



THE MONTGOMERY COUNTY

Elder Law Handbook



A FREE PUBLICATION FOR AREA SENIORS

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*Montgomery County Elder Law
Handbook*

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The printing and distribution of this FREE Publication was partially funded through the Advertisers in the Yellow Resource Section and the Montgomery Bar Association

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ABOUT 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. Such a challenge usually requires training and experience in this special area of the law.

Attorney-Client Relationships

Elder law attorneys often find that it is a son or daughter who brings an aging parent into the office for an initial consultation. However, the parent and child may have conflicting interests. In general, one lawyer cannot represent both sides when clients have differing agendas. Gifting of assets, for example, may appeal to the child, but may not necessarily be in the parent's best interest. Therefore, if more than one person visits a lawyer's office, the attorney must clearly identify the client. The lawyer must state who will be represented, and clearly communicate who is not represented.

Elder Law attorneys represent the aging parent. Frequently the lawyer will ask to meet with the senior in private. This practice of meeting alone with the client facilitates candid communication and can help protect documents such as Powers of Attorney and Wills from charges of undue influence. The lawyer is required to keep what is said private, and is generally not authorized to release confidential information to third parties, even children, without permission.

The Pennsylvania Rules of Professional Conduct require lawyers to set forth fee arrangements in writing. Sometimes legal services are charged hourly, and sometimes fees are billed at a flat rate. A fee agreement or "engagement letter" should clearly identify the client, state what work is to be performed and explain how legal fees are to be calculated.

If a serious fee dispute arises, contact the Montgomery Bar Association at 610-279-9660 to determine whether the matter can be referred to the Montgomery Bar Association's Fee Dispute Committee. Improper conduct by an attorney, such as improper use of client funds, can be reported to the Office of Disciplinary Counsel, District II, 820 Adams Avenue, Suite 170, Trooper, PA 19403; telephone 610-650-8210.

Pennsylvania Lawyers Fund For Client Security

Although the percentage of lawyers involved in theft is extremely low, the legal profession created a fund many years ago designed to compensate those who have suffered such losses. If client funds are misappropriated, the Pennsylvania Lawyers Fund for Client Security may be able to help. The fund does not arbitrate fee disputes or claims of ineffective representation. It will review cases where it is alleged that an attorney accepted a legal fee but did not do any work. Claim forms may be obtained by contacting Pennsylvania Supreme Court, Pennsylvania Lawyers Fund for Client Security, Pennsylvania Judicial Center, P.O. Box 62585, Harrisburg, PA 17106; telephone 1-800-962-4618, or www.palawfund.com.

Choosing An Elder Law Attorney

To choose the best person to act on your behalf in elder law 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 or changes in life situations

such as the need to plan for long-term care? Once your objectives are outlined, you can consult friends, relatives, business colleagues, clergy and others for recommendations. Another source of information is the Montgomery Bar Association's Lawyer Referral Service; telephone 610-279-9660, Option 3.

OLDER AMERICANS ACT

One of the most important laws affecting the elderly 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, 555 Walnut Street, 5th Floor, Forum Place Building, Harrisburg, PA 17101-1919; telephone 717-783-1550.

Montgomery County Office of Senior Services

Our local AAA is called the Montgomery County Office of Senior Services (MCOSS). This agency is responsible for planning, coordinating and monitoring services for county residents who are age 60 and older. These services and programs are available regardless of race, religion, physical handicap, sex, color, residence, national origin or political beliefs. Consumers may be asked to share the cost of some of the services provided, or in some cases, to make a donation. Staff members at MCOSS will help you with information regarding programs relating to elder law needs and protective services.

The MCOSS website is <https://www.montcopa.org/148/Senior-Services>

General phone calls about making a referral for Office of Senior Services programs should be placed to 610-278-3601. Calls regarding general resources for seniors, such as PACE, transportation, housing, rent rebates, etc. should be made to our County office of Community Connections at 610-278-3522. If you believe a senior is being abused or neglected, or if you are concerned about their well-being, you should make an anonymous report to Protective Services by calling the elder abuse hotline at 800-734-2020.

