



IDAHO DEPARTMENT OF CORRECTION  
Resident Concern Form

Resident Name: James D. Hodge IDOC Number: 1311921

Institution, Housing Unit, & Cell: INST B-2-56 Date: 12-1-21

To: HSR Accountant - Tonja Reidly  
(Address to appropriate staff: Person most directly responsible for this issue or concern)

Issue/Concern: My account was recently charged 3 times in the last two weeks: twice on 11-15-21 = HSR # 1608534 and 1621182 and once in 11-30-21 = HSR # 1578127. These charges are for refills and follow-up pertaining to a "SINGLE" persistent health issue I have been dealing with since June - infected lymph nodes in the left abdominal region. Per S.O.P. 411.06.03.001(5) this type of ongoing treatment is co-pay exempt. I would like my account reimbursed for these charges. Thank you for your time and consideration.

(Description of the issue must be written only on the lines provided above.)

Resident signature: [Signature]

Staff Section: \_\_\_\_\_  
(Signature of Staff Member Acknowledging receipt) / Associate ID # \_\_\_\_\_ Collected/Received: \_\_\_\_\_  
(Date collected or Received)

Reply: NO RESPONSE

Responding Staff Signature: \_\_\_\_\_ Associate ID #: \_\_\_\_\_ Date: \_\_\_\_\_

Pink copy to resident (after receiving staff's signature),  
Original and yellow to responding staff (after completing reply, yellow copy returned to resident.) Last Rev. 1/21 PRT3NCRCF

IDAHO DEPARTMENT OF CORRECTION  
Resident Concern Form

Resident Name: James D. Hodge IDOC Number: 1311921

Institution, Housing Unit, & Cell: INST B-2-56 Date: 11-23-21

To: Tonja Reidly  
(Address to appropriate staff: Person most directly responsible for this issue or concern)

Issue/Concern: I'm being charged co-pays for follow-ups, prescription refills, and blood work I haven't even had yet. I should've only been charged one co-pay since June. Could you please refund my account all erroneous charges? If, for any reason, you deny this request, could I get a list of all co-pays I'm being charged since June, listing what I am being charged for?

(Description of the issue must be written only on the lines provided above.)

Resident signature: [Signature]

Staff Section: \_\_\_\_\_  
(Signature of Staff Member Acknowledging receipt) / Associate ID # \_\_\_\_\_ Collected/Received: \_\_\_\_\_  
(Date collected or Received)

Reply: NO RESPONSE

Responding Staff Signature: \_\_\_\_\_ Associate ID #: \_\_\_\_\_ Date: \_\_\_\_\_

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for specific diseases. These laboratory tests were scheduled to be drawn. However, according to the S.O.P., "prescribed laboratory studies and tests" are exempt from medical co-pay. You will be refunded \$2.00 for HSR 1608534.

Mr. Hodge, you will be refunded at total of \$4.00 to your account. Please allow some time for this to reflect on your account. Thank you and have a great day!

**Level 2 - Reviewing Authority Response**

Date Forwarded:	12/22/2021	Grievance Disposition:	MODIFIED
Date Due Back:	01/07/2022	Level 2 Responder:	REIDY, TONJA
Date Returned:	12/22/2021	Response sent to offender:	12/22/2021

Your grievance has been reviewed and I find:

I agree with Grace's response. I am having our Medical records clerk review many of the HSR charges to submit for refund. We can include Mr. Hodges.

**Offender Appeal**

Offender Comments:

**Level 3 - Appellate Authority Response**

Date Appealed:	Grievance Disposition:
Date Forwarded:	Level 3 Responder:
Date Due Back:	Response sent to offender:
Date Returned:	

Your appeal has been reviewed and I find: