-2099**

[DATE]

[NAME]  
[ADDRESS]  
[CITY, STATE ZIP]

Dear NAME:

We received and reviewed your request to correct/amend your health information record. Unfortunately, we cannot honor your request because:

- The existing health information is accurate and complete.
- Due to federal and state laws this health information is not available.
- The record no longer exists or cannot be found.
- Your request does not pertain to your medical and financial records.
- This health information was not created by this organization.
- The record is not maintained by this organization.

You may contact Kelli Campbell or John Peterson at (509) 397-6200 or the address given above if you:

- Have questions;
- Want more information;
- Want to report a problem about the handling of your information; OR
- Want to write a brief statement of disagreement to be added to your medical record. This is your right and must be in writing. It must include you signature, the date, the reason you feel your data needs to be corrected and why you disagree with the decision to deny your request.

Thank you for your patience.

Sincerely,

[NAME]

# PHI DISCLOSURE LOG

Disclosure Date: _____	Employee/Client: _____
Disclosing To: (Name & Address) _____ _____	
PHI Disclosed: _____	
Purpose of Disclosure: _____	
Method of Disclosure: _____	
Disclosed By: (Print) _____	Initials: _____

Disclosure Date: _____	Employee/Client: _____
Disclosing To: (Name & Address) _____ _____	
PHI Disclosed: _____	
Purpose of Disclosure: _____	
Method of Disclosure: _____	
Disclosed By: (Print) _____	Initials: _____

Disclosure Date: _____	Employee/Client: _____
Disclosing To: (Name & Address) _____ _____	
PHI Disclosed: _____	
Purpose of Disclosure: _____	
Method of Disclosure: _____	
Disclosed By: (Print) _____	Initials: _____

**WHITMAN COUNTY LEOFF I BOARD**  
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**HIPAA ACKNOWLEDGEMENT**

I, \_\_\_\_\_, hereby acknowledge that I have received, reviewed and understand the Whitman County Notice of Privacy Practices.

I have also received training regarding Whitman County privacy policies and HIPAA regulations. I have had an opportunity to ask questions of the County's Privacy Compliance Officer about general privacy and HIPAA requirements concerning my department and/or position.

I acknowledge that I am responsible for protecting the Protected Health Information that I may come in contact with during my employment at Whitman County. Violations of those rules may result in disciplinary action.

Should I have further questions, I understand that I may contact Kelli Campbell or John Peterson at (509) 397-6205 or extension 205.

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
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**FAX (509) 397-2099**

**[SAMPLE GRIEVANCE RESOLUTION LETTER]**

[DATE]

[NAME]

[ADDRESS]

[CITY, STATE ZIP]

Dear [NAME]:

I am writing to respond to the concerns that you documented in your letter dated [INSERT DATE]. You expressed concerns regarding the [HANDLING/USE/DISCLOSURE] of [CLIENT'S NAME] protected health information. We respect your right to file a concern. We are very sorry that you are upset.

**[OPTION 1- IF A COMPLAINT IS MADE BY THE CLIENT OR CLIENT'S LEGALLY AUTHORIZED REPRESENTATIVE]** Based on your concerns, we completed an investigation on [INSERT DATE]. As part of the investigation we took the following steps: [INSERT STEPS TAKEN TO INVESTIGATE THE GRIEVANCE – INTERVIEWS, POLICY REVIEW, ETC.]. We found that [INSERT BRIEF SUMMARY OF THE FACTS OF THE INVESTIGATION].

**OR**

**[OPTION 2 – IF A GRIEVANCE IS MADE BY SOMEONE OTHER THAN THE CLIENT OR THE CLIENTS LEGALLY AUTHORIZED REPRESENTATIVE, AND THE CLIENT'S PERMISSION HAS NOT BEEN GRANTED TO AUTHORIZE DISCLOSURE]** Based on your concerns, we completed an investigation on [INSERT DATE]. We [INSERT STEPS TAKEN TO INVESTIGATE THE GRIEVANCE]. Due to privacy and security laws we cannot tell you any details of our investigation or findings. However, we would be happy to give you information, if the client permits us to do so.

Thank you for bringing your concerns to our attention. We try hard to protect all of the health information that we handle. You have given us an opportunity to review our practices and to make improvements.

If you have additional questions, please contact [INSERT NAME] at [INSERT NUMBER].

Sincerely,

[INSERT NAME]

**WHITMAN COUNTY LEOFF I BOARD**  
**400 N Main Street, Colfax, WA 99111**  
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**FAX (509) 397-2099**

**CONFIDENTIALITY STATEMENT**

As an employee of Whitman County I, \_\_\_\_\_ (print), acknowledge that I have a legal responsibility to maintain the confidentiality of employee and client information, records and health care information. I, therefore, agree to the following:

I understand that employee/client information records and health care information compiled, obtained, maintained or reviewed by me in the course of my duties may be confidential. I agree not to disclose or otherwise make known to any unauthorized persons any information regarding confidential information, unless so directed by my supervisor.

