SPONSOR: [illegible]

RESOLUTION NO. 10-07

A RESOLUTION AUTHORIZING A THEN AND NOW CERTIFICATE AND DECLARING AN EMERGENCY.

WHEREAS, pursuant to Ohio Revised Code Section 5705.41(D), the issuance of a then and now certificate is permitted; and

WHEREAS, the Jackson City Council now desires to approve the then and now certificate.

NOW, THEREFORE, BE IT RESOLVED BY THE COUNCIL OF THE CITY OF JACKSON, STATE OF OHIO as follows:

Section 1. The Jackson City Council hereby authorizes and approves the Then and Now Certificate, in accordance with the material attached hereto as Exhibit "A", and made a part hereof.

Section 2. This Resolution is hereby is hereby declared to be an emergency Resolution necessary for the immediate preservation of the public peace, health, or safety of the City of Jackson, and for the further reason that the Jackson City Council must act promptly in approving the Then and Now Certificate. Therefore, this Resolution shall go into effect upon passage and approval by the Mayor, as provided in Ohio Revised Code Section 731.30.

Section 3. In the event this Resolution receives a majority vote for passage but fails to receive the required number of votes to pass as an emergency, then this Resolution shall be deemed to have passed but with no emergency clause, and shall take effect at the earliest time permitted by law.

Section 4. This Council finds and determines that all formal actions of this Council concerning and relating to the passage of this resolution were taken in an open meeting of this Council and that all deliberations of this Council that resulted in those formal actions were in meetings open to the public, all in compliance with the law.

Date: 2/20/07

Ronald B. Spearman
PRESIDENT OF COUNCIL

Linda L Braun
CLERK OF COUNCIL

Approved:

Date: 2-20-07

MAYOR

EXHIBIT "A"

DISTRIBUTION
PT. 1-WHITE - VENDOR
PT 2-YELLOW - FILE
PT. 3-PINK - AUDITOR

Invoice To
CITY OF JACKSON
145 BROADWAY STREET
JACKSON, OHIO 45640-1658

PURCHASE ORDER
NO. [illegible]
(APPENDIX 3.3)

DELIVER AND SHIP TO THIS DEPT. AND DIVISION
[illegible]

PURCHASE ORDER DATE
[illegible]

CONTRACT #

GUARANTEED DELIVERY DATE

EXCISE OR SALES TAX DO NOT APPLY TO CITY

TERMS:
CASH DISCOUNTS WILL BE FIGURED FROM DATE ACCOUNTING OFFICE RECEIVES VENDOR'S INVOICE

NAME AND ADDRESS OF VENDOR
[illegible]

By shipping the goods below or by acknowledging receipt of this order or by performing the work below you agree to the terms and conditions of sale which appear on the face. Any different or additional terms in your acceptance of this offer are hereby objected to.

LINE NO.	DESCRIPTION	ACCOUNT CODE	QUANTITY		UNIT PRICE	AMOUNT
001	DRUG SCREENING S. RHEA & L. FISHER	731-7555-53023	0.00		.00	100.00
					TOTAL AMOUNT NOT TO EXCEED	100.00

INSTRUCTIONS TO VENDORS
1. THIS ORDER IS NOT VALID UNLESS SIGNED BY THE CITY AUDITOR FOR AVAILABILITY OF FUNDS.
2. MAIL INVOICES IN DUPLICATE TO THE ACCOUNTS PAYABLE OFFICE.
3. DELIVERY MUST BE PREPAID TO DESTINATION SHOWN ABOVE. THE CITY WILL NOT PAY FREIGHT OR EXPRESS FEES.
4. NO CHANGE MAY BE MADE IN THIS ORDER WITHOUT WRITTEN CONSENT OF THE FINANCE DIRECTOR.

AUDITOR'S CERTIFICATE

It is hereby certified that the amount of $_____ required to meet the contract, agreement, obligation, payment of expenditure for the above, has been lawfully appropriated or authorized or directed for such purpose and is in the City Treasury or in process of collection to the credit of the _____fund free from any obligation or certification now outstanding.

Feb 6 '06
DATED

[signature] AUDITOR
This order not valid unless City Auditor's Certificate is signed.

IMPORTANT PLEASE NOTE ▶ THE PURCHASE ORDER NUMBER MUST APPEAR ON ALL INVOICES, PACKAGES, PACKING SLIPS, SHIPPING PAPERS AND ON ALL CORRESPONDENCE

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)

PIC (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
FISHER, LARRY	02 08 1959 M F	FISHER, LARRY
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
500 BURLINGTON RD	Self Spouse Child Other	500 BURLINGTON RD
CITY / STATE	8. PATIENT STATUS	CITY / STATE
JACKSON / OH	Single Married Other	JACKSON / OH
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (Include Area Code)
45640 / (000)0000000		45640 / (000)0000000
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 02 08 1952 M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME: CITY OF JACKSON
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: CITY OF JACKSON
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 01/22/2007

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 01 22 2007 TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO / $ CHARGES 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 22 07	11	01	80100	1		50 00	1		NPI	
2			dup orders						NPI	
3									NPI	
4									NPI	
5									NPI	
6			invoice#						NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
311778412 EIN	22810	YES	$ 50 00	$ 0 00	$ 50 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (304) 523-0266
HESS, MD, ROBERT A		OHIO VALLEY PHYSICIANS 1037 6TH AVE HUNTINGTON, WV 25708
SIGNED Robert A Hess III DATE 01/23/07	NPI	a. NPI / b. 311778412

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

SECOND FOLD — FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PATIENT AND INSURED INFORMATION

CITY OF JACKSON
92 BROADWAY ST
JACKSON OH 45640

PROVIDED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

(For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
RHEA, SHALAN	01 31 1977 M X F	RHEA, SHALAN
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
500 BURLINGTON RD	Spouse Child Other	500 BURLINGTON RD
CITY	STATUS	CITY / STATE
JACKSON	Married Other X	JACKSON / OH
ZIP CODE / TELEPHONE (Include Area Code)	X Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (Include Area Code)
45640 / (		45640 / (000)0000000
9. OTHER INSURED'S NAME (Last Na	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GR	a. (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX
		01 31 1977 M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / M F	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
		CITY OF JACKSON
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
		CITY OF JACKSON
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 01/22/2007

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 01 22 2007 TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO / $ CHARGES 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 22 07	23	01	80100		1	50 00	1		NPI	
2			drug screen						NPI	
3									NPI	
4									NPI	
5									NPI	
6			invoice#						NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
311778412	7437	X YES NO	$ 50 00	$ 0 00	$ 50 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (304) 523-0266
SHY, DO, STEPHEN C	OHIO VALLEY PHYS/CORP.HEA	OHIO VALLEY PHYSICIANS
SIGNED Stephen C Shy DO DATE 01/23/07	500 BURLINGTON RD	1037 6TH AVE
	JACKSON, OH 45640	HUNTINGTON, WV 25708
	a. NPI b.	a. NPI 311778412

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WCMS-1500CS

SEE BACK BEFORE FOLDING — FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS — PATIENT AND INSURED INFORMATION