A Guide to Legal Issues for Pennsylvania Senior Citizens

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Foreword

In these difficult times, seniors and their families recognize more than ever the importance of planning for the future. With this in mind, this guide has been updated.

This guide is designed to provide information about legal issues faced by Pennsylvania's older residents and their caregivers. Its authors and publishers intend to help seniors make appropriate choices so they can maximize personal autonomy, minimize costs, navigate through the maze of government benefits, and protect themselves against predators who want to deceive, exploit or defraud.

Senior citizens within Pennsylvania require timely and reliable access to legal information. The Senior Lawyers Committee of the Pennsylvania Bar Association has determined that it can best serve the needs of the legal community by serving the needs of the citizens of Pennsylvania. Its concentration on the creation of this statewide Guide for Senior Citizens is complimented by other programs such as a mentoring project, a pro bono project and the sponsorship of continuing legal education (CLE) programs, all designed to aid the legal community by offering the expertise of older, more experienced attorneys to all Pennsylvania practitioners. This in turn helps to bring the best possible representation to the clients of Pennsylvania Lawyers.

Obviously, no publication can cover all the legal issues relating to a group as diverse as this State's senior citizens. However, this guide offers basic information, points out various services and ways to access them, and outlines areas which may require specific legal advice or expertise, given each individual's needs.

Acknowledgments

Publication of this Guide would not be possible without the financial support and efforts of the Pennsylvania Bar Association, the Pennsylvania Bar Insurance and Trust Fund, and staff. This Guide is modeled upon the Montgomery County Elder Law Handbook, developed by Lois A. Nafziger, Esquire, which was first published in 2000 and annually updated. The Pennsylvania Bar Trust Fund generously awarded the Montgomery Bar Association a partial grant to produce and distribute the Handbook in 2000.

The Pennsylvania Bar Association is a nonprofit organization which was incorporated in 1895. With its headquarters in the state capital of Harrisburg, the PBA represents more than 28,000 lawyers licensed to practice law in Pennsylvania. The PBA was founded to advance the science of jurisprudence; to promote the administration of justice; to see that no one, on account of poverty, is denied his or her legal rights; to secure proper legislation; to encourage thorough legal education; to uphold the honor and dignity of the Bar; to cultivate cordial relations among the lawyers of Pennsylvania and to perpetuate the history of the legal profession and the memory of its members.

The Senior Lawyers Committee of the Pennsylvania Bar Association is the driving force behind the publication of this Guide. They saw a grave need to provide legal information to senior citizens statewide. I commend the vision and efforts of the following esteemed and energetic leaders and pillars of their communities:

Mason Avrigian, Esquire, Chair of the Senior Lawyers Committee enthusiastically conceived and constantly promotes and organizes this publication. He deserves full credit for his leadership in continuing to update and maintain the vitality of this Guide. Richard W. Berlinger, Esquire, is now Vice-Chair of the Committee.

I owe a great deal to the unflagging efforts of these organizations and individuals.

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Pennsylvania Senior Citizens

Table of Contents

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the Elder Law Committee since 1994. She is a past chair of the Family Law Committee of the Montgomery Bar Association where she is also a director. She attended the Sorbonne, graduated from Rosemont College and earned her J.D. from the Widener University School of Law.

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Elder Law

Elder law is the term used by the legal profession to focus on the special legal rights and problems of senior citizens. Attorneys who work in this field need to master an ever-changing body of law, legislation and regulations which deal with financial planning, health care and housing as well as discrimination, abuse and consumer fraud.

Attorney-Client Relations

A big question in elder law is: who is the client? Attorneys fairly often find that a child brings in a parent to the attorney's office. That child and parent may have differing interests. Also, some older people have physical or mental disabilities which may limit their capacity to make proper decisions. Fortunately, attorneys have ethical rules, known as Rules of Professional Conduct, which help to clarify these situations.

According to Rule 1.5, all fee agreements must be in writing. This avoids disputes about what the lawyer is to do and how much these professional services will cost.

Rules 1.6 through 1.12 state what to do to prevent conflicts of interest. In general, one lawyer cannot represent both sides when clients have differing agendas. Therefore, if two people come into a lawyer's office together, the lawyer must make a clear determination about whom to represent. This helps to protect vulnerable seniors when others try to exert undue influence, to coerce or use threats to push them to execute powers of attorney or convey property against their will. Also, Pennsylvania lawyers are required to keep client information confidential.

Rule 1.14 explains that lawyers presume that their clients are competent and can understand what is happening. If the lawyer "reasonably believes" that the client cannot act in their own self-interest, the lawyer can seek a guardian or take other protective action.

Continuing Legal Education

Since 1992, Pennsylvania's attorneys have been required to take at least twelve hours each year of continuing legal education including the Rules of Professional Conduct and professionalism in general. This should have a positive impact on the ethical delivery of legal services, but it is still important for older clients to remember their rights as they work with their lawyers.

Pennsylvania Lawyers Fund for Client Security

Although the percentage of lawyers involved in fraud and theft is extremely low, the news is often given wide play in the media. The fact is that lawyers are often put in positions of trust and temptation which very rarely result in a financial loss to a client. In such cases, the Pennsylvania Lawyers Fund for Client Security can help to recoup some or all of the losses. Claims are submitted on pre-printed forms from the Supreme Court of Pennsylvania, Pennsylvania Lawyers Fund for Client Security, telephone 1-800-962-4618.

Choosing an Attorney

Every individual has notions about how to work with a professional advisor to resolve personal problems. To choose the best person to act on your behalf in legal matters, you should first think about your goals. Is it a simple question of updating your will? Or is it the more complex process of planning the series of financial steps for retirement and changes in life situations? Once your needs are outlined, you can consult friends, relatives, business colleagues, clergy and others for recommendations about attorneys. A good source of information is the Pennsylvania Lawyer Referral Service, a service that refers callers to lawyers in the counties that do not have a referral service of their own. This service covers 46 of the 67 counties in the Commonwealth of Pennsylvania.

Lawyers participate in this service on a voluntary basis and have indicated the areas of law in which they will accept referrals. Computerization ensures lawyers are rotated automatically by county according to the type of case. The PBA LRS operates Monday through Friday from 8:00 a.m. to 4:30 p.m., and can be reached by calling 800-932-0311 Ext. 2209. If callers need a lawyer in a state other than Pennsylvania, they may contact that state's bar association.

Pennsylvania Local Lawyer Referral Services

If you are looking for an attorney in a county listed below, please contact that county bar association's lawyer referral service (LRS) directly.

-Allegheny County, Pittsburgh: 412-261-5555
-Beaver County, Beaver: 412-728-4888
-Berks County, Reading: 610-375-4591
-Blair County, Hollidaysburg: 814-693-3090
-Bucks County, Doylestown: 215-348-9413, 800-991-9922
-Chester County, West Chester: 610-429-1500
-Cumberland County, Carlisle: 717-249-3166, 800-990-9108
-Dauphin County, Harrisburg: 717-232-7536
-Delaware County, Media: 610-566-6625
-Erie County, Erie: 814-459-4411
-Lackawanna County, Scranton: 570-969-9600
-Lancaster County, Lancaster: 717-393-0737
-Lehigh County, Allentown: 610-433-7094
-Luzerne County, Wilkes-Barre: 570-822-6029
-Mercer County, Mercer: 724-342-3111
-Monroe County, Stroudsburg: 570-424-7288
-Montgomery County, Norristown: 610-279-9660
-Northampton County, Easton: 610-258-6333
-Philadelphia County, Philadelphia: 215-238-1701
-Washington County, Washington: 724-225-6710
-Westmoreland County, Greensburg: 724-834-8490
-York County, York: 717-854-8755

If you think you may qualify for free legal assistance, the Pa. Legal Aid Network, Inc. (PLAN, Inc.), formerly Pa. Legal Services, office near you can be located by accessing the website: www.palegalservices.org. When you reach this site, click on Service/Staff Locator, and then on

your county in Pennsylvania. Most legal service offices will do the "intake" to determine if you qualify for legal service assistance.

Older Americans Act

More Americans are living longer and demanding more from local, state and federal lawmakers so more programs for elders are offered, enlarged or refined. One of the most important laws which provides a basic framework for these services is the Older Americans Act of 1965. This law sets up Area Agencies for the Aging (AAAs) all over the United States. In Pennsylvania, AAAs are administered by the Pennsylvania Department of Aging, Forum Place Building at 555 Walnut Street, Harrisburg, PA 17101-1919; telephone 717-783-6207.

Area Agencies on Aging

The ultimate goal of the 52 Area Agencies on Aging in the State of Pennsylvania is to enable seniors to maintain their independence and dignity, to remain in their own homes and communities with appropriate support services and to prevent unnecessary institutionalization.

Services Provided

Pennsylvania's AAA's offer many services to seniors including:

- Information and counseling
- Protective services to prevent or stem abuse or exploitation;
- Transportation;
- Legal assistance for those who cannot afford it;
- Home support to help with tasks of daily living;
- Home health care, attendant care, adult daycare;
- Socialization/Recreation and educational activities;
- Home-delivered meals;
- Advocacy or ombudsman support to help negotiate complaints concerning providers
- Caregiver support services;
- Assessment and case management;
- Aid with shelter and housing;
- Employment

Services are focused in the home and supplemented via a network of nearly 700 Senior Centers and agencies. All Pennsylvanians over the age of 60 are eligible for service from their local Area Agency on Aging. Specific guidelines may apply to individual service programs.

As growing older has become more confusing and expensive, the AAA's provide services to help older Pennsylvanians cope with the challenges and changes related to their physical and emotional health, living conditions, family situations and caregiving responsibilities. Prior to receiving such services, an Assessment is provided by an AAA representative. Based upon that evaluation, specific services are recommended. Depending on each person's situation and level of need, services may be of a wide-ranging variety or be as simple as providing information as to the location and programs in the local senior adult activities for recreation and entertainment. Other services may include a referral to the APPRISE Program, which provides telephone assistance to

older adults in understanding Medicare and Medicaid eligibility benefits.

Attendant Care

The program provides 15 or more hours of service a week for frail or ill elderly individuals who require “hands-on” personal care and help with daily living activities in their home.

Senior Adult Activities Centers (SAAC)

AAA-supported senior centers are found in many communities where older people can meet for social activities, recreation, education, arts and meals. There are a wide variety of other Aging Services Network Programs such as the following which may be offered at your local senior center:

Congregate Meals: Nutritious meals are served in a group setting at least once a day or more depending on the facility in a variety of community sites.

Employment Assistance: AAA’s provide low-income seniors with part-time employment in public and nonprofit agencies. In addition, many AAA’s provide job brokerage services for older workers in private or public agencies as well.

In-Home Services: Several programs are available such as Homemaker Assistance, Personal Care Help, Home-Delivered Meals and Chore Services.

Transportation: Transportation may be provided to persons age 65 and older in both rural and urban areas to and from senior community centers, medical facilities, human service agencies and even stores.

Information/Referral: Each AAA has trained staff available to answer questions and make referrals to community agencies, as needed.

Placement: AAA’s can locate, assess and place adults in appropriate care facilities, in their home, adult daycare or other residential or long term care.

Ombudsmen: AAA’s are agents of the State Long Term Care Ombudsmen and provide intervention and resolution of disputes involving consumers of long term care services.

Protective Services: AAA’s are involved in elder abuse identification and intervention. Anyone may report elder abuse by calling 1-800-490-8505.

Volunteer Services: Many AAA’s have volunteer opportunities in their agencies to help in senior care centers, escorting individuals to medical appointments, delivering meals, serving as companions and more.

Family Caregiver Support Program: Assists caregivers through a reimbursement program for supplies and services through state and national programs.

PDA Waiver Program: Provides intensive in-home services to consumers meeting financial and medical guidelines.

Resources

For seniors who have Internet access, the Pennsylvania Department of Aging has an excellent informational website that describes all of their services offered and the ways to obtain them at http://sites.state.pa.us/pa_exec/aging/ly_aaa.html. The website for the Pennsylvania Association of Area Agencies on Aging is www.p4a.org and their telephone number is 717-541-4214. The Pennsylvania Department of Aging website provides a listing of telephone numbers, addresses and links available by county listing map, city or zip code, or by calling 717-783-1549 or emailing Aging@state.pa.us.

The Department of Aging's toll-free numbers are as follows:

PACE:	1-800-255-7223
APPRISE (Insurance Assistance):	1-800-783-7067
Elder Abuse:	1-800-490-8505
Property Tax/Rent Rebate:	1-800-222-9191
Alzheimer's Information:	1-800-367-5115
Long Term Care Helpline	1-866-266-3636

You can contact your elected representative in the Pennsylvania Legislature by writing to the Pennsylvania House of Representatives at House, Box 202020, Harrisburg, PA 17120-2020. An annual guidebook "Benefits and Rights For Older Pennsylvanians", published by the Department of Aging, is available from your local Area Agency on Aging, from any member of the Pennsylvania Legislature or by calling 717-783-1549.

For listings of your county's nursing homes, adult day care centers, assisted living facilities or for PACE and tax rebate forms, contact your Area Agency on Aging listed in the Guide to Human Services section of your local telephone directory.

Financial Planning

As people grow older they become increasingly aware that "…in this world, nothing is certain but death and taxes." Elder law underscores other sayings: "Plan Ahead!" and "An ounce of prevention…." Senior citizens need to plan now, while they are able, to make sure that their estates are passed to intended beneficiaries. Planning can reduce death taxes administrative expenses and the possibility of disputes among family members and others. Even more important: the peace of mind which comes from knowing that financial affairs are in order.

Income Tax Planning

An excellent starting point for information affecting senior citizens is IRS Publication 554, "Tax Information for Older Americans." This brochure is available free of charge by calling the IRS at 1-800-829-3676. You may also want to check the IRS website: www.irs.ustreas.gov.

Tax Preparation

Many times senior citizens, especially those with fixed incomes, find it difficult to hire a tax professional. For elderly people with limited means, volunteers are available in many areas to prepare tax returns. Your local public library is usually able to help you locate the nearest volunteer

income tax assistance program. The Internal Revenue Service also provides walk-in tax preparation service free of charge. For the IRS service center nearest you, call 1-800-829-1040.

at Age 65

You should be aware that you are allowed an additional standard deduction when you reach age 65. You will want to go over all instructions very carefully, especially as you choose between using the standard deduction and itemizing deductions. When elderly taxpayers itemize deductions, they lose any benefit from the additional standard deduction.

The general rule is that a person must have attained age 65 before the end of the tax year. However if your birthday is on January first, you are permitted to increase the standard deduction for the tax year prior to reaching age 65.

Income Tax Credit Age 65 or Older

Taxpayers age 65 or older may receive a "tax credit" that is subtracted from your income tax if you have limited income. The allowable credit varies according to the taxpayer's filing status. A single individual's credit can be as much as $5,000, whereas a married couple's maximum credit is $7,500. The calculations for determining your tax credit can be complicated and may require the assistance of a tax professional.

Medical Expense Deductions

Medical expenses are deductible only to the extent they exceed 7.5% of a taxpayer's adjusted gross income. Beginning in 2013 you may only make these deductions if they exceed 10% of a taxpayer's adjusted gross income. The medical expense deduction is limited to un-reimbursed, i.e. out-of-pocket, expenditures. Such medical expenses are only deductible if the taxpayer is itemizing. You determine the amount to deduct on Schedule "A" of Form 1040. Those electing to take the standard deduction do not benefit from medical expense deductions.

The entire cost of a long-term care nursing home facility, including meals and lodging, is a deductible medical expense if the principal reason for admission to the facility is the availability of medical care. However in an assisted living facility or personal care home, only a portion of the cost may be deductible.

Equipment and home modifications to accommodate the handicapped (no age limit) that do not increase the market value of the home are deductible as a medical expense. Examples of such deductible improvements include building wheelchair ramps and widening entrances to the home.

When a person dies owing medical expenses, and those expenses are paid by the estate within one year, a medical expense deduction can be taken on the decedent's final income tax return (Form 1040) or on the federal estate tax return (Form 706). If the estate is under the federally taxable limit, $5,120,000 in 2012, or if there will be no estate tax due because of the unlimited marital deduction, it makes sense to deduct these expenses on the personal income tax return.

Sale of Residence; Exclusion of Gain from Income

The tax laws have been simplified for the sale of your home. Generally speaking, capital gains are the increase in value of a home from the date of purchase, less the cost of major improvements made over the years such as a new roof or new windows. An unmarried taxpayer may exclude up to $250,000 of capital gains realized on the sale of a principal residence; married taxpayers can exclude up to $500,000 of capital gains. To qualify for the capital gains exclusion, one must have used the real estate as their principal residence for at least two of the five years prior to sale. The majority of senior citizens will not have to pay a capital gains tax on the increase in the value of their home when they sell it.

Tax Basis; Special Rules for Surviving Spouse

You or your tax preparer will need to know the "tax basis" rules whenever calculating capital gains tax on the sale of appreciated property, such as stocks or mutual funds.
The maximum capital gains rate for long-term investments is now 15%. Collectibles are still taxed a the old higher rate of 28%.

In simplified terms, capital gains tax on appreciated stocks and mutual funds is paid on the difference between the purchase price and sales price of the security. Special rules apply however, where one owner of jointly-held property dies. For a surviving spouse, these rules, known as the tax basis rules, can result in significant tax savings when they sells jointly-owned stock or other appreciated property after the death of a spouse.

The following illustrations show the potentially significant tax savings involved:

Illustration 1:
If during their lifetimes, a husband and wife sold jointly-owned stock worth $10,000 which they bought for $1,000, they would pay capital gains tax on $9,000, the sale price minus the purchase price. The tax due would be about $1,350 at the 15% rate.

Illustration 2:
If the husband in Illustration 1 dies and the same jointly-held stock is worth $10,000 on the date of death, the tax basis is increased from $1,000 to $5,500, one half of the date-of-death value plus half the purchase price. If the surviving spouse later sells the stock for $10,000, taxable gain is only $4,500 and the tax due is cut in half to $675.

Obviously these savings can be significant. Many married people own at least part, and perhaps all, of their property jointly. Since the tax basis rules are important and complicated, elder couples need to discuss these issues and their possible effects with a qualified tax professional to avoid paying more tax than necessary.

Reverse Mortgages (Home Equity Conversion)

A reverse mortgage is a special type of home loan that lets a homeowner convert the equity in his/her home to cash. The lender loans money to the borrower age 62 or older using the borrower's home as security. The loans may be dispersed in a lump sum, monthly payments, or through a line of credit. Unlike traditional mortgages, reverse mortgages are repaid upon death, or when the owner can no longer live in the home. Then the lender can foreclose on the home due to

a senior moving to a nursing home or elsewhere. There are serious implications if the value of the home has declined and the amount of the loan exceeds the fair market value of the home. Then if the home can be sold and/or, if it is foreclosed upon, the homeowner may not receive any proceeds from the sale or the foreclosure. These mortgages are advertised as a good way to overcome the "house rich but cash poor" dilemma that confronts many elderly homeowners but each individual's situation must be considered, especially that of seniors in this unstable market.

There is a federal law that authorizes home equity conversion mortgages for seniors. The purpose of the law is to meet the special needs of elderly homeowners by reducing the effect of the economic hardship caused by the increasing costs of meeting health, housing and subsistence needs at a time of reduced or fixed income, and to encourage lender participation. Your first step should be to consult with your attorney and have all pertinent documents reviewed prior to signing anything.

Basic Requirements

- Borrowers must be age 62 or older; there is no maximum age limit. If there is more than one borrower, they must both be 62 or older.
- The mortgaged property must be used as the principal residence of the borrower and can be one to four units.
- The property must be in good repair; proceeds from the reverse mortgage may be used to make needed repairs.
- The property to be mortgaged must be free and clear of a mortgage or almost mortgage-free. The borrower will be required to pay the balance of the existing mortgage from the proceeds of the reverse mortgage. Credit history is not a factor in either of these federal programs but may be in a purely private reverse mortgage loan or if Pennsylvania institutes its own program again. Liens against the property would be an issue and most likely would have to be paid off with the proceeds of the loan.

Types of Reverse Mortgages

At present, there is no program offered by the State of Pennsylvania. In the past, the Pennsylvania Housing Finance Agency (PHFA) offered a program for seniors who owned a home in Pennsylvania.

Two basic types of reverse mortgages or home equity conversion mortgages:

For the federally-insured "Home Equity Conversion Mortgage" (HECM), your home must be a single-family property, a two-to-four unit building, or a federally-approved condominium or planned-unit development (PUD). For Fannie Mae's "HomeKeeper" mortgage, it must be a single-family home, PUD or condominium.

Reverse mortgage programs generally do not lend on cooperative apartments or mobile homes, although some "manufactured" homes may qualify if they are built on a permanent foundation, classed and taxed as real estate and meet other requirements.

The amount of cash you can get from your home depends on which program you select and within each program-on your age, home and interest rates. For all but the most expensive homes, the federally-insured HECM program generally provides the most cash. Those funds may be

distributed as a lump sum, as a line of credit or in a monthly amount. For the monthly option, it may be for a specific number of years, or as long as you live in your home. All of the reverse mortgages have costs and almost all of them can be put into the borrowed amount so that the only up-front cost to the senior is the appraisal.

Both of these Federal programs require that the homeowner(s) undergo counseling with a HUD-approved non-profit organization before they can obtain a reverse mortgage. For a list of HUD-approved counselors near you, contact the Division of Planning and Research, Department of Aging, 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919 or telephone: 717-783-6207.

Impact of Reverse Mortgages

A reverse mortgage has no impact on an individual's receipt of Social Security or Medicare benefits, but it may have an impact on an individual's ability to receive Supplemental Security Income (SSI) and Medicaid benefits. Reverse mortgage payments to an individual are not income since they are loans. But if an individual receives reverse mortgage proceeds and holds them beyond the month they are received, they are considered "liquid assets" and may adversely affect eligibility for SSI and Medicaid benefits.

Another important feature of these loans is that you can never owe more than the value of the home. In banking terminology they are known as "non-recourse" loans. You may find more information on reverse mortgages from the American Association of Retired Persons Home Equity Information Center, 601 E Street, NW, Washington, D.C. 20049; telephone: 1-888-687-2277 or www.aarp.org. Another excellent source of information is the National Center for Home Equity Conversion. This organization is a purely private, noncommercial wealth of information on this topic. They can be reached at their website: www.reverse.org.

Occasionally, you may find a private lender, such as a bank that offers reverse mortgages and may have more flexibility in setting maximum loan amounts or placing higher age limits on borrowers, etc. However, the overall cost and interest rates may be higher and all the ramifications must be considered. There is a heightened risk of foreclosure on borrowers who are seniors with reverse mortgages. Seniors also may not derive any equity or proceeds from the sale or foreclosure of their homes. The benefit may not outweigh the risks.

Property Tax and Rent Rebates

In Pennsylvania, home owners or renters age 65 or older, widow/ers age 50 or older, or individuals permanently disabled during all or part of the claim year and 18 years or older during the claim year and unable to work because of a medically-determined or mental disability, with a total household income of $35,000 or less, may file a claim with the Pennsylvania Department of Revenue for a real property tax or rent rebate and inflation dividend. Claims applications are due for filing between January 1 and June of the year following the year in which the individual paid the tax or rent. Beginning in claim year 1999, claimants may exclude 50% of their Social Security/Railroad Retirement income in determining their eligibility requirements. So if you make $40,000 or more, you may still qualify for a rebate.

In addition, owners must have paid taxes prior to filing and renters must make certain their landlords were required to pay property taxes or made payments in lieu of property taxes on the rental property. Claimants who qualify can be reimbursed up to $650 a year for the amount they

paid in property taxes or rent; rebate checks are mailed beginning July 1st of each year. Proof of income is required, such as copies of the state or federal income tax returns for the claim year in which you are filing. If you are claiming a rental rebate, you must include proof of the rent you paid, such as an affidavit signed by the landlord or the landlord's agent. If the landlord's signature cannot be obtained, the claimant must complete and submit a notarized rental occupancy permit.

Amount of Rebates

The amount of reimbursement is calculated as a percentage of the claimant's income. A home owner can be reimbursed from 10% to 100% of the total taxes paid, up to a $650 maximum. A renter might be reimbursed 2% to 20% of the total rent paid, again up to a $650 maximum. However, there are no guarantees of these payments. If you require further information on this program, you may call 1-888-728-2937. This toll-free number provides a menu of telephone numbers whereby information specific to your area of inquiry is given. The Taxpayer Service Information Center For Tax Questions is 717-787-8201. Businesses or home owners may call 717-787-1064 with their rent or rebate questions.

If you qualify for the property tax and rent rebate program, you may also be eligible for PACE or PACENET, which are prescription drug programs funded by the Pennsylvania lottery. See pages 52-53 for more information. For further information regarding property tax and rent rebates you can contact the Pennsylvania Department of Revenue at 1-888-222-9190 or 1-800-772-5246 or at their website: www.revenue.state.pa.us. You can get help in filling out PACE and tax rebate forms through your local Area Agency on Aging or at most local senior centers.

Estate Planning

Many people think the term "estate planning" applies only to very wealthy people. Nothing is further from the truth. An "estate" is simply what you own. If you own property, you need to plan ahead in order to make sure the desired people or institutions inherit your property after your death.

If you die without planning your estate, your home, money and other property will be distributed to various relatives, sometimes distant relatives, according to a rigid formula fixed by law known as "intestacy law." This law applies to every person who dies without a will and does not consider special needs of any individual or family.

Without a will, your property may be inherited by people you do not want to share in your estate. Without a will, individuals in control of your estate may not be the people you prefer and they may not even cooperate with each other. If you have no will, the Commonwealth of Pennsylvania in effect, makes a will for you, according to the terms of the intestate law, which controls the distribution of the shares of your estate.

The existence of a well-considered estate plan, most importantly a will, can help avoid disputes among your heirs and will give you the peace of mind that comes with knowing that your final wishes will be carried out.

The Will

A will is an important legal document and the cornerstone of most estate plans. In a will, you direct how your property is to be distributed and you also name a personal representative to administer your estate.

The personal representative named in a will is commonly referred to as the "executor." An executor collects the estate assets, pays the estate debts and makes distributions to the beneficiaries you have designated in your will.

Some estate planning attorneys believe it is generally advisable to nominate one executor and an alternate in your will rather than naming two individuals to serve as your co-executors. Co-executors may have difficulty getting paperwork signed in a timely manner and can delay estate administration. On the other hand, some parents wish their children work together and name them to act jointly.
If you already have a will, take it out and re-read it. Do you understand what it says? Do you agree now with the arrangements you made earlier? Update your will if circumstances have changed. Marriage, death, divorce, birth, asset growth, moving to a different state or a change in estate tax laws are events that may trigger the need for you to revise your will. A good rule-of-thumb is to review your will at least once every five years.

Keep your original will in a secure place such as a fire-proof box, a safe deposit box at your bank or with your attorney. If your lawyer is holding your will, ask whether it is being held in a fire-proof vault or other protected location, and how access will be assured in the future.

If you are afraid that somebody might tamper with or destroy your will if they were to read it, leave it with your lawyer or place it in a safe deposit box where its contents will be kept private. In Pennsylvania, a safe deposit box is accessible upon death of the owner for the limited purposes of retrieving the decedent's will and cemetery deed.

You have the right to request your original estate planning documents from your attorney at any time. The documents belong to you, not your lawyer. You also have the right to revoke your will and write a new one at any time you choose, providing you have the mental capacity to do so.

Trusts

Your attorney might recommend a "trust" in larger estates, estates with young beneficiaries and in situations with special circumstances. What is a trust? Many estate planners explain that a trust is like a box where you can place your property. A person places money in the box, the trust, and designates a manager, known as the "trustee," to safeguard the contents of the box. The trustee then distributes trust assets to the beneficiaries you select, in such amounts and at such times as you direct. Of course the money is not really put in a box. The "box" is usually a brokerage account or a bank account where the funds are invested by your trustee.

For example, a grandparent may wish to set aside money for a disabled grandchild, but may be afraid to do so for fear of disqualifying that grandchild from certain government benefits. A grandparent could place the money in a carefully drafted trust, designate a trustee to invest and safeguard the funds and enable the disabled child to benefit from the trust while maintaining eligibility for government benefits such as Medicaid or Supplemental Security Income (SSI) payments. This trust is sometimes called a special needs trust or supplemental needs trust.

There are many other types of trusts. Credit shelter trusts, also called "by-pass trusts," are commonly used to help protect large estates from federal estate taxes. Trusts can also be used to set aside money for designated purposes, such as for education. Discretionary trusts and "income

only" trusts can be written to protect spendthrift beneficiaries from squandering their inheritance through wasteful spending habits.

Trusts usually cost more money to create because they are more complicated and must be customized for each particular situation. In addition to the costs of drafting a trust, there are continuing attorneys' fees and trustees' commissions over the years as a trust is administered. Many trusts require the filing of fiduciary income tax returns; accordingly, an accountant's services are often needed to help prepare and file these tax returns. Obviously you need to consider the ongoing administrative costs as you decide whether it makes sense to create a trust.

Revocable Living Trusts

Before having a lawyer prepare a living trust, you must determine whether it will be useful for your situation. Living trusts may be helpful, for example, when you own out-of-state real estate and wish to avoid probate outside Pennsylvania. Living trusts may also save costs where the estate is very large, such as federally taxable estates where estate administration costs or legal fees can be higher than the costs and fees for the average estate, however most people do not have federally taxable estates.

Some people are confused by the complexity of revocable trusts and may experience or feel a loss of control over the assets in the trust. Moreover, many feel the benefits of a costly trust can be obtained through less expensive alternatives, such as through the use of a general durable power of attorney. See page 31 for more information.

Living trusts are clearly not for everybody. Consumers should approach sales pitches for "revocable living trusts" with a high degree of caution. In recent years a number of older consumers have been defrauded by salespeople who push the supposed benefits of living trusts in "free" seminars and mail solicitations. Living trust sales pitches are frequently accompanied by an effort to sell high-commission annuities. These annuities typically have expensive surrender penalties when money is withdrawn within the first few years after the annuity purchase. These surrender penalties are especially punishing to seniors who may need to withdraw funds sooner than expected in order to pay long-term care costs. Not all annuities have high surrender penalties, and some products specifically provide for the penalty-free withdrawal in cases where the annuity owner requires nursing home care. When considering the purchase of an annuity, work with a reputable financial advisor, and consider have your estate planning attorney review the annuity before making the investment since there are serious implications for Medicaid.

Living trusts can be more expensive than you are led to believe. There are costs involved in the re-titling of your assets into the trust and they do not save Pennsylvania inheritance taxes.

If you wish to obtain a low-cost second opinion from an elder law or estate planning attorney before proceeding with a living trust, call your county bar association's Lawyer Referral Service or the Pennsylvania Bar Association's Lawyer Referral Service. Tell the service representative that you would like to meet with an estate-planning attorney before going forward with the preparation of a living trust to make sure that it is right for you. A consultation with an estate-planning attorney will save your money and your peace of mind by making you aware of options not mentioned by the salesperson.

Non-Probate Property

Just as you need to review your will periodically, you should check the beneficiary designations on your life insurance and retirement accounts to make sure they are up-to-date. Many people select beneficiaries when purchasing a life insurance policy or opening their accounts but never re-check these decisions. It is particularly important to do so as families change over the years.

You also need to be aware that jointly-held property, accounts held in trust for (ITF) and annuities do not pass according to the provisions of your will. Rather, these items pass by law to designated beneficiaries or to the survivor listed on the account. Be sure these beneficiary designations are carefully reviewed when developing your estate plan.

Inheritance, Estate and Gift Taxes

Over the years, senior citizens have watched tax regulations at all levels grow more and more complicated. Guideline information is offered below with the advice to consult with a professional if you have questions.

Pennsylvania Inheritance Tax

This death tax must be paid by the estate within nine months of death to avoid a penalty. To the extent that the inheritance tax is paid within three months after the date of death, a discount of 5% is given.

The inheritance tax rates in effect based on the recent changes to the Pennsylvania Inheritance Tax Act are effective for dates of death on or after July 1, 2000 and are as follows:

- The tax rate for transfers to a grandfather, grandmother, father, mother, child, lineal descendant or their spouse is 4 1/2%.
- The tax rate for transfers to a spouse is zero %.
- The tax rate for transfers from a child age 21 or younger to a natural parent, an adoptive parent or a stepparent is also at the zero % tax rate.
- The tax rate for transfers from a decedent to a sibling has been lowered to 12 %. The Inheritance Tax Act defines a sibling as “an individual who has at least one parent in common with the decedent, whether by birth or adoption.” This includes a sibling by birth, a stepsibling by birth as well as a sibling by adoption.
- The tax rate for transfers to all other collateral beneficiaries (nephews, nieces, aunts, uncles, cousins, other relatives, friends, etc.) continues to be 15 %.
- Gifts to charities or government entities continue to be deductible from the estate.

Federal Estate and Gift Taxes

The federal estate tax exemption is $5,120,000 for 2012, but may be decreased to $1,000,000 in January, 2012, if Congress does not act to raise the limit. It is expected that Congress will increase

the limit but that cannot be determined at the time of this writing.

Year	Exemption Amount
2012	$5,120,000
2013	$1,000,000

Federal taxation is not a concern for estates with assets under the amount covered by the exemption; however, you should check with your lawyer for other specific concerns. Most decedents' estates are below the current federal estate tax limit, and usually, only Pennsylvania inheritance needs to be paid.

Taxation of gifts does not follow the federal changes for estate taxes. In the year 2012, annual gifts of $13,000 or less per person per donee are not taxed. Thus a husband and wife, combined, may transfer up to $26,000 to each donee (i.e. $26,000 to each of their children) per year, without being subject to federal taxation. There is no federal limit on gifting, but gifts which exceed the $13,000 exemption amount may be considered taxable gifts. See your estate planning attorney for guidance on the taxation of gifts.

Planning For Gifts

As you plan to make gifts in your elder years, you need to know about federal estate and gift taxes, income taxes, real estate law, estate law, wills and divorce law. Your first step should be to consult an attorney.

Your attorney will ask you to gather copies of all federal income tax and gift tax returns, gift checks, recorded and unrecorded deeds, copies of gift letters and trust agreements. After a review of all the documents and a discussion of your goals, you will be ready to select the property to be gifted, with your attorney's assistance as you make your decisions.

You may want to consider a gift to charity. Many not-for-profit institutions have resources to aid you in making gifts, particularly in setting up a charitable gift annuity, which allows you to give cash or securities while providing you with a guaranteed, lifelong income. Under certain conditions you could enjoy a significant charitable tax deduction without incurring a capital gains tax if you give appreciated securities with a low cost basis. Again, you need to see your attorney to help you to review all your options.

The Internal Revenue Service defines a gift as "any voluntary transfer of property from a donor to a donee without what is called full and adequate consideration". A gift will be computed when the donor gives up control over the transferred asset. Your gift to anyone during a calendar year will be a "taxable gift" if it exceeds the annual exemption amount. Your payment of educational or medical expenses for another individual is not generally subject to federal gift tax.

The value of a gift for federal gift tax purposes is the "fair market value" of the property transferred. Fair market value is generally defined as the "price which would probably be agreed upon by a seller willing to sell and a buyer willing to buy where both have knowledge of the facts." Gift tax returns, which list the gifts made in that year which exceed the annual exemption amount, must be filed annually when you file your personal income tax return.

Under the Deficit Reduction Act of 2005, gifts made after February 8, 2006 can make you ineligible for Medicaid long-term care benefits many years after the gift is made. Medicaid caseworks will be looking for gifts going back five years. It is therefore very risky for seniors to make gifts of any size if they might need nursing home care within that window of time. Only those with sufficient resources to pay privately for nursing home care for five years can ignore the new Medicaid transfer penalties. Nursing home care currently costs $8500 *per month* in Pennsylvania, so most seniors should proceed cautiously before making any gifts.

Meeting With Your Lawyer

Perhaps the most difficult part of the estate planning process is overcoming procrastination and scheduling that initial consultation. For the best results, you need to deal with an attorney who provides estate planning services on a regular basis. When you call to schedule your appointment, be sure to ask whether there is a fee for the initial consultation. At your first conference, be sure to ask about the total cost to have your documents prepared. Some lawyers charge for documents on a flat fee basis, while others bill at an hourly rate. In either case, reputable lawyers always discuss fees up-front at the initial consultation and they will put the agreement in writing.
Before you visit your lawyer, you can make the initial meeting more productive by bringing the following information:

- a list of what you own;
- a list of your intended beneficiaries with their names, ages and addresses;
- your choice of executor and at least one alternate;
- a list of all the questions you have about estate planning.

Your lawyer will thus be able to spend more time developing a plan with you and less time writing down basic information. If you suspect trouble in the family, mention this to your attorney so the issues can be addressed in a way that minimizes conflict. Remember that anything you discuss with your attorney is confidential client information.

After working with you to develop your plan, your lawyer will then prepare the necessary documents. It is very important that you understand all papers you sign. Then, once signed, make sure everything is kept in a secure, fire-proof location.

Power of Attorney

A durable power of attorney is a written document authorizing a named person called “agent” to handle certain specified types of transactions for the person making the power of attorney, called the “principal.”

General powers of attorney are very broad and allow many types of transactions. Limited powers of attorney convey the power of attorney to an agent to handle a specified task, for example, to attend and sign documents at a real estate settlement.

The power of attorney is “durable in that it remains valid even after the principal no longer has legal capacity to convey property or handle similar transactions, perhaps due to an injury or an illness such as Alzheimer’s disease. However, legal capacity must exist when the power of attorney is

first executed. All powers of attorney executed since 1993 in Pennsylvania are durable unless otherwise stated.

A "springing" power of attorney can be executed so that it will only take effect if the principal's legal capacity has diminished or the principal becomes disabled. The agent's power to act then "springs" into effect upon the happening of an event such as disability. A major question of a springing power of attorney is: when does it take effect? Springing powers of attorney can include a formula that involves one or more physicians attesting to the fact that the principal has lost their capacity or is disabled in order for the power of attorney to take effect. Documentation that the triggering event has occurred is normally required.

Pennsylvania law now requires a special statutory notice in capital letters at the beginning of the power of attorney, signed by the principal, acknowledging an understanding of the powers and duties being conveyed to the agent under the power of attorney and stating that the power of attorney has been read and understood. The law also requires an Acknowledgment signed by the agent that they have read the power of attorney and understand it and that they are to exercise the powers given to them for the benefit of the principal only. The agent agrees not to co-mingle any assets of the principal with their own assets and further agrees to exercise reasonable care and caution, keeping a full and accurate record of all of their actions.

Pennsylvania law also permits you to allow the agent to make gifts of your assets. This is very risky, so exercise great caution when allowing another person to make gifts of your money or property. For specific procedures you should contact your lawyer.

Revoking a Power of Attorney

As long as the principal has legal capacity, they can sign an affidavit to revoke the power of attorney, name a new agent, or designate a co-agent to check on the actions of the first agent. The power of attorney should be notarized and witnessed since some powers of attorney must be recorded at the Recorder of Deeds Office, for example, when real estate is being transferred. Often, if a power of attorney does not have a recent date on it, institutions will require the financial principal to sign a "certification" that the power of attorney has not been revoked and is still in full force. A power of attorney does not lapse with the passage of time and does not become invalid just because it is old.

Special Powers of Attorney

Health care powers of attorney and financial powers of attorney are special forms of power of attorney that delegate to an agent the power to act on your behalf regarding medical and health issues in the event that you are unable to do so yourself. The agent under a health care power of attorney may authorize the principal's admission to a medical, nursing, residential or similar facility, enter into agreements for care, and authorize medical and surgical procedures. A financial power of attorney is also a special form of power of attorney that delegates to your agent the power to act on your behalf relating to financial affairs only.

Failure to Act

Any person who fails to act according to the directions of an agent appointed by the principal, without reasonable cause, can be subject to money damages if suit is filed.

Fraud

A power of attorney can be an invaluable tool in aiding an elderly individual who needs assistance, but it can also be a means to facilitate fraud. Steps you can take to minimize that potential are:

- Choose the right person to act as your agent under a power of attorney. Make sure that the individual is someone you can trust who will make decisions on your behalf in accordance with your wishes.

- Be careful what powers you give to an agent under a power of attorney. Make sure you read every word and understand what powers are included in any power of attorney before you sign the document. Powers of attorney can be broad or narrow, allowing a full grant of authority to act for an individual or providing only a limited power of attorney for a particular event or situation, i.e. power of attorney for the sale of real estate.

- Consider appointing more than one person to act as your agent. While this may be more cumbersome and less efficient, it may provide a process of checks and balances in that your agents must agree on decisions and actions.

- Prevent premature use of the power by your agent, you can withhold the document until it is needed or require that the document be held by a non-agent with full instructions for release to the agent.

- You may require your agent to account periodically to a disinterested third person.

- Your power of attorney should only be written by your lawyer, pursuant to your specific instructions.

Health Care Provisions in a Power of Attorney

A power of attorney usually deals with financial and personal issues but can include medical treatment. The law allows an agent, appointed by you in your power of attorney, to authorize your admission to a medical, nursing, residential or similar facility, and to enter into agreements for your care if you so state. The agent may, with respect to your admission to a facility, execute consent or admission forms required by the facility and enter into agreements for your care by a facility or elsewhere. The law also allows you to authorize your agent to arrange for and give consent for medical, therapeutic, and surgical procedures, including the administration of medications.

Health Care Powers of Attorney and Living Wills

Pennsylvania recently enacted new legislation governing the requirements for individuals (known as principals), who are of sound mind to write a Health Care Power of Attorney and Living Will for use in the future if they are incapacitated. The legislature recognized the importance of having both documents. However, one cannot be forced to have a Living Will as a precondition to placement in a care facility or for hospitalization. The new law provides for the following:

A. Permits a principal to allow a health care agent to make all the health care decisions for the principal, including those concerning life-sustaining treatment.
B. Permits a principal to appoint multiple and successor health care agents.

C. Provides that a principal may countermand a health care decision made by an agent.
D. Explains how a health care power of attorney may be amended and revoked.
E. Uses the term “Living Will” that becomes operative when the individual is an “end stage medical condition” to ensure that an individual’s wishes are followed and that the individual receives medical care if the individual would benefit from the treatment and it would not merely prolong the process of dying.
F. Authorizes health care representatives to make health care decisions when there is no health care agent and provides who may act as a health care representative if there is no health care agent.
G. Creates a presumption that the principal would NOT want nutrition and hydration withheld or withdrawn and provides how that presumption is overcome, in the absence of a written direction to the contrary.

Individuals who are concerned about controlling their health care decisions can do so directly through written instructions written in advance through a health care agent that they designate for routine care if they are incapacitated or are unable to make health care decisions (Health Care Power of Attorney). Instructions can also be written in advance in Living Wills for directions when an individual is in an end stage medical condition. If these documents are not written in advance, the new law establishes presumptions for a patient’s end care stage. If needed, the law can permit the designation of a health care representative, usually a family member, if a health care agent has not previously been named by an individual in a Health Care Power of Attorney or Living Will. Previously drafted documents remain valid.

If one person is to act as your agent for your financial affairs and another as agent for your health care, you need to create two separate documents.

HIPAA (Health Insurance Portability and Accountability Act)

Privacy requirements were recently enacted under HIPAA or the Health Insurance Portability and Accountability Act. The purpose is to protect an individual’s personal health information and this is the first federal law to do so. HIPAA also enables individuals to access, inspect, copy and correct their health care information and gives them rights to an accounting of certain disclosures of this information.

The regulations apply to health care providers, health plans, health care clearinghouses and the business associations that deal with those entities. Protected health information may not be disclosed to business associates unless a signed patient authorization that meets specific requirements is obtained. An individual’s personal representative and their Agent under a Power of Attorney may obtain medical records and health information if they are specifically authorized to do so in the individual’s Power of Attorney.

Out of Hospital Do Not Resuscitate (DNR) Orders

Out of hospital Do No Resuscitate orders are also recognized by the new legislation. These are known as DNR orders and can be in the form of a written order, bracelet, or necklace, the contents of which are described in the statute. They are primarily intended to direct Emergency Medical Service providers to comply with the patients’ wishes when a patient is experiencing cardiac or respiratory arrest and has both an Health Care Directive and an out of hospital DNR order issued under the DNR Act. An EMS provider can withhold CPR upon observing an out of

hospital order, bracelet or necklace displayed with the patient. The EMS provider can follow the patient's wishes pursuant to the DNR order.

Physician Order for Life-sustaining Treatment "POLST" Form

Pennsylvania has approved a POLST form. The use of POLSTS is intended to help ensure that patients receive appropriate care at the end of life. This is achieved by creating an actionable medical order that directs care that is consistent with patients' goals and preferences for end of life care and treatment. It is provided in a form that can transfer with the patient as they move between medical providers such as if they are admitted to a hospital from a nursing home. The POLST gives patients choices from a full range of care options, from aggressive to limited to comfort care. Health care professionals can discuss options with seriously ill patients or their Agent under their Health Care Power of Attorney, and document those preferences on a standardized medical from and ensure that it travels with the individual. It differs from a Living Will or Health Care Power of Attorney in that it is an actionable medical order dealing with the current medical situation and can even be created if these documents do not already exist, although it is always preferable to have them prepared in advance.

Guardianships

Sometimes people are unable to make decisions about their health or finances and can no longer manage for themselves. Dementia or other progressive mental, emotional or physical illnesses can rob people of the ability to keep themselves safe. In the worst cases, individuals can become victims of others who see opportunities to take cash and possessions while "helping" or doing favors. The impaired person may even be pressed to make important decisions about medical care or living arrangements.

To provide a decision-maker for people in these situations, Pennsylvania law allows the Orphans' Court to appoint a guardian of the person (for living arrangements) and/or a guardian of the estate (for financial matters). Anyone interested in the person's welfare can file the petition seeking a guardian; however, a guardian must be identified and be willing to serve. The court will not produce one and depending on the county, there may be no public guardian service.

To qualify for a guardian, a person must be found impaired in such a way that they are partially or totally unable to manage financial resources or meet essential requirements for physical health and safety. Because a ruling of "incapacity" and appointment of a guardian involves the curtailing of many important legal rights, stringent standards must be met. Notice must be given to the alleged incapacitated person and there is a right to request counsel.

Hearing before the Court

The incapacitated person is required to attend a hearing before the Orphans' Court unless excused, for example, by a doctor. An attorney for the incapacitated person is not required unless ordered by the court, as may be in cases of family conflict. When testimony by qualified persons such as a psychiatrist or other health care provider establishes clear and convincing evidence that the person is incapacitated, a guardian will be appointed. Just because an individual has periods of confusion does not mean that they will be found incapacitated under the law. Now, a jury trial

may be requested for a guardianship hearing.

If incapacity is established, the court will appoint a guardian of the estate and/or person with full or limited powers. It is the duty of the guardian to assert the rights and best interests and to respect the expressed wishes and preferences of the incapacitated person to the greatest possible extent. The guardian must also encourage the incapacitated person to participate in all decisions which affect them to the maximum extent of their abilities. However, the guardian does not have to follow the wishes of that person if they are in conflict with their best interests. For example, many times an incapacitated person wants to continue to live in their home; if the guardian determines that assisted living or skilled nursing care is necessary, the guardian is fully authorized to admit the person to a facility, even over that person's objections. A guardian may also admit an incapacitated person to a psychiatric facility for treatment but may not involuntarily commit a person for treatment.

The appointed guardian has all powers set forth in the court order, usually including making every kind of decision with the exception of admitting to inpatient psychiatric facilities or consenting to relinquishment of parental rights. Court approval is needed for consent to abortion, sterilization, psychosurgery, shock therapy, removal of a healthy organ, or to prohibit marriage, consent to divorce or to consent to experimental procedures.

Typical decisions made by guardians of the person include arranging medical care and consenting to surgery or other treatments, determining where an incapacitated person is to live and contracting for admission to nursing facilities. A guardian for the estate has the same duties as a personal representative, executor or administrator with specific requirements and limitations. Every guardian must file a detailed annual report with the Orphans' Court.

Preparing a comprehensive power of attorney may make guardianship proceedings unnecessary and is less expensive and stressful than the court process. Any person could, of course, name in advance a preferred guardian of the estate or the person for consideration by the court in the event a court proceeding becomes necessary.

A guardian's authority expires upon the death of the incapacitated person. Unless there is someone entitled to act under estate law (a family member, someone entitled to the estate under a will, etc.), there is no one who can make final arrangements, pay bills, distribute assets, sell a house or take other actions which may be necessary. Many times there is no such person willing or qualified to serve as administrator. This leaves a big gap in the ability to take necessary or desirable actions.

Social Security

The Social Security Administration operates a variety of programs and benefits, including retirement and survivor benefits, Social Security disability insurance benefits, Medicare health insurance, and Supplemental Security Income benefits. Your county or region may have one or more local Social Security offices. These offices have several helpful and informative publications available free to anyone who requests them.

Anyone who has access to the Internet can check the Social Security Administration's official website which offers comprehensive information about all of its programs and benefits. The website is www.ssa.gov and it offers more than 10,000 pages of information. You can do a variety of tasks

at this website: request a copy of your earnings record and an estimate of the benefits you and your family will receive when eligible; find out how to file a claim for retirement or disability benefits; find out how to replace a lost Social Security card or change the name on your Social Security records; locate the nearest Social Security office and get a statement verifying the amount of Social Security benefits you receive. You can also download copies of booklets and fact sheets about Social Security disability, retirement and survivor benefits and SSI benefits.

Applying for Benefits from the Social Security Office

Do not delay in applying for benefits for which you may be eligible. Any delay on your part could result in fewer benefits if you are ultimately found eligible for certain benefit programs operated by Social Security. When in doubt, contact Social Security to begin the application process as soon as you may be eligible. To get an estimate of your benefits you can submit a completed form SSA-7004-SM to the Social Security Administration. It takes about six weeks to receive the information.

Deadlines

Keep in mind that Social Security will give you a deadline to finish certain tasks (i.e., file a written application after you call them, file a written appeal if you are dissatisfied with their decision, etc.). You must comply with their timelines or you will lose your right to potential benefits. Typically, their deadlines are within 60 days. However they may be shorter for special circumstances so you must check this carefully.

Toll-Free Social Security Number: 1-800-772-1213; Website: www.ssa.gov

The Social Security Administration maintains a toll-free number which you can call to obtain information, set up an appointment, or transact other business. Be careful. There have been some reports that some Social Security staff members who answer this toll-free number do not always provide accurate or complete information. When in doubt, call your local Social Security office to make an appointment to meet with their staff in person so they can review your file with you. Take a friend or relative with you. People who are deaf or have difficulty hearing may call the Social Security office at their toll-free “TTY” number: 1-800-325-0778.

Written Explanation for Denial of Benefits

If Social Security denies your claim for any benefits, you are entitled to a written explanation giving the reasons for denying certain benefits. If you do not receive a written explanation, ask Social Security to provide you with this documentation.

Correcting Records with Social Security

If you are receiving benefits or applying for benefits from Social Security, it is important that you contact the Social Security Administration to inform them of any changes or corrections in your records. For example, if you move, change bank accounts, or disagree with the earnings records which they have posted to your Social Security account, you should take immediate steps to inform Social Security of any changes or additions.

It has been estimated that a small percentage of Social Security participants have incorrect Social Security retirement accounts. This means that Social Security may not know about all of your

earnings in your lifetime, and therefore your retirement benefits may be lower than they should be. It is important to check your records every couple of years, at least until you are receiving benefits, to verify your earnings records on file with Social Security.

Legal Assistance

If you have a problem with a Social Security claim and desire legal advice, a good contact is the National Organization of Social Security Claimants' Representatives: (NO SSCR) 1-800-431-2804. They maintain a national listing of attorneys who concentrate their law practice in Social Security matters. You may also wish to contact your local Legal Aid office in your community, or if they have one, your local county bar association can direct you to their Lawyer Referral Service which can make a referral in almost any area of the law. If your county does not have a local Lawyer Referral Service, you may contact the Pennsylvania Bar Association Lawyer Referral Service at 1-800-932-0311 Ext. 2209.

Social Security Benefits

The following is a brief description of some of the benefits available through the Social Security Administration. Remember that Social Security is a system of social entitlement; it is neither welfare-based nor based on means. The system provides benefits not only during retirement but also for survivors and dependents in case of death or disability. Keep in mind that this is not a description of all of the eligibility requirements for each of these programs and benefits. Some of the eligibility requirements are complicated and cannot be fully addressed in this guide. When in doubt, contact the Social Security Administration and set up an in-person appointment to ask about your eligibility for benefits.

Retirement Benefits

If you were born January 2, 1942, through January 1, 1943, your full retirement age for retirement insurance benefits is 65 years and 10 months. If you were born January 2, 1943, through January 1, 1955, then your full retirement age is 66. If you work and are full retirement age or older, you may keep all of your benefits, no matter how much you earn. If you are younger than full retirement age, there is a limit to how much you can earn and still receive full Social Security benefits. If you are younger than full retirement age during all of 2012, $1 will be deducted from your benefits for each $2 you earned above $13,560.

If you reach full retirement age during 2012, $1 will be deducted from your benefits for each $3 you earn above $36,120 until the month you reach full retirement age.

Anyone born before 1938 will be eligible for full Social Security retirement benefits at the age of 65. However, beginning in the year 2003, the age at which full benefits are payable will increase in gradual steps from 65 to 67.

No matter what your "full" retirement age is, you may start receiving benefits as early as age 62. However, if you start your retirement benefits early, they are reduced five-ninths of 1% for each month before your full retirement age. There are disadvantages and advantages to taking your retirement benefits before your full retirement age. The disadvantage is that your benefits are permanently reduced. The advantage is that you collect benefits for a longer period of time. Each person's situation is different, so you should contact Social Security before you make any

decisions.

Social Security Disability Insurance Benefits (SSDIB) Title II

If you have worked long enough and earned enough Social Security "credits" to qualify for disability on your own work record, and if you are medically determined to be unable to do "substantial gainful" work for at least one year, you may qualify for Social Security disability insurance benefits on your own account. This is a complicated program and you should visit your local Social Security office in order to apply. This is not intended for a temporary condition; there is no such thing as a "partial" disability benefit program from Social Security.

Supplemental Security Income Benefits (SSI)

The SSI program is based on means. To qualify, you must be "poor" (low income and few assets) and be either medically disabled, blind, or 65 or older. However, this is not a benefit program to "supplement" your income which you may already receive in the form of retirement benefits, SSDIB, or a pension. In other words, in addition to the other eligibility requirement, you must meet strict poverty income guidelines in order to receive this benefit. For example, for a single person in Pennsylvania, if you are medically disabled, but receive more than $674. per month from another benefit such as SSDIB, retirement, or a pension, you will not be eligible for SSI benefits greater than $1.00 because Social Security will consider that you make too much money to qualify for SSI. If more than $1,266.00 is received as earned income, an individual will not be eligible for SSI benefits.

Survivor Benefits

When you die, certain members of your family may be eligible for benefits on your Social Security earnings record if you have earned enough credits while you were working. Family members who can collect benefits include:

- a widow or widower who is 60 or older;
- a widow or widower who is 50 or older and disabled;
- a widow or widower at any age if they are caring for a child under 16 or a disabled child who is receiving Social Security benefits;
- children if they are unmarried and
    - under age 18;
    - under age 19 but in an elementary or secondary school as a full time student;
    - age 18 or older and severely disabled (the disability must have started before age 22);
- your parents, if they were dependent on you for at least half of their support.

Benefits for a Divorced Spouse

One receives Social Security benefits in one of two ways: based on one's contributions to the Social Security system or as a spouse of such a contributor, which benefits are called derivative benefits. The recipient will receive benefits in the manner that provides the higher benefits.

After divorce, one can receive benefits based on the contributions of a former spouse if the marriage was of at least ten years duration. Derivative benefits for divorced spouses do not affect

the benefits of the contributing spouse and family allowance does not apply. If a divorced spouse seeks benefits based on an eligible former spouse's earning record, and the former spouse is not collecting benefits, the divorced spouse can collect benefits only after two years have elapsed from the date of the divorce. In addition, the spouse from whom benefits are derived must be eligible for benefits; that is, at least 62 years of age and fully insured, even if they are not actually receiving benefits. The qualifications of the dependent spouse are: being at least 62 years of age and remaining unmarried.

If you are already a surviving divorced spouse planning to remarry close to age 60, wait until age 60 to avoid the remarriage penalty. In the event you are considering getting divorced, consider the impact on you of social security benefits. If you are a dependent spouse getting a divorce, at any age, and your marriage is close to ten years, defer the divorce until there are ten years from the date of the marriage to the date of the divorce decree. Before having alimony cease at age 62, consider the reduction of benefits and inability to qualify for Medicare. If a divorcing dependent spouse is planning to receive benefits based on the earnings record of the spouse who is not receiving benefits, make sure that benefits are not sought until two years after the date of divorce.

If the dependent spouse remarries, they will not be eligible for derivative benefits from a contributing spouse. However, if such remarriage terminates, the dependent spouse becomes eligible for derivative benefits once again from the former contributing spouse. If a dependent spouse has been married more than once and each time for at least ten years, derivative benefits can come from the former spouse's contributions providing the higher benefits.

The marriage may be a legal marriage, a common law marriage or a deemed marriage, which is a marriage deemed valid by the administration if the relationship cannot be established under state law when in good faith, a person went through a marriage ceremony that would have resulted in a valid marriage except for a legal impediment.

Benefits to Divorced Widow(er)s

If you are divorced, even if you have remarried, your ex-spouse will be eligible for benefits on your earnings record if you are fully insured when you die. In order to qualify, your ex-spouse must:

- be at least 60 years of age, or 50 years of age if disabled, and have been married to you for at least ten years;
- be any age if caring for a child who is eligible for benefits on your earnings record;
- not be eligible for an equal or higher benefit on their own earnings record; and
- not be currently married, unless the remarriage occurred after age 60, or 50 for disabled widow(er)s.

The surviving divorced widow receives 100% of the benefits instead of the 50% received if the former spouse is alive.

Income Tax on Social Security Benefits

The test is whether the individual's adjusted gross income combined with 50% of his/her Social Security benefits plus any tax-exempt interest exceeds a base amount. For individuals, that base amount is $25,000; for married couples, the amount is $32,000. The amount of benefits that will then be included in taxable income is the lesser of half of the benefits or half of the excess of the

taxpayer's combined income (modified adjusted gross income plus half of the benefits) over the base amount.

For individuals whose combined income exceeds a higher adjusted base amount ($34,000 for single individuals, $44,000 for a married couple filing a joint return), the amount of benefits that will be included in taxable income is the lesser of 85% of the benefits, or 85% of the excess of the taxpayer's combined income over the adjusted base amount plus the lesser of half the benefits or $4,500 for a single person, $6,000 for married couples. Because these issues are so complex, you may wish to consult a tax attorney for guidance.

Most pensions are not counted in the retirement test. However, when one spouse works and the other is drawing benefits, the base amount can be easily exceeded. Form SSA 1009 shows the benefits received and is sent each January to every Social Security recipient for inclusion in the federal income tax return.

Considerations and Issues to Be Aware Of if You Already Receive Some Benefit(s) From the Social Security Administration

Social Security has rules which require you, as beneficiary of Social Security, to report changes to the Social Security Administration. There can be consequences to you if you fail or neglect to report changes to Social Security, and these consequences can include sanctions against you, such as overpayment requests, fraud charges or termination of your benefits. Here are a few of the many things to be aware of if you already receive Social Security benefits:

1. If you receive Social Security retirement or survivors benefits:

    A. You must report any changes in your address, or if you change your name, via marriage or divorce;

2. If you work and get benefits at the same time:

    A. If you are over the age of 65, you will continue to receive full Social Security benefits regardless of how much you earn in wages or salaries;

    B. However, an earnings limit still applies to people between the ages of 62 and 65 who collect Social Security and earn wages or salaries over a specified exempt amount. In 2012 for every $2 in earnings above the limit ($14,160 per year), $1 in benefits will be withheld. See Social Security Publication No. 05-10069, How Work Affects your Benefits, if you want more information on how earnings affect your retirement benefit. It has current annual and monthly earnings limits.

3. If you receive SSI disability benefits:

    A. You must report any income changes (increases, decreases) to the Social Security Administration. You should also report any changes in the income of other family members living with you (i.e. spouse, child). Income is a very broad term and includes many things, including wages from a job, the value of food or shelter or clothing that someone else gives to you or the amount of money they give you to help pay your bills, unemployment, annuities, pensions, etc.

B. You must inform Social Security if you move and provide them with your new address.

C. You must inform Social Security if there is a change in the number of people who live with you or if you get married or if your marriage ends. For example, if someone moves into or out of your home, or if someone who lives with you dies.

D. You must inform Social Security if you enter or leave an institution such as a nursing home, hospital, shelter or penal institution.

E. If you return to work, part-time or full-time, you must report this to Social Security. There are special SSI rules to help you try to work. In some cases, your SSI benefits may continue while you work and are still disabled; as your earnings increase, the amount of your SSI will decrease and may eventually stop if you earn too much each month.

4. If you receive SSDIB disability benefits, your benefits will generally continue for as long as your impairment has not medically improved and you cannot work. Social Security will review your case periodically to confirm you are still disabled. If you receive SSDIB benefits:

A. You must report any changes such as change of address or marriage or divorce, or changes (i.e., improvements) in your medical conditions. Failure to report such changes in your medical conditions could mean that you will get payments that are not due to you, and that will have to be repaid to Social Security.

B. If you go to work, part-time or full-time, you must report any earnings to Social Security because earnings may affect your Social Security benefits.

C. Even after you start receiving disability benefits, there are many work incentives that are designed to ease the transition back to work. To understand how work affects your disability benefits, you need to understand how Social Security measures your work. Disability benefits can be paid only if you are unable to do any "substantial" work. The amount of your earnings is the key to determining whether your work is substantial. As of January 1, 2012, if your wages are more than $980 per month, you are generally considered to be performing substantial gainful activity (SGA). In addition, Social Security permits a "trial work period" for nine months during which you can test your ability to work. You must report all earnings to Social Security during such a period. During the trial work period, Social Security disability beneficiaries may work and receive Social Security Disability benefits. After completion of nine trial work months within a 60 month period, the substantial gainful activity level ($1010 per month in 2012) is used to determine whether earnings are substantial or not. If they fall below that level, full benefits will generally continue. If earnings are higher than this level, then cash benefits from Social Security are normally suspended while medical benefits continue. Extended period of eligibility: After your trial work period, you have 36 months during which you can work and still receive benefits for any month your earnings are not "substantial". In 2012, earnings of $1010 or more ($1690 if you are blind), are considered substantial. In 2013 SGA is $1040 for non blind and $1740 for blind individuals. Your free Medicare Part A coverage will continue if your Social Security Disability benefits stop because of your earnings. During the trial work

period, there are no limits on your earnings. During the 36 month extended period of eligibility however, you usually can make no more than $1010 in 2012 per month or your benefits will stop, unless you have extra work expenses as a result of your disability.

Resources

Social Security pamphlets include:

- "Basic Facts" SSA-05-10080
- "Understanding the Benefits" SSA-05-10024
- "Retirement Benefits" SSA-05-10035
- "Disability Benefits" SSA-05-10029
- "Supplementary Security Income" SSA-05-11008
- "Survivor Benefits" SSA-05-10084
- "What You Need To Know When You Get Retirement Or Survivors Benefits" SSA-05-10077
- "What You Need To Know When You Get SSI" SSA-05-11011
- "If You Are Blind How We Can Help" SSA-05-10052
- "A Guide For Representative Payees" SSA-05-10076
- "What You Should Know When A Representative Payee Manages Your Money" SAA-05-10097
- "Receive Your Benefits By Direct Deposit" SSA-05-10123

These are available by calling the Social Security toll-free number 1-800-772-1213 or through their website at www.ssa.gov.

MEDICARE

Instituted in 1965, Medicare is a program administered by the federal government to assist older Americans in meeting their medical expenses. The program also assists younger persons who are disabled. Medicare is run by the Center for Medicare and Medicaid Services (CMS), under the U.S. Department of Health and Human Services.

The Original Medicare program has two parts. Part A helps to cover costs for stays in hospitals and skilled nursing facilities, and also covers, home health services and hospice care. Part B assists with doctors' and therapists' services, lab costs, many preventive services, and durable medical equipment. Only services that are considered medically necessary will be paid for through the Medicare program. In 2006, Medicare added Part D for outpatient prescription medication.

Most people become eligible for Medicare on the first day of the month that they turn 65. You also become Medicare eligible if you are under 65 but have been receiving disability benefits from Social Security for 24 months, or if you have ALS (Lou Gehrig's disease.

Part A: Hospital Insurance

For most people, Part A is premium-free because Medicare taxes were withheld from your

(or your spouse's) earned income during your working years. However, persons with less than 10 years of covered employment can purchase Part A insurance by paying a monthly premium of as much as $451 (in 2012).

You are required to pay the first $1,156 of hospital costs per benefit period (which begins when you enter a hospital or skilled nursing facility and ends when you haven't received any further care for 60 straight days). After you pay that deductible, Medicare then pays all other costs through day 60. For extended hospital stays, there are coinsurance charges of $289 a day for days 61 through 90, and $578 a day for up to 60 additional "lifetime reserve" days.

If you receive care in a skilled nursing facility following a hospitalization, you are entitled to up to 20 days each benefit period. For days 21 through 100, you will pay coinsurance of $144.50 a day in 2012 and $148.00 per day in 2013.

Hospital or skilled nursing care must be medically reasonable and necessary, which means that if the treatment could safely and effectively be given in an outpatient setting, Part A will not provide coverage. However, people who are terminally ill can receive hospice care, which is usually given in your home by a Medicare-approved service.

You should be aware that all of the deductible and coinsurance amounts cited above are subject to increase every year, typically by about three or four percent. The amounts shown here are for 2012. Please note that Medicare does not pay for elective and cosmetic surgery; nor will it cover vision, hearing, or dental services unless they are medically necessary. During your hospital stay, Medicare will not pay for your TV or telephone, of course.

Part B: Medical Insurance

Persons enrolled in Part B pay a monthly premium of $90.90 in 2012 and $104.90 in 2013, which for most people is deducted from their Social Security check. Under Part B, you pay the first $140 in medical costs a year; but after reaching that deductible, Medicare will pay 80% of the Medicare-approved amount for doctors' services, outpatient therapy, many lab tests and preventive services, and durable medical equipment. You are responsible for the other 20%. For outpatient mental health care, Medicare pays 60% and you pay 40%. In the future, this will continue to change until it reaches the same 80%/20% payment provisions that apply to other Part B services.)

Also, you pay the cost of the first three pints of blood you receive as an outpatient. Additional blood costs are divided 80%/20% (unless you or someone else donates blood to replace what you use).

Part B will pay for certain medications administered in a doctor's office (for example, cancer drugs taken as outpatient treatment). Preventive services covered by Medicare include bone mass measurement, cardiovascular screening, diabetes screening, flu shots, glaucoma tests, hepatitis B shots, prostate cancer screening, Pap test and pelvic exam, a pneumococcal shot, and screening mammograms. (There is no cost for most preventive health services.) If you are new to Medicare, you are entitled to a "Welcome to Medicare" physical exam during your first 12 months under Part B. In addition, you can receive a "Wellness" exam every year; but this is not as extensive as the kind of annual physical exam to which you may have become accustomed. It involves minimal testing and is mainly intended to monitor changes in your ability to take care of yourself.

If you (or your spouse) are still working and you have coverage through the employer' s or

union's group health insurance policy, you do not have to enroll in Part B because the other insurance will pay for these services. However, if/when your job-related insurance is going to end, you should enroll in Part B so that you can make a smooth transition to Medicare and not have a break in your health coverage.

The Part B premium and the annual deductible are subject to change every year. The scope of services included under Part B can also change. For instance , the preventative services covered by Medicare have expanded over the years and beginning in 2012, most of those services are available without requiring any co-payments.

Additional Insurance for Parts A and B

Medicare pays a lot, but beneficiaries also pay some of the costs through the various deductibles and coinsurance charges mentioned above. Many medical procedures can be extremely expensive; and even if Medicare picks up significant portions of the costs, your deductibles and coinsurance responsibilities could become quite substantial. Some or all of those expenses can be covered by other insurance. You can obtain additional coverage through (1) a Medicare supplement insurance policy, or (2) a Medicare Advantage plan.

Some retirees receive help with medical costs through group health insurance they have from a former employer or union, or through a spouse' job. Such coverage usually is cost-effective; but often, if you ever decide to leave that plan, you cannot rejoin it later. Typically, retiree coverage will be provided through a supplemental insurance policy or a managed-care plan that may resemble (but isn't exactly like) a Medicare-contracted plan.

Supplement ("Medigap" Insurance)

You can supplement your Original Medicare coverage by purchasing a "Medigap" insurance policy. They are nicknamed "medigaps" because they can pay for some or all of the deductible and coinsurance "gaps" in Medicare Parts A and B. In Pennsylvania, these policies are sold by some 50 or 60 insurance companies, which are regulated and must be approved by the Department of Insurance. When you purchase a Medigap policy from one of these companies, you will be charged a premium, usually payable monthly. As long as you pay your premium, the policy is guaranteed renewable no matter what changes might occur in your health conditions.

The best time to buy a Medicare supplement policy is when you first enroll in Part B, because you can select any Medigap policy sold by any company, without regard to pre-existing health conditions. Because you may develop serious health conditions as you age, you could find it very difficult to be obtaining a Medigap policy later in your life.

Congress established 10 standardized Medicare supplement plans in 1992 and labeled them "A" through "N" though some previously approved plans have been dropped from this alphabetic sequence. Plan F covers all the deductibles and coinsurance gaps of original Medicare and is the most popular supplement policy. Plan C is similar. Plans A and B offer less coverage but are also less expensive. The other supplement plans provide variations in gap coverage that perhaps can be tailored to suit your needs. New Plans labeled K and L became available beginning in 2006 to pay for 50% and 75% of Part A and Part B deductibles and coinsurances. The additional options or new plans M and N became available in June 2010. Besides the introduction of these two new plans, a number of other changes in the Medigap lineup occurred on June 1, 2010. Perhaps most importantly, insurance companies are no longer allowed to sell plans "E", "H"

and “J” to new enrollees, though if you currently hold one of these policies you will be permitted to keep it.

If you are an individual with Original Medicare with a Medigap supplement, you show the hospital or doctor your Medicare card and your insurance card when you receive service.
The health care provider will submit their claims to Medicare, which will pay the appropriate Medicare-approved amount. Then, Medicare will forward the balance of the claim to your Medigap insurance company. Depending on which supplement plan you have purchased, the insurance company will pay its share; and if there still is a remaining balance not covered under your policy, you will be responsible for that amount.

Pennsylvania law forbids medical service providers from charging more than the Medicare-approved amount. If you are charged in excess of those amounts, you are not
liable. Any effort to collect such an excess charge should be reported to the Pennsylvania Department of Aging (717-783-8975).

Medicare Advantage

You might be interested to know that this arrangement is, formally, Part C of the Medicare program! Until recently, these plans were typically composed of managed-care plans such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). However, they now include several new types of arrangements, known as Private-Fee-For-Service (PFFS) plans and Medical Savings Accounts (MSAs).

Medicare Advantage (MA) is the means by which the federal government pays private health insurance companies to provide your Part A and Part B Medicare-covered services — and often your Part D benefit as well. If you enroll in a Medicare Advantage plan, you are still in the Medicare program, but the billing arrangements for health services involve you, the service provider, and the plan’s company. No claims are forwarded to Medicare.

Managed care is the most common way that beneficiaries receive health services under Medicare Advantage. As is typical of managed-care plans, you will make copayments for most office visits. Starting a few years ago, plans also instituted co pays for the more expensive health-care services such as hospital and skilled nursing stays, outpatient surgery, and ambulance services. However, you probably will receive some services that are not covered by Medicare, such as vision care, hearing services, perhaps dental care, and fitness programs.

You have an opportunity to change your MA plan during the Open Enrollment Period that begins October 15 of each year and runs through December 7. Your new plan will take effect on the next January 1. Most plans charge a monthly premium, as well as copayments for most covered services, and these costs are likely to change from year to year. You will receive an Annual Notice of Change by the end of October that will tell you what changes are to be made to your plan for the following year. If you would like to consider a different plan - from the same company or from another company - is the time you should do so.

The lowest-priced managed-care plans are Health Maintenance Organizations (HMOs). You are required to choose a primary care physician (PCP) who will coordinate your health care. If you need to see a specialist, your PCP must approve a referral for that service. (Nowadays, referrals are handled electronically and should not present a problem for you to obtain.) Your medical care will be restricted to service providers who are in that company’s network; so if you go

to doctors or hospitals outside the network, you will be responsible for all costs. You should make sure the doctors, hospitals, and specialists you are accustomed to seeing are in the network.

Higher-priced managed-care plans such as Preferred Provider Organizations (PPOs) offer more flexibility in receiving services. They often are called "choice" plans. Although they also are network-based, you can receive services out of network (but you will have to pay part of the cost when you do so). As a general rule, referrals are not required. Because in-network services will cost you less, you should check to see that the physicians and hospitals you are likely to use are in the network of the managed-care company you select.

Even though networks are geographic-based, if you travel outside of your HMO or PPO network area (generally, the five counties of southeastern Pennsylvania), you will be covered for emergencies or for urgently-needed care. Try to notify your doctor or call your plan as soon as it's feasible for you to do so. Under rare circumstances, they may prefer that you return "home" when they believe you would receive better care here.

The newer Medicare Advantage plans have been introduced too recently for experience to accumulate regarding their usefulness or effectiveness. The Private-Fee-For-Service (PFFS) plans are similar to managed-care in some ways; and although they do not rely on "networks" *per se,* you must be sure that the medical service providers you choose to use will accept the plan's payment schedule. However, as of 2012, the companies that offer PFFS plans have very small networks, and are especially limited in the hospitals that accept their payments.

The Medical Savings Account (MSA) arrangement is unique. As with other MA plans, Medicare pays the insurance company a specified amount for your health care. The plan then deposits part of that payment into your medical account for you to use to help pay your health costs. However, these are high-deductible plans, so you must first pay out-of-pocket (and/or out of your medical account) before the plan begins to pay for your Medicare-covered services.

A Special Needs Plan (SNP) is typically for persons who have chronic or disabling conditions and/or are living in institutions and/or are enrolled in both Medicare and Medicaid. SNPs are networks of doctors and hospitals that specialize in treating conditions such as diabetes, congestive heart failure, mental health problems, and HIV/AIDS.

Medicare Savings Program

This program may be able to help you pay for Parts A and B of Medicare. It is a Medicaid program and is jointly funded by the federal government and each state. This Medicare Savings Program is called "Healthy Horizons" in Pennsylvania. Various levels of assistance are possible, depending on your income; but the resource (or asset) limitations are very restrictive. (However, the resource limit is waived for beneficiaries who have dependent children living with them.)

The deepest level of support is provided through the Qualified Medicare Beneficiary (QMB) - Categorically Needy Program. Help is available to single persons with a monthly income of no more than $931 ($11,780 a year) and total resources of less than $2,000. For a married couple, the income limit is $1,261 a month ($15,130 yearly) and the asset limit is $3,000. The program provides full Medicaid health benefits, including all Medicare-covered services (and you pay no premiums, deductibles, or coinsurance), plus providing such additional assistance as eyeglass coverage and dental care.

At the same income limits but at slightly higher resource limits ($6940 for one person, $10,410 for two) is the Qualified Medicare Beneficiary (QMB) — Medicare Cost-Sharing Program. This will pay the Medicare Part A premium (if applicable), Medicare Part B premium ($99.90 a month in 2012), and all of the Part A and B deductibles and copays. For both of these QMB programs, you have to fill out a detailed application and have a face-to-face interview at the County Office of Assistance where you reside.

The Specified Low-Income Medicare Beneficiary (SLMB) program covers persons with monthly income between $931 and $11170 (annually $11,170 to $13,400) and with assets of no more than $6600. The program pays the Medicare Part B premium of $99.90 a month. You can apply by mailing an application to the County Office of Assistance where you reside. Qualifying monthly income for married couples is between $1,261 and $1,513(or $15,130 to $18,155 a year); qualifying resources can be no more than $6600.

A program called Qualified Individual 1 is for persons of slightly higher incomes. This also pays the Medicare Part B premium ($99.90 a month). To qualify, a single person's income must be between $1170 and $1257 a month (equal to $13,400 to $15,080 a year), and assets are limited to $6940. For a married couple, the monthly income must be between $1513 and $1703 (or $18,155 to $20,435 a year), with an asset limit of $10,410.

Income limits for the various Medicare Savings Programs are revised every year, usually in March. Resource limits have not been changed in many years.

Notices, Questions and Appeals

If you have Original Medicare (with or without a Medigap), claims are submitted to and processed by companies that are under contract to Medicare. For every month that claims are received and processed on your behalf, you will receive a Medicare Summary Notice (MSN) that identifies the service providers and the medical services for which they submitted claims. You should review the MSNs to make sure that you actually received the specified services.