MCOSS Location and Mailing Address:

Central Office
Human Services Center
Office of Senior Services
1430 DeKalb Street
P.O. Box 311
Norristown, PA 19404-0311
Phone: 610-278-3601

Monday through Friday, 8:00 AM - 4:30 PM

The following list illustrates what services are offered through MCOSS:

- Care Management provides casework support to plan and monitor consumer services to meet their individual needs.
- Caregiver Support Program assists caregivers through a reimbursement program for supplies and services.
- Home Care Services provides assistance with personal care, home delivered meals, adult day care and home support.

-
- Long-Term Care Assessment provides a determination of appropriate level of care.
 - Ombudsman Services provides investigation of complaints and conflicts within long term care facilities.
 - Protective Services provides intervention in cases of abuse, neglect, exploitation and abandonment for those at risk over age 60. The elder abuse hotline is (800) 734-2020.
 - Community Program Development unit provides health and wellness education, as well as new programs targeted to educate our seniors on various safety programs. Check out the programs at: <https://www.montcopa.org/3283/Community-Programs-Development>

Resources

In order to access resources available to seniors of Montgomery County please contact the Health and Human Services Community Connections Office at 610-278-3522.

The Pennsylvania Department of Aging publishes an annual guidebook Benefits and Rights for Older Pennsylvanians which is available from any member of the Pennsylvania Legislature or by calling the Pennsylvania Department of Aging at 717-783-1550.

Please visit the MCOSS website for up to date long term care facility listings:

<https://www.montcopa.org/2447/Long-Term-Care-Facilities>

FINANCIAL PLANNING

As people grow older they become increasingly aware that "...in this world, nothing is certain but death and taxes." Senior citizens need to plan now, while they are able, in order to make sure that their estates pass to the intended beneficiaries. Planning can reduce death taxes, administrative expenses and the possibilities of disputes among family members. Peace of mind comes with knowing that one's 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 Forms Distribution Center at 1-800-829-3676. You can also order forms online at www.irs.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 basic tax returns. The IRS' Tax Counseling for the Elderly (TCE) program offers free tax help for all taxpayers, particularly those who are 60 years of age and older, specializing in questions about pensions and retirement-related issues unique to seniors. Your local public library is usually able to help you locate the nearest volunteer income tax assistance program. See Appendix A for the list of public libraries in Montgomery County. The Internal Revenue Service also provides help with tax preparation free of charge, by

appointment. For the IRS service center nearest you, call 1-800-829-1040. Be sure to identify all the deductions and credits that may be available to you as a senior citizen, such as the Homestead Rebate and others.

Standard Deduction at Age 65

You should be aware that you are allowed an additional standard deduction when you reach age 65. A basic chart is offered below but 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 listed below:

Filing Status	Standard Deduction (2020)	Additional Standard Deduction (2020)
Single	\$12,400	\$1,650
Married filing jointly	24,800	2,600
Married filing separately	12,400	1,650
Head of household	18,650	1,650
Surviving spouse	24,800	2,600

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 1st, you are permitted to increase the standard deduction for the tax year prior to reaching age 65.

Medical Expense Deductions

After a flurry of legislation, for 2019 and 2020 taxpayers may only take medical deductions if they exceed 7.5% of the taxpayer's adjusted gross income. The medical expense deduction is limited to unreimbursed, i.e. out-of-pocket, expenditures. Such medical expenses are only deductible if the taxpayer is itemizing. You calculate 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 skilled care facility, nursing home, 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 many cases the fees paid to an assisted-care facility may be partly personal in nature, and not entirely deductible. Consult IRS Publication 502 for details on when assisted living and memory care expenses are tax 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 expenses. 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 federal taxable limit, \$11,580,000 in 2020, or if there will be no estate tax due because of the unlimited marital deduction or otherwise, 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. Many 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 capital gains tax rate for long-term investments in 2020 ranges from 0% to 20%. The 3.8 Medicare surtax increases the effective top rate to 23.8%. 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 sell jointly-owned stock or other appreciated property after the death of a spouse.

The following illustrations show the potentially significant tax savings involved, and assume the 15% capital gains tax rate:

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.