No privileged information, whether written or oral, will be shared with my family members and/or friends.

I understand that I am not to read information, records and health care information concerning clients and case reports or any other confidential documents for my own personal information unless for the purpose of enabling me to perform my assigned duties.

I will, whenever possible and in the course of my duties, discuss confidential information in a location where privacy is assured. I will be mindful that these discussions do not take place in hallways, elevators, bathrooms or other public areas.

All documents concerning employee/client confidential information will be kept in a secure location when not in use.

When working on computer files, I will use passwords, screensavers and other protective steps to prevent access to confidential files and databases.

I will not disclose my computer password or voice mail security code to unauthorized persons.

I understand that a breach of security or confidentiality may be grounds for disciplinary action, which may include termination of employment.

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Supervisor's Signature**

\_\_\_\_\_  
**Date**

Copy to Employee File

Original to HIPAA File

**WHITMAN COUNTY LEOFF I BOARD**  
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**FAX (509) 397-2099**

**AUTHORIZATION TO RELEASE PRIVATE INFORMATION**

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), I authorize the use/disclosure of my protected health information to the entity/person listed below and/or their authorized agent for purpose(s) listed below. I agree that by my signature below such information may be communicated under the Protected Health Information Rule\* and may be used for audit or statistical purposes. I understand that my authorized representative or I will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.

**I authorize the following people/organization to use/disclose my protected health information (please initial beside each person/organization):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**The following people/organization may receive my protected health information (please initial beside each person/organization):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**THIS REQUEST/AUTHORIZATION APPLIES TO:**

**Please describe in detail the information to be used or disclosed:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please describe in detail purposes for use/disclosure of each piece of protected health information (The statement "at the request of the individual" is a sufficient description of the purpose if you do not wish to elaborate. Please place a different date next to each use/disclosure in necessary):** \_\_\_\_\_

---

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Information will be sent via regular First Class Mail unless a space below is checked authorizing us to send via E-mail, over the phone and/or fax. Permission to send via E-mail, phone and/or fax is authorized. I understand the information sent in this manner is not secure and agree to hold Whitman County, the receiving party and/or authorized representatives blameless for any misdirection that may occur exposing protected information.

Please send the above listed information via: \_\_\_\_\_E-mail \_\_\_\_\_Fax \_\_\_\_\_ Phone

- I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of HIV (AIDS) virus, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnoses, testing or treatment if related to the authorization above.
- I understand that this authorization can be revoked or rescinded upon written request to the disclosing party. However the revocation will not have any affect on any action the entity took before it received the revocation.
- I understand that I may see and copy this form, and the information described, if I ask for it.
- This is not a condition for health care benefits, and I am not required to sign this form to receive my health care benefits (treatment, payment, enrollment).
- Information used or disclosed to the authorized party is subject to re-disclosure and no longer protected by the Privacy Rule. You may seek assurances from the recipient to extend the protections of this authorization.

**Unless otherwise revoked or rescinded in writing to the disclosing party, this authorization will remain in full force and effect until, \_\_\_\_\_20 \_\_\_\_\_.**

\_\_\_\_\_  
Signature of Employee or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship or status if signed by anyone other than employee (parent, legal guardian, etc.)

\* Protected Health Information (PHI) is any individually identifiable information transmitted or maintained in any form or medium (electronic or otherwise). Identifiable information may include demographic, financial, medical/health, and/or social data.

**WHITMAN COUNTY LEOFF I BOARD**  
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**(509) 397-5246**  
**FAX (509) 397-2099**

**VOLUNTEER/SERVICE PROVIDER**  
**CONFIDENTIALITY STATEMENT**

As a volunteer, service provider, or authorized visitor of Whitman County you have the responsibility of maintaining the confidentiality of all health-related client or employee information or records. By signing this statement you agree to the following:

I understand that employee/client information, records and health care information compiled, obtained, maintained or reviewed or observed by me in the course of my duties may be confidential. I agree not to disclose or otherwise make known to any unauthorized persons any information regarding confidential information, unless so directed by Whitman County.

No privileged information, whether written or oral, will be shared with my family members and/or friends.

I understand that I am not to read data, records and health care information concerning clients and case reports or any other confidential documents for my own personal information unless for the purpose of enabling me to perform my assigned duties.

I will, whenever possible and in the course of my duties, discuss confidential information in a location where privacy is assured. I will be mindful that these discussions do not take place in hallways, elevators, bathrooms or other public areas.

All documents concerning employee/client confidential information will be kept in a secure location when not in use.

When working on computer files, I will use passwords, screensavers and other protective steps to prevent access to confidential files and databases.

I will not disclose my computer password or voice mail security code to unauthorized persons.

I understand that a breach of security or confidentiality may be grounds terminating my relationship with this agency.

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Copy to Recipient**

**WCLIB #26**