If you are charged for services that you think you did not receive, or if you are denied Medicare benefits to which you believe you are entitled, you have the right to appeal. Your MSN will include information on when and how to appeal. Medicare also has a
contract with an independent Quality Improvement Organization (QIO) to which you can submit complaints about the care you have received. For example, if you are denied admission to a hospital, or are asked to leave the hospital before you feel you are well enough, or if you are dissatisfied with the quality of hospital or medical care that you received, you should not hesitate to register your appeal with the QIO.

Questions and appeals can be cumbersome, however. If you have a question about any Medicare claims, or about the nature and quality of your services call 1-800-622-4227 (1 -800-MEDICARE). You will be offered several voice-activated options. Pick "Billing" at the first prompt; then depending on what has influenced you to call, pick "Hospital" for Part A claims, "Doctor" for Part B claims, "DME" for durable medical equipment. You will have to specify that you live in Pennsylvania, and you then will be connected to the appropriate Medicare contractor who handled those claims. If you ask for "Agent," you will be able to get to the Quality Improvement Organization.

For those who are enrolled in Medicare Advantage plans, questions and appeals are directed - at least initially - to your insurance company, which is required by law to establish procedures for you to raise your concerns and challenge unfavorable decisions. You probably will have several levels of appeal open to you, so if you are denied at one point, you can continue to a subsequent level.

Appeals

You may be able to receive some assistance with your Medicare complaints and appeals. Medicare requires that every state have a health insurance information program. In Pennsylvania, the program is called "**Apprise**" and is administered by the Department of Aging. The toll free Apprise Hotline Number is: 1-800-783-7067. All services are free and confidential. Some Apprise counselors have experience with complaints and appeals and might be able to assist you. If you have a problem with your Medicare enrollment and/or with your Prescription Drug insurance, Apprise can forward your complaint to the local Medicare office for investigation and resolution.

CARIE is another excellent source of help. This group is the Center for Advocacy for the Rights and Interests of the Elderly. It serves primarily to protect the elderly from abuse and fraud, but its staff also have a deep understanding of Medicare rules and procedures. CARIE maintains a free telephone consultation service for the elderly, their caregivers, and professionals. Their number is 215-545-5728.

The Pennsylvania Health Law Project (PHLP) provides free legal services and advocacy to Pennsylvanians who are having trouble accessing publicly funded health care coverage or services. Call their helpline at 1-800-274-3258.

Part D: Prescription Drug Insurance

Until 2006, outpatient prescription drugs were not included in Medicare. The Medicare Modernization Act that was passed in December 2003 provided for this new benefit, which took effect January 1, 2006. Participation is voluntary; but for those with even modest prescription drug needs, this program should provide significant help with the cost of medications.

For 2012, Part D's "standard prescription drug program" requires that you pay a monthly premium to the company you choose to provide this benefit. You also will pay the first $320 in annual drug costs; but after you meet that deductible, Medicare and you will share the cost of the next $2,930 of your prescriptions, with Medicare paying 75% and you 25%. Thus, Medicare will pay for as much as $2930. That's about two-thirds of the plan's cost for those medications. However, only the amount that you yourself pay is counted toward your out of pocket tally.

When total drug costs pass $2930, that is, what both you and the plan have paid, you will pay just half the cost of your plan's brand name medications (but 86% until your total out of pocket prescription expense reach $4550. This is the cost sector known as the coverage gap. After you have spent $4700 out of your own pocket, you come under Part D's "catastrophic coverage" and Medicare will pick up the bulk of the cost of your drugs (about 95%) and you will make small copayments (about 5%). Persona with very low income and limited assets may qualify for "Extra Help" under part D, which provides for reduced or even zero premiums, low or no deductibles, and generally minimal co-pays. (See the section that follows).

Selecting a Part D Plan

You can obtain Part D insurance in ways similar to how you get additional coverage under Parts A and B. If you have a Medicare Advantage plan and also want help with the cost of your prescription medications, you must obtain your Part D coverage from your managed-care company. These are called MA-PD plans. If you have Original Medicare with a Medigap supplement, or if your MA company does not offer Part D coverage, you would purchase a so-called "free-standing" Prescription Drug Plan (PDP) from one of the 24 companies that offer this insurance for 2012. In addition to the "standard" plan described above, most MAPD and PDP insurers also offer "enhanced" drug coverage that might reduce or eliminate the deductible and provide some help with the "coverage gap," but you should expect to pay higher premiums for those added benefits.

When you select a Medicare drug plan, consider whether the plan covers all of your prescription medications, and what will be charged for each drug. Medications that are not on a plan's list (formulary) will not be included in the Medicare cost-sharing feature, or count toward your out-of-pocket requirement for catastrophic coverage. Therefore, study the alternative plans carefully.

Participation in Part D is not mandatory; but if you did not sign up during your initial enrollment period, and if you do not have alternate coverage that is deemed at least as good as what Medicare offers, you may face higher premiums if/when you enroll in Part D later.

You do not necessarily need to enroll in a Part D insurance plan. If you have another type of drug coverage, and if it is considered "at least as good as" the Medicare program's standard plan, you do not have to take Part D. This is called "creditable coverage" and it would include such programs as Pennsylvania's PACE and PACENET, the Veterans Administration, and the Defense Department's TRICARE programs. If you have prescription insurance through a retiree plan, you should be informed whether that coverage is creditable. If you now have coverage that is creditable but should ever lose it, you will not have to pay a penalty for late enrollment in Part D - as long as you pick a Medicare drug plan within 63 days of losing your previous coverage.

Part D has annual open enrollment periods just as there is for Medicare-Advantage plans. It also runs from October 15 to December 7, with next year's plan taking effect on the following January 1. You can join Part D, or change your current Part D coverage, during this period.

The Part D deductible, coverage limit, coverage gap, and catastrophic threshold have increased each year since the program started, by an average of 4% or *5%* annually.

Part D Assistance for Persons with Low Income

Medicare provides extensive subsidies for those whose incomes and assets are very low. Persons who are "dual eligible's" — that is, who are enrolled in both Medicare and Medicaid - are automatically enrolled in Part D and pay no monthly premium and no deductible, and will have minimal copayments for generics and a little more for brand-name drugs. When their total drug costs reach the catastrophic threshold, they pay nothing more for their prescription medications.

Those with somewhat higher incomes - up to 35% above the federal poverty limit, *i.e.,* $15,079.50 a year for single persons, $20,425.50 for couples - and with assets as high as $11,570 for singles ($23,120 for couples), also will not pay a monthly premium, have little or no

deductible, and make low Rx copayments.

Persons and couples with incomes up to 50% above the poverty level ($16,755 single, $22,690 married) will receive some reduction in the monthly premium, pay a $60 annual deductible, and pay 15% coinsurance for the rest of their drugs until they reach the catastrophic threshold. They have the same asset limits as the preceding group.

If you think you are eligible for Part D's Low-Income Subsidy, submit your application to Social Security. They will notify Medicare if their review of your income and assets indicates that you are qualified for "extra help" with your prescription drugs. The assets considered do not include your home or your car. Only "liquid" assets such as bank accounts, stocks and bonds, and mutual funds, are counted. Call Social Security toll-free at 1-800-772-1213.

PACE and PACENET

(Pharmaceutical Assistance Contract for the Elderly)

Pennsylvania's PACE program covers elderly residents age 65 and over, with a yearly income up to $14,500 (couples up to $17,700). Under PACE, you will pay no more than $6 for generics or $9 for brand-name drugs. Some residents qualify for both the Part D subsidy and PACE because the income limits are very nearly the same. They are encouraged to do so because it takes some of the financial burden off the Pennsylvania budget. If you enroll in a Part D plan with which PACE has a signed agreement, PACE will cover the plan's 2012 premium up to $29.23 a month, but you will pay any amount over that benchmark. Under the PACE program, citizens are eligible if their annual income is not higher than $14,500 for a single person or $17,700 for a married couple. You must have lived in Pennsylvania for at least 90 days prior to the date of your application and you must not be eligible for pharmaceutical benefits under medical assistance. PACE has no deductible to be met for eligibility.

PACENET is for Pennsylvanians with somewhat higher incomes. The limits are $23,500 for single seniors and $31,500 for married couples. Co-payments are up to $8 for generics and $15 for brand-name. If you are enrolled in a Part D drug plan that has a signed agreement with PACENET, your co-pays will go toward meeting your monthly premium (which will be collected at the pharmacy when you purchase drugs). If your plan is not partnered with PACENET, you will pay the premium directly to the company. If you qualify for both Part D Extra Help and PACE, you may want to consider enrolling in both plans. Whatever your Medicare Part D plan may not cover, PACE or PACENET will cover.

Unlike Medicare's Part D, there are no asset qualifications for participating in PACE or PACENET. Another benefit of both programs is that you will not have a coverage gap. You probably can pick up an application at your local pharmacy. The previous year's income will be used to determine your eligibility. You can call PACE/PACENET toll-free at 1-800-225-7223. Note, however, that even if you are disabled, you must be at least 65 years old to qualify for PACE or PACENET.

Medicaid

Medicaid is another federal program that helps pay for long-term care. In most cases, the individual receiving these benefits must contribute their monthly income, less a $45 for personal needs, and less an allowance for the spouse who remains in the community. Some benefits are

available for at-home care.

Eligibility

Benefits are available only to individuals who meet these Medicaid eligibility standards:

Medical:

> An applicant for Medicaid benefits must actually need long term care in a skilled nursing facility or, in limited cases, at home. Usually the nursing home requests a medical assessment automatically when an application for Medicaid benefits is made. To avoid delay, one should be certain this assessment is completed.

Financial and General:

- The applicant must be 65 or older or disabled;
- The applicant must be a citizen of the USA or equivalent;
- The applicant must be a resident of Pennsylvania.

Benefits are available only to individuals who meet these Medicaid eligibility standards. An applicant for Medicaid benefits must prove medical and financial eligibility. The Office of Aging and Adult Services in the County in which the facility is located determines medical eligibility for nursing facility care. The nursing home requests a medical assessment automatically when an application for Medicaid benefits is made. To avoid delay, one should be certain this assessment is completed. Establishing medical eligibility is rarely a problem in qualifying for Medicaid to cover nursing home costs. The main challenge is verifying financial eligibility.

All income and resources must be disclosed to the Medicaid caseworker. The applicant's non-excluded, available resources must not exceed the applicable limit. Single applicants with monthly income over $2,022 must have total resources under $2,400. Single applicants with income less than $2,022 have a resource limit of $8,000.

The eligibility rules for married Medicaid applicants are much more complicated. An elder law attorney familiar with Medicaid planning should be consulted in order to make sure you do not spend-down more money on nursing home costs than is required under Medicaid rules. Medicaid rules provide that the person in the nursing home will have the $2,400 or $8,000 limit described above. The spouse of the nursing home resident (community spouse) must also meet certain resource limits. Absent exceptional circumstances, the maximum community spouse resource allowance is $113,640, effective January 1, 2012. The minimum allowance is $22,728. The community spouse is also allowed to have a certain level of income to avoid impoverishment, between $1,892 and $2,841 depending on shelter costs.

Some assets are "excluded resources" and are not counted when determining initial eligibility. For example, the residence is usually an excluded resource where the applicant intends to return home or in cases where there is a spouse. An automobile is also an example of an excluded resource.

Disqualification

Certain gifts or transfers for less than fair market value will make the applicant temporarily ineligible for Medicaid benefits even if all of the stated criteria have been satisfied. Such gifts within that window cause one month of Medicaid ineligibility for every $8500 given away starting on the first day of the month in which the gift is made. Gifts made after February 8, 2006 are subject to a five (5) year look-back, and the penalty period begins to run when the Medicaid applicant is otherwise eligible for Medicaid but for the gift. In short, gifting of any kind can cause major problems with Medicaid eligibility.

Gifts made more than five years before the trigger date do not cause ineligibility. However, if nursing home care and Medicaid benefits are needed within five years after the date of the gift, the gift may well cause ineligibility for a very long time.

A gift to a spouse does not cause ineligibility. Neither does a gift to a specially established trust for the benefit of a disabled child. In some circumstances, a gift of a home will not cause ineligibility if it is to a child care giver under specific circumstances.

Estate Recovery

Upon the death of a person who has received Medicaid benefits, the government must attempt by law to recover the amounts paid to a nursing home for that person. At present, recovery is permitted only from the "probate estate" of that person, i.e., any assets titled in the individual's name alone at the time of death. The services of a skilled elder law attorney may avoid or plan for estate recovery.

Medicaid Planning

Under certain circumstances, Pennsylvania law allows individuals or their spouses to keep their homes and much of their money without becoming ineligible for Medicaid benefits. However, relevant laws are extremely complicated and extremely vague, so Medicaid planning should not be attempted without the assistance of an elder law attorney.

APPRISE

Medicare requires that every state provide a State Health Insurance Assistance Program (SHIP) to offer free Medicare insurance counseling. In Pennsylvania, this program is called APPRISE – a verb that means "to inform."

APPRISE is administered by the Pennsylvania Department of Aging. About 15 Volunteer counselors are available to give personalized assistance. They help residents understand what Medicare is and how it functions. They can identify what insurance options you have and help you clarify the alternative plans and policies that can benefit you.

Counselors can also provide information on long-term-care insurance and on health insurance options for persons who aren't yet eligible for Medicare. Some counselors have had experience helping clients to handle insurance appeals.

Local APPRISE counselors are located in each county's senior centers, the office for Aging and Adult Services, and in some libraries and hospitals. You can call the state Apprise telephone

number 800-783-7067 and leave a phone message asking for a counselor to call. Easy questions often can be answered on the telephone. More complicated inquiries are best handled by making an appointment to see one of the counselors. CMS, the Center for Medicare and Medicaid Services can also be contacted directly at 1-800-MEDICARE (1-800-633-4227) or on the internet at www.medicare.gov for information or to locate your regional office.

Clients often ask "What do you recommend that I do?" However, counselors cannot make your decision for you, because doing so can appear to promote specific insurance products; so they will politely deny your request. They will review your options with you and try to make clear what factors you should consider in coming to your decision.

Bear in mind that there are no "perfect answers" to what kind of Medicare insurance you should get. Your decision depends on how you would like to receive your medical services, what kind of coverage you'd like to have, and how much you feel you can afford.

Pennsylvania Low Income Home Energy Assistance Program (LIHEAP)

The Pennsylvania Department of Public Welfare provides a low-income home energy assistance program to help low income families pay a portion of their winter heating bills. LIHEAP is not a welfare program or loan, and no lien is placed on the home. Consumers do not have to pay the money back. For information on eligibility guidelines call your county Area Agency on Aging. The minimum cash grant is $200.00 increased from prior years when it was only $100.00, and residents in need of crisis assistance will see their maximum grant rise to $800.00, up from $300.00. A family of four can qualify with income of up to $33,075. For information on eligibility guidelines call you your local county assistance office.

Public Benefits

The Pennsylvania Department of Public Welfare administers several other programs which may provide benefits such as food stamps and medical assistance. For information you should refer to the Guide to Human Services Section (blue pages) of your local telephone directory for the location nearest to you. The Department of Health that serves you can also be located in this way, as can Meals on Wheels. An excellent website launched to help connect people age 55 and over is www. benefitscheckup.org. By accessing the website, you can receive information, addresses and telephone numbers for programs such as Supplemental Security Income, Medicaid, state prescription drug benefits, Meals on Wheels, food stamps, health insurance counseling, veterans' medical care and transportation for which you may qualify. This is determined by answering a confidential on-line questionnaire.

Railroad Retirement Benefits

A variety of benefits, such as retirement annuities, are offered for railroad workers and their families. An applicant may also be eligible for other benefits including benefits for survivors, sickness, unemployment and temporary or permanent disability. Information and applications for benefits may be obtained by accessing the independent website of the United States Railroad Retirement Board at www.rrb.gov/ or by contacting your local district office of the Railroad Retirement Benefits Board. Military service in a branch of the uniformed Armed Forces of the U.S. may increase or provide eligibility for a RRB benefit. Proof of birth is required for all applications. Retirement benefits are available if the worker is age 62 or older and was employed by the railroad

industry no less than ten years. If a railroad employee was employed for 30 years or more, that employee may be eligible for retirement with benefits at age 60.

Disability Benefits

Occupational Disability - If a railroad employee has been employed for 20 years with the railroad, or is age 60 and has worked for ten years for the railroad, that worker may obtain disability benefits providing other conditions are met. Those conditions are that the worker be disabled from work in their regular railroad job and has been employed for the railroad job for 12 months of the previous 30 months before the month the railroad retirement annuity began. This is the "current condition" requirement that may entitle an applicant to benefits.

Total Disability - Total disability benefits may be available to a railroad employee permanently disabled from all regular railroad work providing they had at least ten years of employment and meet other requirements.

Benefits for a Spouse, Widow(er), Unmarried Parent, Divorced Spouse - Benefits may be available for these additional classes of people. You should investigate whether you are eligible for benefits.

Veterans' Benefits

Federal Benefits for Veterans and Dependents

There are a variety of federal benefits available to veterans and their dependents. Eligibility depends upon individual circumstances. Contact the nearest Veterans Affairs Benefits Office at 1-800-827-1000 to apply. Counselors can answer questions about benefits, eligibility and application procedures. They may also make referrals to other VA Offices and facilities, such as medical centers and national cemeteries. You may find telephone numbers of VA Offices and facilities in the Federal Government section of your local telephone directory under "Department of Veterans Affairs".

Veterans' Health Care

For most veterans, entry into the VA healthcare system starts with enrollment at a VA healthcare facility. Veterans with Internet access may apply for enrollment on-line at www.VA.Gov/1010ez.htm by completing VA Form 10-10EZ, Application for Health Benefits, which can also be obtained by calling the toll-free Veterans Affairs telephone number. Once enrolled, a veteran is eligible to receive services at VA facilities anywhere in the country. VA healthcare facilities also provide information on medical care. Veterans who have enrolled at the VA are eligible for a benefits package of in-patient and out-patient services. These include: nursing home care, adult day healthcare and homeless programs, preventative medicine services, primary care, surgery, mental health and substance abuse treatment, home healthcare, respite and hospice care, emergency care in VA facilities and drugs and pharmaceuticals.

There is a pension benefit available to all veterans and their families for home health and assisted living/personal care homes. It is the "Aid and Attendance Program" (AA). In order to be eligible for the AA program, a veteran must have served 90 days on active duty (the requirement is longer for recent veterans) with at least one day during a war, and must have been honorably discharged. Also, the veteran must be permanently and totally disabled due to a non-service connected

condition. A veteran is eligible for up to $1,703 per month, while a surviving spouse is eligible for up to $1094 per month. A couple is eligible for up to $2019 per month. Their assets must be under $80,000. The Aid and Attendance Benefit is considered to be the third tier of a VA program called Improved Pension. The other two tiers are Basic and Housebound. Each tier has its own level of benefits and qualifications.

Eligibility for hearing aids, eyeglasses and dental care is determined by whether the veteran has been given a disability rating by the VA which is a percentage rating of "service connected". "Service connected" means that the veteran has been given a disability rating by the VA which is for an injury or illness related to their military service. In many cases, veterans are receiving compensation for that disability. A Means Test is also imposed as a measure of the veteran's family's annual income and assets and used to determine if non-service connected and zero percent connected veterans need to make co-payments for medical care.