The savings can be significant. Many married people own at least part, and perhaps all, of their property jointly. Even if no inheritance tax is due, the date-of-death values of jointly owned assets should be obtained for future reference in computing capital gain. Since the tax basis rules are important and complicated, elder couples may wish to discuss these issues 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 their home to cash. The lender loans money to the borrower age 62 or older using the borrower's home as security. The amount of cash you can get from your home depends on your age, value of your home, and interest rates. The loans may be dispersed in a lump sum, monthly payments, or through a line of credit. Unlike traditional mortgages which require monthly payments, reverse mortgages require no monthly principal and interest payments and are repaid upon death, or when the owner can no longer live in the home. There are no monthly payments until one of these events happens. These mortgages can

be a way to overcome the “house rich but cash poor” dilemma that confronts many elderly homeowners.

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 and required counseling session. Borrowers must undergo counseling with a HUD-approved nonprofit organization before they can obtain a reverse mortgage. For a list of HUD-approved counselors near you, contact HUD’s interactive phone system at 800-569-4287 or go to the HUD website: www.hud.gov.

Basic Requirements

- Borrowers must be age 62 or older; there is no maximum age limit. If the borrowers are married, only one must be 62 or older, the other has to be at least 18
- The mortgaged property must be used as the principal residence of the borrower and can be one to four units. If the last surviving borrower can no longer reside in the home due to mental or physical incapacity, and has been out of the residence for 365 consecutive days, then the property will at a certain point no longer be considered the borrower’s principal residence and the loan may be called by the lender, potentially forcing the sale of the home. This is a something to be aware of, but is not normally an issue.
- The borrower will be required to pay the balance of the existing mortgage from the proceeds of the reverse mortgage. While not a factor in the past, credit and income are now considered when applying for a reverse mortgage. Pre-existing judgments and liens against the property will likely need to be paid off with the proceeds of the loan.

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 impact 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.

Property Tax and Rent Rebates

In Pennsylvania, homeowners 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 are 18 years or older during the claim year, and are unable to work because of a medically-determined or mental disability, with a total household income under the limit (\$35,000 for homeowners, and \$15,000 for renters) may file a claim with the Pennsylvania Department of Revenue for a real property tax or rent rebate of up to \$975. Claimants exclude 50% of their Social Security/ Railroad Retirement income when determining eligibility. Check the form for

the applicable filing deadline. To request a Property Tax/Rent Rebate Program application or assistance, call (888)-222-9109 or visit their website: www.revenue.state.pa.us or contact a PA Department of Revenue district office, Senior Services, senior center or a state legislator's office.

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. For further information regarding property tax and rent rebates you can contact the Pennsylvania Department of Revenue Property Tax and Rent Rebate Unit at 1-888-222-9190 to talk with a representative. You can get help in filling out PACE and tax rebate forms through any of the Montgomery County Senior Services offices or at any local senior center.

ESTATE PLANNING

Estate planning is not just for wealthy people. You need to plan ahead to make sure that the people and charities you care about inherit your property when you die. The word "estate" simply means all of the property that you own at the time of your death.

If you die without planning for your estate, then your property (your home, your money, your car, and everything else) will be distributed to various relatives – sometimes even distant relatives whom you do not know – according to a rigid formula set forth in the intestacy laws. The word "intestacy" means dying without a valid will. The intestacy laws apply to every person who dies without a will. These laws make no exceptions for the special needs of any individual or family.

If you die without a will, your property may be inherited by people from whom you are estranged. The individuals whom the court names to distribute your property may not be the people you would have preferred, and they may not even cooperate with one another. If you do not make your own will, the Commonwealth of Pennsylvania essentially creates one for you, using the terms dictated by the intestate laws.

Thus, by planning for your estate while you are alive – and, most importantly, by writing a will, you can prevent disputes among your heirs and gain the peace of mind that comes from knowing that your final wishes will be carried out.

The Will

A will is the cornerstone of most estate plans. The main purpose of a will is to ensure that your property ends up with the people or charities that you choose. A will is a legal document that will be observed by the courts as long as it is signed correctly. In a will, you specify how your property is to be distributed and you name a personal representative who is responsible for carrying out your wishes.

The person writing the will is called the "testator." The people or charities to whom you leave your property are called the "beneficiaries." The person whom you name to manage this process is called an "executor" or a "personal representative." The executor is responsible for the administration of the estate. He or she collects the estate's assets, pays the estate's debts and taxes from the assets he or she has collected, and makes distributions of any remaining assets to the beneficiaries. The executor can be anyone you choose: for example, your child or other relative, a trusted friend, or an attorney or accountant. It is usually advisable to nominate a single executor and an alternate executor, rather than two co-executors. Co-executors sometimes have difficulties in reaching mutually agreeable

decisions or getting paperwork signed in a timely manner. These problems can delay the administration of the estate.

