GL-25-21

COUNTY OF KENOSHA — COUNTY CLERK

Regi Bachochin

1010 - 56th Street
Kenosha WI 53140
(262) 653-2552
Fax: (262) 653-2564

CLAIM AGAINST KENOSHA COUNTY

FULL NAME (daughter+POA) Laura J. Kriofsicy DATE 12/20/2021

ADDRESS 2808 16th St.
Kenosha, WI

TELEPHONE NUMBER: Home: 262-883-4470
~~Work:~~ Cell 262-705-4922

DATE & TIME OF ACCIDENT OR LOSS I don't know - it was during covid when I wasn't allowed in the building.

LOCATION OF ACCIDENT Brookside care center lost the hearing aid - Noone knows where or when.

DESCRIPTION OF ACCIDENT OR LOSS My mom had a hearing aid last year before covid. During covid, I wasn't allowed inside Brookside to see her for several months. When visitation started again I noticed she never had her hearing aid in, so I asked them to start putting it in. Found out a short time later that they couldn't find it. Talked + checked with several Brookside staff + They supposedly did an investigation but noone there had any answers where it is.

WITNESS: Name

Address N/A

Phone

AMOUNT OF CLAIM (damages) $ Cost of a new hearing aid (see attached) $2084.00

CLAIMANT'S SIGNATURE Laura J. Kriofsicy

Please attach receipts, estimates, and/or other supporting data to this form.

RETURN THIS FORM TO: KENOSHA COUNTY CLERK
1010 – 56TH STREET
KENOSHA WI 53140

RECEIVED
DEC 22 2021
REGI BACHOCHIN
COUNTY CLERK

Please help! It's affecting her quality of life.

MRN # 110228

August 02, 2021

LAURA KRIOFSKY
Janice Kraemer
2808 16th St.
Kenosha, WI 53140-0000

HealthDrive
bringing integrated healthcare to you

THIS IS NOT A BILL

RECOMMENDED TREATMENT PLAN
PLEASE READ AND APPROVE

Re: Plan of Care Recommendation

Dear Laura Kriofsky,

On July 24, 2021 I had the pleasure of providing an audiological exam to Janice Kraemer at Brookside Care Center. As an audiologist, my examinations are meant to identify any medical problems that may affect the health of the ears. I also check for the presence of obstructing earwax. My exam may sometimes reveal hearing loss that can be corrected by an assisted hearing device. Hearing well is important, particularly in the nursing home environment, because it will let Janice participate freely in conversations, enjoy the radio or TV and stay socially connected. Based on the results of that examination, I am recommending the following plan of care:

Recommended Care:	Fee
Starkey Muse i1000 ITE Hearing Aid	$2,084.00
One post-insertion follow-up adjustment/fitting	No additional charges
Name Engraving and One Year Full Warranty	No additional charges

To move forward with this recommended plan of care, we need your written approval and payment.
To approve this plan of care please complete, detach and return the form (below), along with payment, in the enclosed business reply envelope. If you do not wish to proceed with this plan of care, kindly notify my office at (888)964-6681, **Option 3** so that we know you did receive this letter and have had a chance to review the recommendation. Our Documentation Specialists are available to assist you and to answer any questions you may have.

Respectfully,
Sheila Chamberlin, CCC-A (license #65-156)
HealthDrive Audiology Group

Dignity • Compassion • Concern

100 Crossing Blvd, Suite 300 Framingham, MA 01702 (888)964-6681, Option 3/FAX (888)662-0859

========Please complete the appropriate section below and return the form in the enclosed self-addressed envelope. ==========

PRIORITY CARE AUTHORIZATION FOR: Janice Kraemer at Brookside Care Center #043 7/24/21 MRN #110228 Dr. Chamberlin

☐ **I approve of this care plan.**

1. Starkey Muse i1000 ITE Hearing Aid

☐ **I do not approve of this care plan.**

Please explain: _____

_____

Check Payment Options

ÿ My check, in the amount of $2,084.00 and made payable to HealthDrive Audiology Group, is enclosed.

Credit Card Payment Option

1.ÿ Please charge $2,084.00 to my credit card

2.ÿ 3 monthly payments of $694.67 for a total of $2,084.00. Please make 3 monthly charges to my credit card

Cardholder Name: _____ Authorization code: ____

Card # : _____ Exp:__/__/__

ÿ Mastercard
ÿ Visa

For Medicaid Recipients Only: If Janice is covered by Medicaid, please write the 10-digit Medicaid Number in the space provided.

Signature: _____ Print Name: _____ Date:__/__/____

MRN WI 110228
Dr. Chamberlin

Fax **SIGNED** Clearance to:
(888)662-0859

HealthDrive
AUDIOLOGY GROUP

Audiogram Date
07/24/2021

HEARING INSTRUMENT MEDICAL CLEARANCE FORM

ATTENTION: MD/ DO
Medical Doctor Name

Patient Name: KRAEMER, JANICE		**Gender:** F	**DOB:** [redacted]
Facility #043	**Facility Name:** BROOKSIDE CARE CENTER		**DOS:** 07/24/2021
Account Number: [redacted]	**Insurance:** Medicaid		

To Be Completed by the Audiologist

Otoscopy Findings
Right Ear Non-Occluded.
Left Ear Non-Occluded.

Audiological Findings
Right Ear Moderate to Severe Sensorineural Hearing Loss
Left Ear Severe to Profound Sensorineural Hearing Loss

Hearing Aid Recommendations: Right Ear

Make/Model: Starkey Laboratories, Inc. / Starkey Muse i1000 Series ITE
or Comparable

Benefits of Amplification: Patient is eager for amplification to improve hearing in all situations.; Patient is requesting new hearing aid because his/hers is/are lost.

Audiologist's Signature: Chamberlin, Sheila MS
Date: 07/26/2021

To Be Completed by the Medical Doctor

REQUIRED

Please check one of the responses below. Then sign, print your name, and indicate the date you examined the patient. Thank you.

☐ **YES** I have examined the above named patient and found him/her to be medically cleared for hearing aid(s) use.

☐ **NO** I have examined the above named patient and found him/her not to be medically cleared for hearing aid(s) use

Date of Examination **by the MD/DO**: ____/____/____ **(must be within the last six months)**

MD/DO

Medical Doctor Signature Only **(Required)**

Date Signed **(Required)**

MD/DO

Medical Doctor Name **(Required)**