Co-payments are charged by the VA for in-patient and out-patient medical treatment, daily charges for in-patient treatment and for medication co-payments. The VA pharmacy will only fill prescriptions written by VA clinicians. In some instances, some co-payments may be as low as two dollars or may be waived for certain classes of veterans. Veterans may also be eligible for other benefits such as Aid and Attendance and Extended Care Services.

The Veterans' Uniform Benefits Package and Medicare

A veteran's Medicare and supplemental insurance policy may pay up to twenty percent (20%) of charges. If the supplemental does not cover the VA co-payment, the veteran is responsible for the remaining amount. The VA is not presently authorized to bill Medicare for healthcare services to veterans. However, the VA can file claims with any other insurance under which you are covered. In all cases though, veterans should apply for benefits under the Uniform Benefits Package because the VA's Uniform Benefits Package emphasizes preventative and primary care.

Additional Prescription Benefits for Members of the Uniformed Services

There are additional pharmacy programs providing pharmacy benefits available in the United States to older Americans who are registered in the Defense Enrollment Eligibility Reporting System, were in the Uniformed Services and are age 65 and over. Eligible beneficiaries must be enrolled in Medicare Part B in order to use mail-order and retail pharmacy benefits which may be available to them.

Beneficiaries may also continue to use military hospitals and clinical pharmacies, but additionally, may be eligible for benefits to obtain low cost prescription medications. The providers of low cost prescriptions are the National Mail Order Pharmacy (NMOP) and Tricare Network and non-network civilian pharmacies. Initial registration forms can be obtained by calling Tricare toll-free at 1-800-903-4680. In addition, you must ensure that the Defense Enrollment Eligibility Reporting System has your current address by contacting them at 1-800-538-9552. For more information, the toll-free helpline at (1-877-363-6337) or www.tricare.osd.mil. can be contacted.

Legal Counseling for Veteran's Benefits

It is a violation of federal law for an individual to charge a fee to represent an applicant in the filing of a VA benefit claim. Law firms may file VA claims free of charge or pro bono. However,

attorneys are permitted to charge a fee for counseling individuals on eligibility for VA benefits and for arranging their affairs to enable them to qualify for benefits. Therefore, the legal services of an attorney specially certified to counsel veterans can be sought if needed.

Public Benefits for Non-Citizens

As of August 2001, some non-citizens (aliens) who were present when the Welfare Act was passed in 1996 that subjected them to a five year ban may now become eligible for Medicaid, Medicare and Social Security benefits if they fit the definition as being qualified immigrants. Aliens who were receiving SSI prior to August 1996 retain their program eligibility. Also, individuals who were legally residing in the USA prior to August 1996 and who become disabled can obtain SSI.

A qualified non-citizen is as follows: a lawful, permanent resident, an alien granted asylum or granted withholding of deportation, a Cuban/Haitian entrant, or certain battered spouses and children. However, the Welfare Act gives states the option to deny benefits to qualified immigrants. As of this writing, only one state, Wyoming, had chosen to deny qualified aliens access to Medicaid. Emergency Medicaid, which is treatment for only medical conditions with acute symptoms and communicable diseases, is not subject to immigrant restrictions.

Due to the complexity of the laws governing benefits for senior non-citizens, an experienced immigration lawyer familiar with governmental benefits should be consulted.

Low Cost Legal Services

For individuals who qualify, legal services at a reduced cost may be obtained through Pennsylvania Legal Services. Low income individuals may call 1-800-322-7572 or look in the Guide to Human Services section of your local telephone book for the area Legal Aid office. Pennsylvania Legal Services also has a website at www.palegalservices.org. By accessing the website you can obtain information from a state map, color-coded by region that will direct you to the appropriate Legal Aid office. You can also email Pennsylvania Legal Services at plssupport@earthlink.net. Individuals needing assistance with problems such as bankruptcy, debtors' rights or landlord/tenant issues, even if they do not qualify for Legal Aid, should still seek legal advice. You may contact the Pennsylvania Bar Association Lawyer Referral Service at 1-800-932-0311 Ext. 2209 to refer you to a lawyer in your area or contact your local bar association for their lawyer referral service if available.

Additionally, the Pennsylvania Senior Law Help Line at 1-877-727-7529 can be contacted since they are dedicated to the legal rights and interests of seniors in need. They focus on and prioritize the problems of seniors most in need. The Senior Law Center provides a combination of legal services, community education, outreach, and advocacy, incorporating a comprehensive approach to representing and empowering its clients. The Center's legal staff and volunteer attorneys serve seniors including victims of elder abuse and financial exploitation, elders facing housing crises and homelessness, and grandparents raising grandchildren. They are based in Philadelphia. More information is available at www.seniorlawcenter.org. The Pennsylvania Senior Law help line is a toll-free, state-wide, legal information, advice and referral service for Pennsylvania senior citizens (60 years and older).

Long Term Care Facilities

Long term care facilities can be thought of as housing with integrated supportive services. The level of service varies with the type of facility. This section outlines important aspects of the most common types: nursing homes, assisted living facilities and continuing care retirement communities. For lists of these facilities contact your Area Agency on Aging which can be located through the Guide to Human Services section of your local telephone directory.

Nursing Homes

A nursing home is a facility where residents receive round-the-clock nursing care designed to help an individual with the activities and needs of daily living and health care. These residents do not need the kind of acute health care provided in a hospital. A person usually enters a nursing home after all other long term care options, such as an assisted living facility or living at home with supportive services, are found to be inadequate.

Medicare does not provide substantial coverage for long term nursing home care. Medicare may pay for a portion of the cost for the first 100 days of a nursing home stay, under very limited circumstances. Those circumstances are:

- Skilled nursing or rehabilitation services are provided within 30 days of a Medicare-covered hospital stay of more than 3 days;
- A doctor certifies the resident's need for skilled care on a daily basis;
- Skilled care is actually received on a daily basis;
- The facility is Medicare-approved.

If these requirements are met, Medicare will fully cover the first 20 days of skilled care and a portion of the cost for the next 80 days of skilled care. Note that Medicare does not cover custodial care. Medicaid is the only public benefit program that covers intermediate or skilled care provided in a nursing home after Medicare benefits are exhausted, as described above.

Residents' Rights

Upon admission to a nursing home, a resident or his/her family will be required to sign an admission contract. Entering into a nursing home can thrust a family into emotional turmoil. A prospective resident or the family member or members responsible for the resident might feel pressure under emergency circumstances to sign a nursing home admission contract without a careful review of its terms. Do not be pressured. Read the contract and have it reviewed by an attorney before signing. Federal and state laws have been enacted to protect individuals entering nursing homes and an experienced advisor can make sure that you get the benefit of these protections. For example:

- A nursing home cannot require a resident to waive his/her right to apply for Medicaid. Furthermore, a nursing home cannot discriminate against a resident who is receiving Medicaid. Nursing homes must establish and maintain identical policies and practices regarding transfer, discharge and covered services for all residents regardless of source of payment.

- A nursing home cannot require a third party guaranty of payment as a condition of admission or continued stay. A nursing home is allowed to require that an individual having legal access to a resident's income and assets, such as an agent under a power of attorney, sign a contract, without the agent incurring any personal liability, promising to pay for a resident's care from the resident's funds.

- A nursing home cannot require a resident to agree to pay privately for a specified period of time before the nursing home will "allow" the resident to convert to Medicaid.

Once admitted to a nursing home, a resident enjoys certain rights mandated by both federal and Pennsylvania law. For example:

- A nursing home must conduct a comprehensive assessment of every resident's functional capacity within 14 days of admission. This assessment must be used to develop, review and periodically revise, as necessary, an individualized plan of care for each resident. The resident, the resident's family and, if desired, the resident's legal representative must be given full opportunity to participate in the development of the plan of care.

- A resident has the right to choose a personal attending physician and to be kept fully informed about care and treatment.

- A resident has the right to remain free of physical and chemical restraints which are not required to treat the resident's medical condition.

- A resident has the right to privacy with regard to communications in writing and by telephone and with regard to visits of family and meetings of resident groups. A resident must be provided with reasonable access to the use of a telephone where calls can be made without being overheard.

- A resident has the right to access to clinical records upon request by the resident or the resident's legal representative.

- A resident has the right to voice grievances with respect to treatment or care without fear of reprisal.

- A resident can only be transferred or discharged from a nursing home under limited circumstances which are spelled out in the law, upon 30 days advance written notice.

A nursing home must inform every resident of his/her legal rights, orally and in writing, at the time of admission. Pennsylvania maintains an ombudsman program to investigate and resolve complaints made by or on behalf of residents of nursing homes and other long term care facilities. The Pennsylvania Department of Aging has designated the Area Agency on Aging for each county to be the local providers of these ombudsman services. Your Long Term Care Ombudsperson can be contacted at your local Area Agency on Aging.

Assisted Living and Personal Care Homes

Assisted living and personal care homes provide housing for older individuals who need some assistance with the activities and needs of daily living and perhaps some medical help, but who do

not need the degree of care provided in a nursing home. The goal of these facilities is to help people live as independently as possible.

An important benefit of residency in an assisted living facility (ALR) or a personal care home is help with medication. A resident can be reminded when to take medication and a nurse can assist the resident in taking medications.

Personal care homes differ from assisted living facilities due to the recent enactment of legislation. In order for an ALR to be licensed as such, it must meet particular requirements in their construction and units offered, staffing and personnel, and the level of care provided which is higher than that provided by a personal care home. Both facilities must have an initial assessment of the resident, develop a support plan, and have a written contract between the resident and the residence. Many facilities have decided not to become licensed as ALRS and instead provide services as a personal care home and meet those licensing requirements. Their residents are not supposed to require the services in or of a licensed long term care facility but do require supervision or assistance in activities of daily living.

Payment for residency in an assisted living facility is almost exclusively through private arrangements with the resident. If a resident needs some sort of skilled medical or nursing care, Medicare may cover such care under the same rules that would apply to home health care in general. Long term care insurance will pay benefits for residency in an assisted living facility or personal care home if the policy's "benefit triggers" requirements are met by a resident's need for assistance with activities of daily living or by a resident's cognitive impairment. Most long term care insurance policies define "activities of daily living" as including dressing, eating, bathing, toileting and transferring from a bed to a chair, and usually require that an individual needs assistance with a certain number of these activities of daily living.

Questions

Upon entrance to an assisted living facility or personal care home, a prospective resident should carefully review the admission contract. Significant issues to consider in evaluating an admission contract include:

- What personal care services are to be provided? Who delivers these services? Is the service provider licensed or certified?

- What are the monthly or other charges for such services? Are housekeeping services included? How can fees be increased and what happens if fees are increased and a resident cannot afford the higher fee?

- In the case of a married couple, what happens upon the death of a spouse? Is a change of living unit required? How would fees be affected?

- What recreation or cultural activities are available and are they included with the monthly fee?

- Is transportation provided to such things as doctor appointments, shopping and community activities? Is a separate fee charged?

- Are nursing services available at the site? What happens if a resident's health declines? Is the facility responsible for coordinating medical care?

- How does the facility determine the point at which a resident cannot be served by the facility? What recourse does a resident have to challenge the facility's decision? Is there a grievance process?

Residents' Rights

Under Pennsylvania law, residents of an assisted living facility have the following rights:

- The right to privacy, including the right to have access in reasonable privacy to a telephone and the right to have uncensored access to the mail;

- The right to receive visitors;

- The right to leave and return to the home;

- The right to participate in religious activities;

- The right to exercise the rights of a citizen and to voice grievances;

- The right to be provided with 30 days advance written notice of the facility's intent to terminate a resident's stay and the reason for termination;

- The right to be free of chemical and physical restraints.

Continuing Care Retirement Communities (CCRC)

Continuing care retirement communities provide different levels of care based on the particular needs of the individual resident. New residents usually move into independent living units. As they age and become physically disabled and need assistance with the activities and needs of daily living, residents move to an assisted living facility located on the grounds of the continuing care retirement community. Some continuing care retirement communities provide assisted living services in the independent living units so that a resident does not have to move. If physical decline continues and more intensive care is needed, nursing home care is also available within the confines of the continuing care retirement community.

Upon entrance into a continuing care retirement community, a resident enters into a contract whereby the continuing care retirement community agrees to provide housing, a certain level of activities and health care support as needed in return for the resident's payment of an entrance fee and monthly occupancy fees. In most cases, residents do not own their living unit. The services offered can vary; most provide house-cleaning, laundry facilities and at least some meals. The monthly fee for residents who move into the assisted living or nursing home facilities may be higher than if they had remained in an independent living unit.

A careful review of the contract, preferably by an attorney, is advised to make sure the resident understands what they are buying. Some continuing care retirement communities offer unlimited health services in exchange for the entrance fee, while others provide that residents pay an

additional fee for health care services as they are needed. Still others offer a combination of the two. The fee-for-services arrangement is becoming increasingly more common. Other important issues to be reviewed in a continuing care retirement community contract are:

- Who determines when a resident must change living arrangements due to a decline in health?
- What are a resident's rights and responsibilities with regard to furnishing and altering his/her living unit?
- Under what circumstances would the entrance fee be refundable?
- Under what circumstances can the monthly service fee be increased?
- What services are not covered by the monthly service fee?

Pennsylvania law mandates that all continuing care retirement community contracts:

- provide for continuing care;
- specify all services to be provided and provide that a resident cannot be liable to a health care provider for services that the continuing care retirement community promises to furnish
- describe any exclusions or limitations on coverage for pre-existing conditions; provide for termination by either party upon 30 days written notice and the terms for refund upon termination;
- contain notice of rescission rights before moving in.

The advantages of living in a continuing care retirement community are:

- An individual whose health declines can move into an assisted living unit or, if necessary, to a nursing home within the same residential community.
- Payment of the entrance fee locks in a fixed price for continuing care at an amount that is usually less than the market rate for nursing home care. For this reason, some people consider a continuing care retirement community as a form of long term care insurance. However, if there will be a substantial increase in the monthly service fee upon moving into the assisted living or the nursing home portion of the continuing care retirement community, there could still be a need for long term care insurance.
- A couple that moves into a continuing care retirement community ensures that, if one spouse must enter the nursing home, the other spouse will be living on-site and can easily visit.

Because a continuing care retirement community comprises both assisted living and nursing home care, different activities within the continuing care retirement community can be governed by different laws and regulations. Residents would be protected by the laws that apply to assisted

living facilities and personal care homes while they are receiving these services and they would be protected by the laws that apply to nursing homes when residing in the nursing home component of the continuing care retirement community. See previous sections covering assisted living facilities, personal care homes and nursing homes for a description of these protections.

Housing Options

The Pennsylvania Department of Aging outlines several types of housing options for all levels of independence.

Services for Individuals Who Remain in Their Homes

- Homemaker assistance for daily household activities.
- Personal care for those who cannot manage alone.
- Home delivered meals.
- Family caregiver support which includes one-time grants for home modifications to help with mobility problems.
- Transportation services.
- Senior community centers where older people can get together for social activities, recreation, education, creative arts, physical health programs, and nutritious meals.
- Adult day care centers which provide personal care and medication management for individuals who cannot be left alone during the day.

You can contact your local Area Agency on Aging for more information regarding these services.

Independent Housing Options

- Continuing Care Retirement Community (CCRC) offers independent living, usually in an apartment or cottage, and access to a higher level of care such as personal care or a nursing facility. Residents move between levels of care as their needs change. Services, such as meals, medical care, social and recreational activities, are provided through a contractual arrangement for the lifetime of the resident. Residents usually pay an entrance fee and a monthly charge.

- Retirement Communities offer independent living in an apartment or cottage. They are intended for healthy, mobile older people and generally offer no special services. Units may be rented or purchased. Many retirement communities offer recreational amenities such as golf, swimming or tennis.

- Subsidized Housing is made available by the federal government providing rental assistance to low income elderly people. Income eligibility is 50% of the median income for the county of residence; individuals must be age 62 or older. Assistance is determined by an individual's income with tenants paying 30% of their income toward the rent.

Housing Options for Individuals Who May Require Assistance or Supervision

- Domiciliary Care Services for Adults is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of demonstrated difficulties in accomplishing daily activities, social or personal adjustment, or resulting from disabilities. The Area Agency on Aging is responsible for assessment and placement of residents in domiciliary care homes. Residents are eligible for a domiciliary care supplement payment if they are eligible for SSI or have an income less than the combined federal/state payment for domiciliary care and are not related to the provider.

- Nursing Facilities provide medical care, rehabilitation, or other health services to individuals who do not require the care and treatment of an acute-care hospital. Most nursing facility residents are unable to take care of themselves on their own and may have chronic illnesses or were transferred from a hospital following a serious illness, accident or operation.

- Personal Care Homes, sometimes called "assisted living facilities," offer room and board and assistance with the activities of daily living (such as bathing, grooming and meal preparation, taking prescription medication) but do not require the level of care offered by a hospital or nursing home.

National Housing Locator for Seniors

On July 21, 2008, the **National Association of Area Agencies on Aging** (**n4a**) introduced a new "online navigational tool to help older adults search for senior housing, no matter where they live." The resource was described in **n4a**'s Press Release, entitled **"National Association of Area Agencies on Aging rolls out nationwide senior housing resource during annual meeting in Nashville."**

Powered by SNAPforSeniors®, the Senior Housing Locator makes objective, nationwide information available 24-hours a day, seven days a week.

Consumers and professionals alike will now have access to the n4a Senor Housing Locator through a link on n4a.org.

The tool allows users to search a database of more than 60,000 senior housing listings, including all licensed senior housing in the nation.

The National Family Caregiver Support Program

The motto of this program is "home is where you want to be, no matter what your age". The major focus of the National Family Caregiver Support Program is to reinforce the care being given to frail family members in their homes by reimbursing some of the costs of caregiving supplies, services, assistive devices and home modifications. The major benefit is that it allows caregivers to choose from available services and to provide the type and quality of care they would like to choose for their loved ones at home. The caregiver does not need to reside with the family member receiving the care.

An assessment begins the process to determine which of the packages of benefits is best suited to the needs of the caregiver and senior receiving the care. Benefits may also include counseling, educational and financial information, and a care manager will assist the family with their choices and options. A cost-sharing approach grants income-eligible families up to $500 per month to help with out-of-pocket expenses ranging from respite care, adult day care or in-home services. In addition, one-time grants of up to $5,000 may be given to qualified families to modify the home or purchase assistive devices or supplies to accommodate their senior family member. Such adaptations might include installing stair glides or wheelchair ramps or modifying a bathroom.

Eligibility for the program is based on a sliding scale and household income, or income of the recipient of the care if the senior lives alone. Area Agencies on Aging can determine if your family might benefit from this program and establish eligibility. You should contact your local AAA for additional information.

Because the National Family Caregiver Support Program guidelines differ from the more restrictive State FCSP guidelines, families may qualify for one program more than the other program. The tracking for state and national funding will be kept separate. The differences in state and national FCSPs include:

State FCSP - caregiver must be related to care receiver.
National FCSP - caregiver does not need to be a relative of the care receiver.

State FCSP - caregiver must live with the care receiver.
National FCSP - caregiver does not need to reside in the same household as the care receiver.

State FCSP - care receiver must be ago 60+ with at least 1 ADL (Activity of Daily Living) deficiency or under age 60 when diagnosed with dementia.
National FCSP - care receiver must be age 60+ and unable to perform at least two ADLs independently.

State/National FCSP - sliding scale used for up to 380% of the federal poverty guidelines.

State FCSP - all household income included in determining eligibility.
National FCSP - if care receiver lives alone, only individual's income is counted.