If you have already prepared a will, you may find that you need to update it. It's a good idea to take a look at it every five years. Do you understand what it says? Do you still agree with the arrangements stated in it? Here are some (but not all) of the reasons why you may need to revise your will: marriage or divorce (yours or that of one or more of your children); death of a spouse, child, or other beneficiary; birth of a child or grandchild; a major change in your personal wealth; a move to a different state; or a change in the estate tax laws.

You should keep your will in a safe place, such as in a fireproof box. If you leave it in a safe deposit box, due to bank regulations there may be a delay in retrieving it. In Pennsylvania, upon the owner's death access to a safe deposit box is limited to the surviving spouse, if any. Others may access the box only for the limited purposes of retrieving the decedent's will and cemetery deed.

If you fear that somebody might tamper with or destroy your will, ask your lawyer to safeguard it (and make sure you give your future heirs and executor the name and address of the lawyer). You have the right to request your original estate planning documents from your attorney at any time. You also have the right to revoke your will and write a new one at any time and for any reason, provided that you have the mental capacity to do so.

Trusts

Trusts can serve a myriad of purposes. If you own a house or other property located outside of Pennsylvania, or have heirs who are minors or beneficiaries with special needs, your attorney will probably recommend a trust to hold some or all of your assets. A trust can be thought of as a virtual container for your property. The person who establishes a trust is called the "settlor" or the "grantor." The grantor establishes a trust by signing an agreement to place property you designate in the trust, and you name a person, called the "trustee," to manage and safeguard the contents of the trust. The provisions of the trust are governed by this trust agreement, which must be signed by the settlor and the trustee. Once property has been placed in a trust, the property is legally owned by the trustee and is titled in the name of the trust. For this reason, the property held in a trust is not subject to probate. The trustee must distribute the trust assets to the beneficiaries named in the trust, in such amounts and at such times as the settlor has directed. The trustee can have the trust assets held and invested in a trust account in a bank or brokerage.

Trusts are either **revocable** or **irrevocable**.

Revocable Trusts (also known as Living Trusts): Revocable trusts are trusts whose provisions can be changed by the grantor as long as he or she has the mental capacity to do so. Often, the grantor is named as a trustee of his or her trust and can make distributions from the trust to himself or herself. During the grantor's lifetime, income earned by the property in the trust can be distributed to the grantor. When the grantor dies, the provisions can no longer be changed. After the grantor's death, income earned by the property in the trust is distributed or held for the remaining living beneficiaries.

Revocable trusts are not used as often in Pennsylvania as in other states. They may be helpful, for example, when you own out-of-state real estate and wish to avoid probate outside Pennsylvania.

Irrevocable Trusts: These are trusts whose provisions cannot be changed, even by the grantor. They are used for various purposes, such as for making gifts. Once property is placed in an irrevocable trust, it cannot be taken out of the trust by the grantor.

Within these major categories, trusts can be established for various special purposes. Here are some examples:

Testamentary Trusts: These are trusts which are included in a will and hold property owned by a testator (the person who made the will). Non-testamentary trusts are known as “stand-alone trusts.” Testamentary trusts are always irrevocable, because they do not go into effect until the death of the settlor. And when the settlor of any trust has died, that trust can no longer be modified, unless there are exceptional circumstances. In many cases a parent will set up a testamentary trust to hold the inheritance s/he is leaving to his or her minor children or grandchildren, because minors cannot take direct possession of property they inherit. Or the parent of a disabled child or grandchild will set up a testamentary special needs trust, which is a special needs trust (see below) that takes effect upon the testator’s death.

Special Needs/Supplemental Needs Trusts: Special needs trusts, which are also called supplemental needs trusts in some states, are designed to hold funds for a mentally or physically challenged person without disqualifying that person from receiving government benefits. These trusts are often used to receive the proceeds from a personal injury lawsuit, insurance settlement, or an inheritance. Most kinds of government benefits available to the disabled are “needs-based,” meaning that they are limited to beneficiaries with income below a certain level. Since the income received from many kinds of trusts would disqualify a disabled person from receiving government benefits such as Medicaid or Supplemental Security Income (SSI), the trust agreement must be carefully drafted to conform to federal and state laws.

