

MEDICAL CLAIM FORM

KCDRB Form 9

LEOFF-1 Assessment of Need for Nursing Home or Assisted Living Care

Please submit this form to the LEOFF-1 employer, which must submit this form along with an employer's form and the completed application to the King County Disability Retirement Board, The Chinook Building CNK-ES-0240, 401 Fifth Avenue, Seattle, WA 98103-2333. If you have questions, call the King County Disability Retirement Board at 206-263-6394, or 206-684-1556 (call center).

This section to be completed by responsible family member or legal representative.

Name of LEOFF-1 member: _____ Date of Birth: _____

Responsible family member
or legal representative: _____ Phone: _____

Family street address: _____

City: _____ State: _____ ZIP: _____

Party responsible for payment: _____ Daily rate: _____

Type of accommodation (private, semi-private, other): _____

Type of facility: nursing home or assisted living care facility

Charges for additional services/equipment: Yes No If "Yes," attach itemized statement (**required**).

Long-term care insurance? Yes No Medicare? Yes No

Other medical insurance? Yes No Name of insurance carrier: _____

This section to be completed by director of nursing.

Director of nursing: _____ Phone: _____

Name of nursing home/
assisted living care facility: _____

Street address of facility: _____

City: _____ State: _____ ZIP: _____

Who referred resident to your facility? _____

Admitted directly from hospital stay? Yes No

Hospital: _____

Diagnosis requiring hospitalization: _____

Date of hospital discharge: _____

Discharge summary attached (required). Yes No

Date of admittance to facility: _____

Level of care required at admittance: _____

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

Signed: _____ Date: _____
Director of Nursing

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

(Dictate for typing or print ONLY.)

Name of resident: _____

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

Street address: _____

City: _____ State: _____ ZIP: _____

Diagnosis upon admission to facility: _____

History of illness/condition leading up to placement: _____

Patient's prognosis for recovery: _____

Current level of functioning: _____

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

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

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

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

Signed: _____ Date: _____
Medical director physician/primary care physician

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

Instructions for completing KCDRB Form 9

LEOFF-1 Assessment of Need for Nursing Home or Assisted Living Care

Under Board Rule 9.10-G, a LEOFF-1 member may submit an application for prior approval of reimbursement of costs for long-term custodial care in a nursing home or for residential placement in an assisted care facility.

The procedure for submitting a claim requires completion of KCDRB Form 9, "Assessment of Need for Nursing Home or Assisted Living Care," and KCDRB Form 6, "Member's Claim for Reimbursement of Medical Expenses." Additional required information must then be attached (see below). Finally, all forms and attachments are submitted to the LEOFF-1 employer, which will complete the application and forward it to the King County Disability Retirement Board for review.

NOTE: The King County Disability Retirement Board will consider each claim on a case-by-case basis. No claim can be brought before the board unless all required forms and information have been completed and included in the application packet. Any claim that is submitted with missing information will be returned to the employer or member for completion.

Filling out KCDRB Form 9

KCDRB Form 9 is a two-sided form with three sections. The first section is to be completed by the LEOFF-1 applicant.

- Member's identifying information can be filled out by a responsible family member, legal guardian or other appointed representative.
- An itemized statement of costs must be attached to the form. This statement should include the facility daily residence rate, charges for medical supplies, medications, and personal care items, and other service charges for additional care.

The second section is to be completed by the facility's director of nursing. If the member was hospitalized within six months preceding placement in the facility, the hospital discharge summary must be provided by the director of nursing and attached to KCDRB Form 9.

The third section on the reverse side of KCDRB Form 9 is to be filled in, signed and dated by the medical physician in charge of the member's care, be it his primary care physician or the physician attending to the care of all residents in the facility (an M.D. designated as "medical director"). A list of current medications and treatment plans for each therapy prescribed must be provided by the physician and attached to KCDRB Form 9.

The completed KCDRB Form 9, with required attachments, is to be submitted to the LEOFF-1 employer which, in turn, will add an employer's form and submit the completed application to the King County Disability Retirement Board office.

Any questions about the form, procedures for submitting a claim, or other board policies can be addressed to the board administrator, Curt Nakata, at 206-263-6394, or 206-684-1556 (call center).