State FCSP - up to $200 reimbursed for caregiving services/supplies each month and up to $2,000 to reimburse home modifications and assistive devices.
National FCSP - up to $500 reimbursed for caregiving services monthly (no supplies) and up to $5,000 reimbursed for home modifications, assistive devices and consumable supplies.

For more information on Family Caregiver Support Programs, contact your local Area Agency on Aging.

Geriatric Care Managers

What is a Geriatric Care Manager? In this day and age of many options for seniors, a Geriatric Care Manager can help connect families to services that are appropriate for their needs. A Geriatric Care Manager can:

- provide assessment, if certified to do so;
- evaluate physical, emotional, and financial needs and propose an individualized life care plan for you or your family members;
- evaluate housing options for seniors;
- help select an appropriate placement and assist with the admission process;
- coordinate a move or home sale by working with real estate agents, moving services, and others.

In the event that staying in the home is appropriate, a Geriatric Care Manager can provide a variety of services including:

- arrange for home health care services;
- review adult daycare options;
- help coordinate insurance and public benefits and suggest consultations with elder lawyers and other professionals;
- provide every day assistance to the homebound such as shopping for seniors, transporting seniors to doctors' appointments and following up with care.

Occasionally assistance in financial matters is necessary and Geriatric Care Managers can even provide bill paying and record keeping services, coordinate insurance, Medicare, and other entitlements and assist in these matters. There are even banks that have financial programs that are specifically tailored to Geriatric Care Managers and their clients.

In the event of nursing home placement, a Geriatric Care Manager can interface with the facility and advocate on behalf of the resident, if necessary. As always, in selecting the Geriatric Care Manager with whom you wish to work, your referral network should be consulted.

Nursing Home Licenses: Problems, Sanctions and Revocations

Although nursing home placement is a difficult decision, there are people to help you to verify that you are placing your loved one in a secure environment. One contact person is your county's Long Term Care Ombudsperson who responds to care issues in all licensed facilities in your county. Your county's Area Agency on Aging can provide you with the telephone number.

Any employee or administrator of a licensed facility who has reasonable cause to believe that a resident of the facility is a victim of abuse is required under Pennsylvania law to report the abuse immediately. The law does not require that the reporter be a direct eye witness; having more than a suspicion obligates them to make an oral report at once, followed up by a written report to law enforcement officials. This reporting requirement protects a care-dependent person and applies to all caretakers. Civil and criminal fines and imprisonment for up to one year can be imposed upon the person or facility that commits the violation or abuse.

Pennsylvania law protects nursing home residents by requiring criminal history background checks by the Pennsylvania State Police of all employees of public or private nursing homes, personal care facilities, adult daycare and home healthcare providers. Employees with certain felony and misdemeanor convictions are precluded from working in these facilities.

The final sanction under Pennsylvania state law is that a facility can have its license revoked or its licensing withheld in the first place for any one of the following reasons: gross incompetence, negligence, misconduct in operating the facility or mistreating or abusing an individual cared for in the facility. This sanction applies to both physical and mental abuse of a patient. This law serves as a deterrent to such abuse since the facility cannot do business without a license. Court cases in Pennsylvania have upheld the decision to revoke the license of homes for abuse of patients.

To investigate licensed personal care homes, contact your county's Department of Public Welfare Facilities. To find out about nursing homes, check with your county's Department of Health. Foe home health agencies, the telephone number to call is 1-800-222-0989. To search for various types of long term care facilities, visit the website agingpa.psu.edu/g_index.htm.

The Pennsylvania Department of Health website, www.health.state.pa.us, is another resource that reports the results of surveys and on-site inspections of all long term car facilities in the state. The website contains valuable factual public information. Survey results of complaints and deficiencies are reported for the last 18 months to two years. Constant vigilance and checking of the website is recommended, especially in the event of a change in administration at the facility, which is a frequent occurrence.

Resources

- "How To Select Long Term Care in Pennsylvania;" "A Guide for Selecting a Nursing Home in Pennsylvania," and "Know Your Rights as a Nursing Home Resident;" Pennsylvania Department of Aging, 717-783-7247

- "Home Away From Home: A Consumer Guide to Board and Care Home and Assisted Living;" American Association of Retired Persons, 1-800-424-3410, www.aarp.org.

Long Term Care Insurance

The term "long term care has generally been understood to mean the kind of care needed by the old and frail who are, for example, suffering from a dementia such as Alzheimer's disease or other disabilities of old age. Today, people realize that long term care is any degree of care, support, or supervision received for a year or more, with roughly 40% of the people receiving care in the US under the age of 65. Long term care mostly consists of custodial care, i.e., care designed to assist an individual to perform the activities and meet the needs of daily living. Such activities and needs include eating, bathing, dressing, toileting and transferring from a bed to a chair. Supervision or assistance to assure the safety of those with cognitive impairments is also considered custodial care. Long term care can be provided in the home or in a long term care facility, such as a nursing home or an assisted living or adult day care facility. Facilities are either free-standing or, in a growing number of cases, part of retirement communities.

Neither Medicare nor supplemental Medigap insurance covers long term custodial care – at best, these programs may only cover skilled, post-hospital, recuperative care and together pay less than

3 % of long term care expense. Long term care insurance sold by commercial insurance companies can b purchased to cover the vast majority of long term care expenses that other insurance does not cover.

Long Term Care Costs

The statewide average cost of nursing home care in Pennsylvania is over $8500 per month, but the actual cost of nursing facility care in the county in which you reside may exceed the statewide average. Assisted living and personal care home costs are usually less than nursing home car, running approximately $4,000 to $5,000 per month on average. Hourly in-home care may be a less expensive alternative for long-term care, particularly if family caregivers can assist. However, around-the-clock care can cost as much as or more than nursing home care.

Services Covered

While most people receiving care are older than 65, it is critical that people look into their options, including long-term care insurance, when they-re fairly young and healthy. Today, the majority of people looking into long term care insurance are in their 40's and 50's, and often younger, especially when presented to employees and association members. Denial ("it's not going to happen to me" or "I'm young and healthy – I'll wait until I'm older") and lack of information often preclude people from addressing the issue until health issues or age makes insurance unattainable or unaffordable. When you purchase a long term care insurance policy, it is critical that you understand the types of services that will be covered. Most policies today are labeled "comprehensive," and cover care provided in a home as well as facility setting, again including assisted living facilities, adult day care, as well as nursing homes. A policy should be carefully reviewed so you understand exactly the kinds of services that it will cover.

Most people would prefer to stay at home, and today policies generally include features such as care coordinators to help people, including those without spouses or children in the area, to remain at home. Policies differ widely in how home care coverage is provided, so a very careful review of this type of coverage is strongly advised. While some policies limit home care coverage to skilled services, i.e., those performed by registered nurses, licensed practical nurses and occupational speech or physical therapists, most comprehensive policies today cover informal home care which includes services of home health aids who can assist with custodial care, as well as homemaker or chore worker services such as aides who cook meals and do housework. Most policies will not pay benefits to family members who perform home care services.

Coverage Needed

Most polices express benefits in terms of a daily or monthly amount. In order to make an informed decision as to the amount of coverage that you will need, you must have an idea of the amount of long term care costs that you anticipate. If your ideal long term care facility charges $200 a day today, you may want to buy a policy that covers that amount, or you may want to co-insure a portion of the costs out of income. For example, if you receive Social Security benefits of $1,500 a month ($50 a day, based on a 30-day month), you will need, at the bare minimum, a policy with a daily benefit amount of $150.

Factors Affecting Costs

Most polices include a waiting period, sometimes call an "elimination period," before benefits can

begin. This means that you can choose to have benefits begin 20, 30, 60, and 90 or 100 days after you enter a long term care facility. The longer the waiting period, the lower the cost of the policy. Of course, you will have to have resources to cover the cost of long term care during the waiting period. Many policies offer the option, which most people take advantage of, to waive the elimination period for home health care, thereby offering "day one" coverage at home.An important feature to consider in any long term care insurance policy is inflation protection. Long term care that costs $6,000 a month now will cost about $12,500 a month in 15 years and about $25,000 a month in 30 years, assuming an annual inflation rate of 5%. The younger you are when you purchase the policy the more important it is to consider adding inflation protection. Obviously, this protection adds to the cost of the policy, although it's much less expensive to add inflation up front than electing the "guaranteed purchase option," which allows the purchaser to add inflation benefits every few years, but at your then-current ages. The traditional 5% compound inflation protection rate that existed in most policies then years ago is less typical today, as inflation rates have been low, and policies with a fixed 5% compound inflation may be less rate-stable than policies with lower or new, innovative inflation options, as insurance carriers are, in this period of low investment returns, unable to get a yield of 5% or more on their investments, to fund this inflation option. Make sure your LTDC specialist fully explains the costs, benefits, and effects on rate stability of the inflation options you choose. Recent inflation options, which may be a good deal less expensive than traditional compound inflation, are either for lower percentages (for example, 3% compound), and one or two carriers have an innovative option for inflation that is 30-40% less expensive, and based on the CPI, so that the benefits per month and total pool of money go up each year depending on the CPI, without limit, so that as long as the costs of LTC, based mostly on housing and labor, continue to mirror the CPI, as they have over most of the last 30 years, this may be a better, more flexible, as well as less expensive option.

Benefit Triggers

When the benefits are payable under a long term care insurance policy is determined by what are commonly called "benefit trigger." A benefit trigger is a medical condition or a degree of physical or mental disability that an individual must meet before qualifying for benefits.

For a person with a physical, as opposed to mental disability, policies usually provide for benefits to begin when that person cannot perform a specified number of "activities of daily living (ADL's), i.e., eating, bathing, dressing, continence, toileting and transferring from a bed to a chair, without continual supervision. Today, most policies are called "tax qualified," which not only may provide a tax deduction and makes the benefits when received likely not taxable, but also provides some level of assurance of standardized benefit triggers (needing supervision in 2 of 6 ADL's or due to cognitive impairment). The more clearly a policy defines its benefit triggers, the easier it will be to make a claim when necessary.

Most policies today, and all Federally tax qualified policies, provide for a separate trigger for cognitive impairment. This is critical, as many people with dementia or other cognitive impairment can do all o most of the ADL's, cut still require care and supervision. Although Alzheimer's and other organic brain diseases are now always covered in tax-qualified plans, you may want to check the "exclusions" section of the policy to ensure that other non-organic mental conditions, including depression, are not excluded from cover.

Newest Developments

Before 2006, only four state (New York, California, Connecticut, and Indiana) offered two types of plans, including a type called a "partnership plan" which allowed purchasers buying certain minimum benefit levels to legally shelter their some of their assets (and in some cases, income) and receive the benefit of quality care while still going on Medicaid, the state-administered health program designed for the impoverished. While partnership plans are right for some purchasers and not for others, this clearly created a "win-win" in which people who purchased private long-term care insurance could get access to quality care, generally including care in the home, and the states would lessen their exposure to already-strained Medicaid funding of long term care expenses.

As of February 2006, Congress passed legislation to allow other states to develop partnership plans that shield some assets, and Pennsylvania has recently received its approval to develop and offer such plans. Virtually off of these partnership plans are underwritten for health. Note that one done NOT have to wait for the availability of such plans in his state, and risk his eligibility; anyone purchasing a plan from this point forward will have the option of a penalty-free conversion to the partnership plans for a period after they are first offer in each state. Also note that Partnership plans typically do not cost more than non-partnership-qualified plans. In Pennsylvania and in most other states, the requirements for Partnership qualification are met by almost all well-developed plans.

Consumer Tips

- Utilize long-term care specialist (someone who's focused exclusively on long-term care) to help you determine if you need LTC insurance, and if so, through which company and what levels of benefits. The best specialists represent multiple insurance companies, and will recommend the best companies that your health allows, instead of having a bias towards certain carriers.
- Ask questions.
- While you want to understand the benefits fully before you decide to buy and keep a policy, it makes sense to apply, and bind your health, with the best carrier that your health will allow, and then in the 6-8 weeks that that company is deciding if they'll accept you, complete your research to make sure the policy meets your needs. Over the last several years, the better, more rate-stable companies have tightened underwriting standards, indicating that while you may not need LTC insurance, it is preferable to explore your options while you are at your youngest and healthiest point in your life, and then decide if it is appropriate and necessary for you, either to protect assets, or to avoid burdening family members with your care, or for other reasons.
- Get the actual policy and read it before you decide to keep it. In PA and most states, you have 30 days after you receive the policy to decide if you want to keep it, and if not, get all of your money back.
- Ask the insurance agent for a thorough explanation of what degree of disability triggers benefits.
- Do not let the attractiveness of a lower premium push you into a policy that provides less coverage than you really need. A cheap policy that leaves you underinsured is not bargain and a waste of money.
- Consider policies form at least two or more companies. NO two long term care insurance policies are alike.
- Do not spend more than 5% or 6% of your annual income on long term care insurance

premiums if you're still working, or more than 40-50% of the passive income on investments that you reinvest, or expect to reinvest, upon retirement.

- Check the financial stability of the insurance company you are considering – for people with good health, companies should be rated "A" or better by A.M. Best, an insurance company rating service.

Independent Advice

While a long-term care insurance expert can help you determine when to apply for long-term care insurance, and what levels of monthly benefits, benefit terms, deductibles, and other initial selections are best, an independent advisor, such as an elder law attorney, can be invaluable in providing the following services:

- Reviewing the financial suitability of an individual for long term care insurance.
- Confirming the financial soundness of prospective insurance companies.
- Understanding, explaining and comparing policy features.
- Pinpointing uncertain terms in the policy and obtaining written clarification from insurance companies.
- Recommending a policy that services the individual's needs over the long term.

Resources

- US Department of Health and Human Services
- "A Shopper's Guide to long Term Care Insurance;" The National Association of Insurance Commissioners, 816-842-3600.
- "Overview of Long Term Care Insurance;" Pennsylvania Department of Aging, 1-800-783-7067.
- Long Term Care Planning Guide, 9th Edition, 1999; by Phyllis A. Skelton.
- American Health Care Association; ww.ahca.org; "What Consumers Need To Know About Private Long Term Care Insurance."
- Long Term Care Insurance National Advisory Council; ww.longermacareinsurance.org.
- Health Insurance Association of America; ww.ahip.org; "Guide to Long Term Care Insurance.
- Long Term Care Partnership Policies-Questions and answers about Pennsylvania's newest option for long-term care insurance.

Elder Abuse and Neglect

Be aware that elder abuse or neglect can occur at any time, in any community, at any economic level, among all races and nationalities. Federal and state laws now affirm everyone's right to be safe; no one has to tolerate abusive situations. Federal and state laws also protect older adults who lack the capacity to protect themselves and are at immediate risk of abuse, neglect, exploitation or abandonment.

Signs of Abuse or Neglect

Abuse can be any one or more of the following:

- infliction of injury;
- unreasonable confinement;
- intimidation;
- any punishment that results in physical harm;
- causing mental anguish;
- depriving food, necessary medication or medical services;
- sexual harassment;
- rape;
- any physically or emotionally controlling behavior that restricts independence or activity.

Elder abuse and neglect is not always easy to identify; signs to consider include:

- bruises and broken bones blamed on falls; the real cause may be pinching or beating;
- weight loss might be result of starvation or neglect, not just illness or lack of appetite;
- dementia is not always a part of aging; malnutrition or the misuse of medications can also be causes.

If You Observe Abuse or Neglect — Call Your Local Protective Services!

If You Are Abused — In an emergency: call 911

You should not confront your abuser. You need to wait until the abuser is gone or has calmed down so you can secretly and safely call one of these numbers for help:

- Elder Abuse Hotline 1-800-734-2020
- Domestic Violence Hotline 1-800-773-2424
- Pennsylvania Department of Aging 717-783-3126

Be sure to call. You may be able to prevent the next abusive situation by getting help from people who have worked with these problems and will work with you to develop your own personal safety plan. This could mean the difference between life and death.

Protection from Abuse Orders (PFAs)

You can go to court to obtain an order to keep your abuser away from you. Your local Women's Center will help you file the necessary papers and will go with you to court. The abuser may be arrested and if a court deems it appropriate, they may be imprisoned and/or fined.

Zero Tolerance for Abuse

You should know that many organizations are working in Pennsylvania on zero tolerance of abuse. Any time you hear or see abusive behavior you should call 911. If you ignore abuse or think it will improve without intervention you may be risking your life or the life of someone you know. Without help abuse always gets worse; everyone should know that help is available.

Americans with Disabilities Act (ADA)

The Americans with Disabilities Act was designed to protect people who suffer from a disability and

to prevent discrimination against any person because of a disability. Significantly, this protection extends to a person's right to be employed. The ADA mandates that, under certain circumstances and presuming certain conditions are met, a person cannot be denied employment solely because of a disability.

Disability Defined

The first question to consider is what, exactly, is a "disability"? The language of the ADA defines a disability as "a physical or mental impairment that substantially limits one or more major life activities of an individual." That means if a person has a long-term physical illness or injury or has a mental condition which prevents or limits him/her from doing something that other people normally do, they probably would be labeled as having a disability under the ADA. What are the things that people normally do? They are the simple things that the average person does with little or no difficulty, such as caring for oneself, walking, seeing, hearing, speaking, breathing, learning, sitting, standing, lifting, reaching, reading, etc. Many written cases in the law define what is a major life activity and what is not. To be considered a disability under the ADA, the disabling condition must be permanent or long-term. So even if a temporary condition, such as a broken bone, the flu, or pneumonia, limits a person's activities as described, it is not considered a disability under the ADA.

Accommodations

Under the terms of the ADA an employer must make what is called "reasonable accommodations" to an employee, or potential employee, who has a disability. If an employee can perform the essential functions of a job, i.e. the primary duties of a job position, with a reasonable accommodation being made by an employer, then the employer cannot fire or refuse to hire the employee because of a disability. If an employer refuses to hire a person, or fires a current employee solely because of a disability or to avoid having to accommodate that disability, then that employer has discriminated against that person, according to the ADA.

Reasonable accommodation is necessarily determined on a case-by-case basis. As a general rule, an accommodation is any change in the work environment or in the way things are normally done on the job so that a person with a disability can perform the essential functions of the job safely and adequately. This change or accommodation will vary according to the circumstances, i.e. what type of job and what type of disability. The accommodations an employer makes can be as simple as bending the work rules (perhaps allowing more breaks to a person with a chronic bladder problem), or as difficult as removing a physical barrier (such as installing a ramp so that a person in a wheelchair can get up a flight of steps). The most common forms of accommodation are physical changes to the work area (as with the handicap ramp); part-time or modified work schedules (for example to accommodate therapy appointments); modified equipment (i.e. an amplifier for a phone for someone who is hard of hearing); or special equipment, such as a Braille typewriter for someone who is blind. But there are limits to how much an employer is obligated to do to accommodate a person with a disability.

First of all, no employer is required to lower production standards or eliminate an essential job function or duty as a reasonable accommodation. This applies across the board. While an employer may be obligated to make accommodations so that an employee can meet production standards, or perform their job duties, the production standards and job duties themselves do not have to be changed as part of that accommodation. Furthermore, an employer may argue that making a certain necessary accommodation will cause an "undue hardship" to their business, and

thus they should be relieved of that obligation. This is a very "sticky" point and is decided on a case by case basis. However, as a general rule, an undue hardship is any accommodation that would cause significant difficulty or expense to the company, or that would be so disruptive as to seriously affect the operation of the business and the ability of the business to continue operating.