Some other types of trusts:

- **Credit shelter trusts**, also called bypass trusts, are used to protect a portion of a large estate from federal estate taxes.
- **Marital trusts** hold funds designated for the use of a surviving spouse after the death of the first spouse to die.
- **Pet trusts** can protect funds to be used for the care of a pet after its owner’s death.
- **Spendthrift trusts** allow the grantor to specify when and how the beneficiaries can access the trust property. This kind of trust is used, for example, by the parents of free-spending or chemically-dependent children.

A **stand-alone trust** (i.e. a trust which is not part of a will) can cost more to prepare and administer than a will. Trusts can be expensive to prepare because they are complicated and should be carefully customized for each client’s situation. In addition to the costs of preparing a trust, ongoing trustee’s commissions must often be paid during the years of the trust administration. Special trust income tax returns, called fiduciary returns, must be filed by the trustees of irrevocable trusts. The services of an accountant may be required to prepare them.

Pros and Cons of Revocable Living Trusts

Before you go through the process of creating a living trust and putting your property in it, determine whether it is truly useful for you. Nowadays, do-it-yourself trust “packages” are available online and are sold on TV. Beware! These trusts are not tailored to the laws of each state and may even contain provisions that will conflict with your will and require you or your heirs to pay an attorney to straighten things out down the road.

Pros: Living trusts are useful for Pennsylvania residents who own property outside of Pennsylvania. If out-of-state property is not placed in a trust, it will be subject to probate in the state where it is located. That can be a long and expensive process.

Cons: When properly prepared and funded, living trusts can be more expensive than you might think. There are costs involved in re-titling your assets into the trust. Also, property held in a living trust does not avoid Pennsylvania inheritance taxes.

Living trusts are rarely necessary for Pennsylvania residents, since trusts can be established in their wills. Furthermore, many of the benefits of a costly living trust can be obtained through less expensive alternatives, such as by using a durable general power of attorney, creating joint bank accounts, or re-titling accounts in the names of designated beneficiaries.

The property placed in a living trust is not subject to probate. You may have heard that probate is a long and expensive process, thereby making avoiding probate the best reason to establish a living trust. This is not true in Pennsylvania, where probate is usually inexpensive and relatively simple.

Living trusts may be suitable for some people, but they're clearly not for everybody. Consumers should approach online and in-person sales pitches for revocable living trusts with great 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.

Note: 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 during 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. However, 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 having your estate planning attorney review the annuity before making the investment.

If you wish to get a low-cost second opinion from an estate-planning attorney before proceeding with a living trust or annuity purchase, call the Montgomery Bar Association Lawyer Referral Service at 610-279-9660 extension 201, weekdays between 9:00 am. and 4:00 pm. Tell the service representative that you would like to meet with an estate-planning attorney. A half-hour consultation costs only \$40. This meeting might save you money and increase your peace of mind by making you aware of the entire range of estate planning options that may be available to you.

Non-Probate Property

Your will does not control the disposition of some categories of property, such as retirement accounts, life insurance, joint accounts, "transferable on death" (TOD) accounts, and "in trust for" (ITF) accounts. These are all considered "non-probate property" and pass upon at your death according to the designated beneficiaries or the survivor listed on the accounts. Be sure to review all of the beneficiary designations when you are developing your estate plan.

Many people select beneficiaries when purchasing a life insurance policy or opening their retirement accounts but never revisit these decisions. It is particularly important to do so since family situations change over the years.

Inheritance, Estate, and Gift Taxes

Over the years, senior citizens have watched tax regulations at all levels grow more and more complicated. Some general guidelines are offered below, but you should consult with a professional if you have more specific questions.

Pennsylvania Inheritance Tax

All Pennsylvania estates, no matter how small, must pay Pennsylvania Inheritance Tax on all property not left to charity. All real property and all tangible personal property of a resident decedent, including but not limited to cash, automobiles, furniture, antiques, jewelry, etc., located in Pennsylvania at the time of the decedent's death is taxable. All intangible property of a resident decedent, including stocks, bonds, bank accounts, loans receivable, etc., is also taxable regardless of where it is located at the time of the decedent's death.

This tax must be paid by the estate within nine months of death in order to avoid interest and possible penalties. To the extent that inheritance tax is paid within three months after the date of death, a discount of 5% is available.

The following inheritance tax rates are effective for individuals whose dates of death occurred on or after July 1, 2000:

- The tax rate for transfers to a spouse, transfers to a parent from a child aged 21 or younger, or transfers to charitable organizations is 0%.
- The tax rate for transfers to a child, father, mother, grandfather, grandmother, step-child, lineal descendant or their spouse is 4.5%.
- The tax rate for transfers from a decedent to a sibling is 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 step-sibling 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 non-lineal relatives, friends, etc.) is 15%.

Pennsylvania inheritance tax has been eliminated on certain real estate and businesses maintained by a family for agricultural or family business purposes, if certain conditions are met.

Federal Estate and Gift Taxes

The federal estate tax exemption for 2020 is \$11,580,000. Federal estate tax is not a concern for estates with assets under the amount covered by the exemption. Additionally, the unused exemption of one spouse can be used by the surviving spouse if a tax return (Form 706) is timely filed and makes the "portability" election. Most decedents' estates are below the federal estate tax limit at present, and only need to pay Pennsylvania inheritance tax.

For tax year 2020, gifts of \$15,000 or less per person and calendar year are excluded from gift tax. Thus a husband and wife, combined, may transfer up to \$30,000 to each donee (i.e. \$30,000 to each of their children or to any other person) per year, without being subject to federal taxation. There is no federal limit on gifting, but gifts which exceed the \$15,000 exemption amount may be considered taxable gifts and reduce the \$11,580,000 lifetime exemption from estate and gift taxes. See your estate planning attorney for guidance on the taxation of gifts.

Planning for Gifts

Be very careful when you make gifts. Gifting your property before you die can have unexpected consequences, especially if you intend to qualify for Medicaid (Pennsylvania Medical Assistance). In order to avoid potentially costly mistakes, it is recommended that you consult with an attorney before you make any gifts that exceed \$500 in any given month. That means \$500 in total, not \$500 per person. Furthermore, if you are an agent under power of attorney for another person, you should consult with an attorney before making ANY gifts of that person's property.

Medicaid 5-Year Look-back and Transfer Penalty. Under federal law, gifts can cause you to be ineligible for Medicaid long-term care benefits for many years after the gift is made. When you apply for Medicaid benefits to help pay for long-term care costs, such as nursing home costs, caseworkers with Pennsylvania's Department of Human Services will examine bank records going back five years in order to see if you made any gifts during that period. Gifts within this 5-year "look-back" period can cause periods of Medicaid ineligibility and a denial of your application for Medicaid long-term care benefits.

To summarize, Medicaid rules can impose a period of ineligibility (the so-called "transfer penalty") for most gifts that exceed \$500 per month (in aggregate, not per person) within the 5-years prior to the filing of an application for Medicaid long-term care benefits.

Seniors should make sure their own long-term care needs can be met and exercise caution when it comes to making gifts. It is risky for seniors to make any gifts at all if they might need nursing home care within five years. Only those with sufficient resources to pay privately for nursing home care for five years after making a gift can ignore this Medicaid transfer penalty. The annual gift tax exclusion amount of \$15,000 per person does not apply in the Medicaid application context. In other words, there is no \$15,000 exemption when it comes to determining eligibility for Medicaid long-term care benefits.

Gifting by Agent under Power of Attorney. An agent under a power of attorney is not permitted to make gifts unless the power of attorney document specifically permits gifting. If the document does not specifically describe what gifts are permitted, and to whom, then gifting is not allowable under the power of attorney document. If the agent makes gifts anyway, he or she can be sued and will potentially be personally liable.

Charitable Gifts. You may want to consider making a gift to charity. Many not-for-profit institutions have resources to aid you in making gifts. Instead of making a gift directly to a charity, consider setting up a charitable gift annuity. A charitable gift annuity allows you to give cash or securities to the charity and receiving a guaranteed, lifelong income in return. Under certain conditions you could enjoy a significant charitable tax deduction without incurring a capital gains tax if you give appreciated securities to a charity.