An important factor to consider regarding undue hardship is the size of the company. What may be considered a financial hardship to a small restaurant or shop may be no big effort for a large corporation. Also the nature of the business itself is a big factor. For instance, if a waitress in a restaurant needs to take a five minute break every half hour, this might be considered an undue hardship since it would be disruptive to the normal demands of the business. However, if the employee requesting the five minute break every half hour is a computer programmer, this may not be quite so disruptive to the job or the business in general. Similarly if the very nature of the job makes an accommodation impossible or impracticable an employer will be relieved of the obligation. For instance, a blind person cannot be a proofreader of news articles and a person with a serious speech impediment cannot reasonably perform the job of a telephone receptionist.

Reassignment

In order to qualify for protection under the ADA, an employee should be able to perform the essential functions of their job, with reasonable accommodation. However, the courts have found that if a person is unable to perform the essential job functions of their current position, the employer may still be obligated to reassign them to another position that they can perform, with or without accommodation. This obligation to reassign an employee kicks in under three different circumstances:

- If the employee cannot perform the essential functions of their present position, despite reasonable accommodations;

- If the employer claims the accommodation needed to keep the employee in their current position would cause undue hardship; or

- If no accommodation is practicable or possible for the person to perform the job duties of their current position.

Furthermore, if reassignment is appropriate, there has to be a position available; the employer need not create one. The position must be vacant and the employee must qualify for the new position. In the example where the employee has a speech impediment and cannot act as a telephone receptionist: if the employer has a vacant word processing position available and the employee can effectively use a word processor and perform the duties of that position, then reassignment is appropriate. Although reassignment seems like a great idea, it can be to a lower paying position, or outside the geographical area, in which case the employee pays the moving expenses. If the employee refuses the position because of lower pay or a move being required, they cannot later come back and make a claim against the employer under the ADA, since the employer satisfied the obligation.

Age Discrimination in Employment Act (ADEA)

The Age Discrimination in Employment Act is designed to protect people who are age 40 and over from discrimination in the workplace. Discrimination in this instance is any act by an employer

which treats a person unfairly because of their age. This not only includes firing someone because of their age, but includes actions which result in those over the age of 40 being treated differently and less favorably. For instance, if someone over the age of 40 is receiving less pay for doing the same job as someone who is younger, when both employees are otherwise on the same level, there may be a claim for age discrimination. The protection also extends to hiring practices. If a person feels that they are being passed over for a job solely because they are age 40 or over, the ADEA may offer protection. The person claiming discrimination in this instance should be able to show that they are qualified for the job, that someone younger and less qualified was hired in their place, and that there was no other valid reason for the failure to hire.

Sometimes employers try to disguise age discrimination by claiming that the layoff or discharge of an employee is caused by a reduction in workforce or downsizing. Even in such an instance, if the discharged employee is over the age of 40 and can show that they are as qualified for the position as other younger employees who were retained and not fired, that employee may have the basis for a claim for protection under the ADEA.

Protection from Discrimination Against Caregivers

Recently, the ADA and the EEOC (Equal Employment Opportunity Commission) regulations have been the subject of federal court cases. The regulations found in both these laws are very clear that people who may not have disabilities, whether age-related or otherwise, but who are discriminated against anyway based on their known relationship or association with a person with a disability may find protection in these provisions of these laws.

It is generally known that the ADA protects individuals with disabilities from employment discrimination. However, it also offers protection against discrimination that a current or future employer may impose based upon their knowledge and the employer's actions taken based on that knowledge. If the employer knows about a family member or friend's disability and then limits or terminates your job opportunities, you may be protected by this federal law. For example, if a family member who is a caregiver to either a chronically ill or disabled person, or to a person with an age-related disability is offered a job, but then has the offer withdrawn when the employer finds out that you have a family member in this situation. Watch out for employers who may deny you opportunities or promotions at work under the pretext of "reducing your stress." Also, an employer may terminate or limit hiring or job opportunities due to their concern about increasing health insurance costs for a person's relative or caregiver. The courts may extend protection in the event that is it proven that the employer discriminated based upon their knowledge of the caregiver being related or associated with a disabled or chronically ill person. However, the courts have not been overwhelmingly favorable to the assertion of these types of associational claims.

Special Agencies

The Pennsylvania Human Relations Commission (PHRC) is the agency set up by Pennsylvania to assist in discrimination cases; the Equal Employment Opportunity Commission (EEOC) is the parallel agency of the federal government. These agencies are fairly "user friendly," designed to assist you with any claim for discrimination you feel you may have. However, you have deadlines by which you must notify either the EEOC or the PHRC of any act of discrimination. The PHRC gives you 180 days after the discriminatory act to give them notice and file the necessary paperwork. The EEOC gives you 300 days to do so. If you feel your employer has treated you unfairly because of your age, you should not wait to take action. You should contact the EEOC or

the PHRC without waiting for the matter to be resolved by your employer, because if it doesn't get resolved within their time frames, you may have lost your right to make a claim. The ADEA is there to protect your rights but in order to be protected you must discharge your responsibilities in the matter. Contact the PHRC at 101 South Second Street, Harrisburg, PA 17101; telephone 717-787-4410.

Consumer Protection

Pennsylvania Consumer Protection Bureau

The Pennsylvania Consumer Protection Bureau can help you with your consumer complaints, such as if you believe you have been defrauded by a business or door-to-door salesperson, illegally harassed by an unscrupulous debt collector, or victimized in deceptive sales practices by a home improvement contractor or mail order business. This office, an agency of the Pennsylvania Office of the Attorney General, investigates and mediates consumer complaints. An office in your region can be located in the Human Services section of your telephone directory or you can call the toll-free consumer protection hotline at 1-800-441-2555 or access the Pennsylvania Attorney General's website at www.attorneygeneral.gov.

Suggestions for Resolving Complaints

The Office of the Attorney General publishes consumer protection booklets which include these suggestions if you plan to resolve a complaint yourself:

- Decide on the specific complaint you wish to make;
- Have a clear statement of the specific action you want the person or business to take to remedy your complaint;
- Proceed without delay;
- If you are making the complaint in person, take along the purchase receipt, any guaranty or warranty, and if possible, the product;
- Be assertive! If you are told by a salesperson or company representative that they cannot deal with your complaint, ask for a higher authority;
- If you complain by mail, give the brand name, model number, size, color and other details needed for identifying the product. Include in your letter a specific explanation of the circumstances surrounding your complaint;
- Keep copies of your letter and all correspondence you receive. If you return the product, be sure to insure it.

If you are unable to resolve your consumer complaint, you can file a written complaint on a preprinted form with the Bureau of Consumer Protection, Strawberry Square, 15th Floor, Harrisburg, PA 17120. Their hotline number is 1-800-441-2555.

Avoiding Scams

The Office of he Attorney General periodically publishes the "Consumer Reference Guide for Seniors," a pamphlet that can help you to avoid scams and frauds. The pamphlet reiterates the phrase "If it sounds too good to be true, it probably is," and points out that scam artists typically use the "nice guy" approach. It also states that con artists often use words or expressions including:

- "Cash only" - Why is cash necessary for a proposed transaction? Why not a check or credit card?
- "Secret plans" - Why are you being asked not to tell anyone?
- "Get rich quick" - Any scheme should be carefully investigated.
- "Something for nothing" - A retired swindler once said that any time you are promised something for nothing, you usually get nothing.
- "Contests" - Make sure they aren't a hoax to draw you into a money-losing scheme.
- "Haste" - Be wary of any pressure to act immediately or lose out.
- "Today only" - If something is worthwhile today, it is likely to be available tomorrow.
- "Too good to be true" - Such a scheme is probably neither good nor true.
- "Last chance" - If it is a chance worth taking, why is it offered on such short notice?
- "Left-over material" - Left-over materials might also be stolen or defective.

If you are unable to obtain the relief that you expected from the Bureau of Consumer Protection, you should promptly seek legal advice from a qualified, reputable local attorney, because there are strict time limits in which you must pursue any legal actions for fraud. Typically, a written civil complaint must be filed with the appropriate court within two years of the commission of the fraud.

Charitable Organizations

Senior citizens who are solicited by charitable organizations can call the Pennsylvania Department of State's Bureau of Charitable Organization's toll-free number at 1-800-732-0999 to find out if the organizations are registered to solicit contributions; how much income the organizations receive; how much the organizations spend on programs, services, administration and fundraising. Seniors can also call the toll-free number with any complaints they have about organizations which have solicited funds from them.

Some precautions when you are called for donations:

- Ask for written information, including the charity's name, address and telephone number.
- Ask for identification, if the solicitor refuses, hang up.

- Call the charity to check whether they are aware of the solicitation. If they are not responsible, you should report the call to your local police department so they can investigate the potential for fraud.

- Watch out for organizational names which sound like established charities; some phony groups use titles that closely resemble respected legitimate organizations.

- Know that "tax-exempt" is not the same as "tax-deductible." The exemption refers to the organization, but your contribution may or may not be deductible and, if that is important to you, ask for a receipt for the amount of your contribution.

- Be skeptical if someone thanks you for a pledge you do not remember making. Keep records and check them.

- Refuse high pressure appeals. No legitimate organization should pressure you for your gift.

Mail Fraud or Identity Theft

Mail fraud is illegal but it nevertheless remains a perfect means for a con artist to try and trick you. Do not respond to sweepstakes or contests that ask for money or your credit card. For additional information on mail fraud, call the U.S. Chief Postal Inspector at 202-268-2284 or your local postmaster. If you think you are a victim of mail fraud you can write them at ATTN: Mail Fraud, 222 S. Riverside Plaza, Suite 1250, Chicago IL 60606-6100, or visit their website at www.usps.com and submit as Mail Fraud Report. If you think you are victim of theft of your personal information or identity you can call the federal Trade Commission at 1-877-987-3728.

Telemarketing

Telemarketing is another method commonly used to get your personal information such as credit card numbers, checking account numbers, Social Security number, driver's license number, etc. Do not give out this information unless you placed the call yourself to a well known, reputable company. Other tips include:

- never pay for a prize over the phone;
- never allow a caller to pressure you into acting immediately;
- the law prohibits telemarketers from calling consumers who have stated that they do not want to be called.

Pennsylvania law permits telemarketers to make calls only between the hours of 8:00 a.m. and 9:00 p.m. If you want your name removed from telemarketing lists, send your name, telephone number (including area code) and address to the Telephone Preference Service, Direct Marketing Association, P.O. Box 9014, Farmingdale, New York 11735-9014. This action will help reduce the number of unsolicited calls even if it won't stop all the calls.

Do Not Call Lists

Under this law, those who telemarket in Pennsylvania, with some major exceptions, such as charities and political groups, are required to check their own lists on a quarterly basis, to monitor

who they may not call. In order to be placed on the do-not-call list, you can sign up on the internet (www.nocallsplease.com) or by telephone (1-888-777-3406). Over 2.2 million Pennsylvanians have signed up for the do-not-call list.

Enforcement: If you believe a telemarketer is violating the law, you can file a complaint on line or by telephone at the above number or Internet address. There are no first tries, every violation should be reported.

Prerecorded calls are more problematical but a complaint can be filed with the FCC by calling 1888-225-5322; online at www.fcc.gov/cbg/complaints.html, or by letter to the FCC Consumer and Governmental Affairs Bureau, Consumer Inquiries and Complaints Division, 445 12th Street, S.W. Washington, DC 20554. Prerecorded calls are illegal if made to residential phone lines. Exceptions include calls from tax-exempt non-profits or from companies which you already have an established business relationship.

On-line Scams

On-line scams also are abundant in today's age of the information superhighway. For the most part, the same rules apply so beware of being misled. For additional information about on-line scams, contact the National Fraud Information Center, Consumer Assistance Service at 1-800-876-7060 or visit their website at www.fraud.org.

Resources

The U. S. General Services Administration Consumer Information Center publishes annually a comprehensive "Consumers' Resource Guide" which is available by writing the Consumer Information Center, Pueblo, CO 81009 or accessing the CIC website at www.pueblo.gsa.gov.

This publication has two parts: "Buying Smart" contains general advice on shopping; information on how to shop for major items such as cars, credit or home improvement; suggestions on how to complain effectively including a sample letter of complaint. The second part is a "Consumer Association Directory" with lists of offices of consumer organizations, corporations, trade associations and government agencies at all levels.

Grandparents' Custody and Visitation Rights

All fifty states now give grandparents the right to visit with and to obtain custody of their grandchildren in certain situations. Pennsylvania custody laws permit a court to grant partial custody or visitation when parents are divorced or separated for six months or more, if this would be in the best interest of the child and would not interfere with the parent-child relationship. The court must consider the amount of personal contact between the parents or grandparents and the child prior to the grandparents filing in court for these rights. This section of the law also may permit visitation by grandparents where the parents of the child are unmarried.

In all cases involving custody of children the paramount concern of the court deciding custody or visitation matters is the best interest of the child. This standard is broadened in the case of a grandparent to include that the granting of rights should not interfere with the parent-child relationship.

At any stage, an agreement may be reached between the parents and grandparents instead of proceeding further in the legal system. Grandparents may also petition for either partial custody and visitation if an unmarried grandchild has lived with the grandparents or great-grandparents for one year or more and is subsequently removed from the home by their parents.

A grandparent may want to gain full custody of a grandchild and can bring a case to court since they are deemed to have legal standing to do so. The standard the court will look at in this situation is whether it is in the best interest of the child not to be in the custody of either parent and if it is in the best interest of the child to be in the custody of the grandparent instead. In order to be awarded custody by the court, the grandparents must meet three conditions:

1. They must have genuine care and concern for the child;

2. They must have begun their relationship with the grandchild due to a court order or the consent of a parent; and

3. They must have assumed the role and responsibilities of a parent to the grandchild for the last year, due to the child being declared a dependent child by the court due to a juvenile proceeding, or due to the child being at risk from the parent's abuse, neglect, drug or alcohol abuse or mental illness. An emergency temporary order may be obtained in the latter situation.

Grandparents may wish to act against the separation from their grandchildren that might occur after one parent dies, or after parents separate or divorce and custody of the child is with one parent, or after the child has lived with the grandparents for a significant period of time and is then removed by the parents. However, in all cases in which the grandparent is seeking visitation or custody, it is the grandparent who has the burden of proving to the court that the visitation or custody is in the best interest of the child.

A grandparent is not entitled to be granted visitation rights to grandchildren where the parents are not deceased, separated or divorced and the children never resided with the grandparent. Also grandparents' rights do not apply if the child has been adopted by a person other than a stepparent or grandparent, even if the grandchild resided with the parent, a parent is deceased, or the parents are divorced or the parents are separated.

Recent cases have stated that grandparents occupy a favored position among other third parties (such as state agencies or others) in custody disputes, and they have standing to petition for physical and legal custody from a natural parent, providing the conditions listed above have been met. At any stage, an agreement can be reached between parents and grandparents, instead of proceeding further in the legal system.

Mediation Services

In the context of aging, there are sensitive topics such as finances, changes in living arrangements, healthcare concerns and end-of-life decision-making that need to be discussed between older adults and the significant people in their lives. Addressing these issues can be overwhelming, emotional and involve conflict. Struggles may occur regarding an older adult's desire for independence and concerns of others about safety.

Mediation is a way for those in conflict to talk together with the help of an impartial third party. Mediators are trained to listen carefully, clarify issues, and help older adults; their families and care providers better understand each other and make decisions.

- **Intergenerational family conflict –** Differences among parents, adult children and grandchildren about what is best for the aging family member including driving, safety, need for supportive services

- **Finances –** Conflict regarding financial matters, available resources, control of the finances, actions by agents under power of attorney

- **Housing Transitions –** Conflict about an elder moving from independent living into a new setting and/or the sale of the family home

- **Caregiving –** Disagree over the care of an elderly parent/relative and how to provide the care needed

- **Adult Guardianship –** Family conflict over the need for and/or selection of a guardian and the terms of adult guardianship

- **Long-Term care –** Conflicts among staff, residents and family members regarding care and relationships within the facility

- **Healthcare –** Older adult or family disagree with healthcare provider about medical decisions or quality of care

Benefits of Elder Mediation

No matter how hard individuals and families try, sometimes they can't work it out on their own. Mediation can help those in conflict have productive conversations regarding issues associated with aging. Benefits include:

- A timely and confidential way to deal with the conflict
- Having a productive conversation that can lead to decision making
- Agreements can be reached
- All involved in the conflict have an opportunity express themselves, their preferences and their concerns
- Improves understanding
- Supports collaboration with health care and long-term care providers to improve satisfaction with care;
- Provides an alternative to litigation

Seniors and their families may also contact their local bar association or consult an attorney to obtain information about participation in mediation or alternative dispute resolution.

Drivers' Licenses

Having a drivers' license is considered a privilege. Therefore this license may be recalled or suspended and the privilege to drive an automobile may be revoked upon a determination of incompetency or a finding by a physician of a condition that prevents one from safely operating a motor vehicle. Upon the report of a physician or psychologist, the Commonwealth of Pennsylvania Department of Transportation Bureau of Driver Licensing will send a letter to inform you that your license has been revoked or suspended and must be returned in approximately one month from the date of the letter.

If this occurs, the recall or suspension of a license can be appealed. A petition for appeal must be filed in court. However, the filing of the appeal will not act as a stay or postponement of the recall of the driver's license. A hearing will be held in court sixty days from the filing of the appeal. The attorney for the Pennsylvania Department of Transportation will argue that the license should remain revoked based upon the medical evidence of the examining doctor or the statements of the psychologist.

This evidence can be countered by presenting medical evidence and reports of other doctors or by successfully passing an actual road test that is given by various hospitals that may administer driving rehabilitation programs. They make a determination whether the individual can or cannot drive. If the driver is successful, they will send a letter to the Pennsylvania Department of Transportation (PennDOT) and the license will be returned. If unsuccessful, there is always further review by a higher court, although again, filing an appeal will not reinstate the license until the next court decision.

Identification Cards

Most establishments require a driver's license for identification. An ID card, similar in appearance to a driver's license, can be obtained by non-drivers at the Pennsylvania Department of Transportation Driver License Centers. Any Pennsylvania driver who voluntarily surrenders his/her license for medical reasons can obtain this ID free of charge. All others, including those who have never had a driver's license, must pay a $9.00 fee. You must bring proof of identification such as a birth certificate, your old driver's license and your Social Security card.

Handicapped Parking

If you are disabled and need a special parking placard or place you can contact the Pennsylvania Department of Transportation; Bureau of Motor Vehicles, Riverfront Office Center, 1101 South Front Street, Harrisburg, PA 17104; telephone 1-800-932-4600 or www.dmv.state.pa.us.

Personal Records

It is important to keep complete written records so that your personal information is readily available when needed. In only one place record where the original of your will, power of attorney, and living will are kept. Also include information such as your Social Security number, bank accounts and other investments (including account numbers), real estate holdings, insurance policies, and other important legal and financial information. All of this is required by your agent or guardian in case of your disability or incapacity and is required by your executor or personal representative upon your death.

A Checklist for Your Personal Filing System

- Income tax returns (federal, state and local)
- Birth, marriage, divorce, custody, adoption and death certificates
- Naturalization papers
- Military records
- Papers documenting real estate and home leases and purchases, mortgages and home improvements
- Medical records
- Social Security records and communications
- Bank account, brokerage and mutual fund statements
- Business and partnership agreements
- Stock option and pension fund agreements

Index

I

L

M

N

O

P

R

S

T

V

W