Federal Gift Tax. A gift occurs 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 gift tax exemption amount (currently \$15,000 per donor and per donee). However, paying educational or medical expenses on behalf of another individual is not generally subject to federal gift tax when these expenses are paid directly to the school or medical provider. Married couples can "split" their gifts, making a total of \$30,000 in gifts to the same person in the same year.

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." If you have made a taxable gift, you should file a gift tax return (IRS Form 709) by April 15 of the following year. This allows the IRS to keep track of the gifts you have made during your lifetime and deduct them from your lifetime exemption amount from

federal estate and gift tax (discussed above). Unless you are wealthy and make extremely large gifts, your “taxable gifts” will probably only result in a reduction of your lifetime exemption from federal estate and gift tax, and you

will not need to write a check for gift tax. You should consult with an attorney if you have any questions about gift tax and making gifts.

Meeting with Your Lawyer

Perhaps the most difficult part of the estate planning process is overcoming procrastination and scheduling an initial consultation with an estate planning attorney. For the best results, you should deal with an attorney who provides estate planning services on a regular basis. A “simple will” may turn out to be much more complicated than you realize. When you call to schedule your appointment, be sure to ask whether there is a fee for the initial consultation. Many attorneys do charge for the initial consultation. At your first conference, 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 fee arrangement in writing.

You can make the initial meeting more productive by collecting the following information and bringing it to the meeting:

- a list of what you own and its approximate value;
- a list of your bank and brokerage accounts;
- addresses of your real estate holdings; and
- a list of your intended beneficiaries with their names, ages and addresses;

Think in advance about:

- your choice of executor and at least one alternate; and
- your choice of agents for your powers of attorney

You should also bring along a list of all the questions you have about estate planning.

Using this information, your lawyer will be able to spend more time developing a plan with you and less time writing down basic information. If you suspect someone might contest your will, or if there is disharmony among your children, mention this to your attorney so the issues can be addressed. 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 and arrange for them to be signed. It is very important that you read and understand all papers you sign. Make sure you keep your signed documents in a secure, fire-proof location.

Computer Programs Vs. Attorneys

Maybe you believe that your situation is simple and that you can prepare your own will with the help of one of the many estate planning programs now available. We do not recommend using online estate planning programs to create your estate planning documents. Even though these programs can be quick, convenient and inexpensive, using them can lead to major errors that are only discovered after your death. At that point, it will be too late to sign a new will, and your heirs may have to spend thousands of dollars sorting everything out.

One of the most valuable services an estate planning attorney can provide is the chance to discuss your situation with an expert who has seen many estate plans in action, who keeps abreast of changes in the laws, and who knows what can go wrong.

It is especially important to consult an attorney for complex situations such as multimillion-dollar estates, disabled children who require special needs trusts, blended families (especially when the children from earlier marriages do not get along with the new spouse), property in other states and countries, and family businesses.

POWER OF ATTORNEY

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

General powers of attorney are very broad and allow many types of transactions. They can cover financial and healthcare matters. Limited powers of attorney convey the authority to an agent to handle a specified task, for example, to 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 mechanism 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 now requires a special statutory notice to appear in capital letters at the beginning of every financial power of attorney. The document must have two witnesses (other than the agents named in the document) and be acknowledged before a Notary Public. PA law further requires that an acknowledgment be signed by agents indicating that they have read the power of attorney and understand certain basic duties. This is often the last page of the document. The agent should not commingle any assets of the principal with his or her own assets.

Pennsylvania law also permits you to allow the agent to make gifts of your assets - or not! Granting such power in a POA is very risky, so exercise great caution when allowing another person to make gifts of your money. A well-drafted gifting clause can be customized by your estate planning attorney so that your POA is specific as to what gifts can or cannot be made by your agent. If the power of attorney is silent on the topic of gifting, then gifting is generally prohibited.

Revoking A Power of Attorney

As long as the principal has legal mental capacity, he or she can sign paperwork to revoke the power of attorney, name a new agent, or designate a co-agent to check on the actions of the first agent. Financial institutions will sometimes require an attorney or the agent to sign a "certification" saying that the power of attorney has not been revoked and is still in full force. Under Pennsylvania law, a power of attorney does not lapse by mere passage of time. A court can take away the power of an agent under power of attorney.

Failure To Act

With the rise of identity theft, banks have become more cautious when it comes to following the instructions of someone who says they are an agent under power of attorney. Normally you can work things out with the financial institution directly. If needed, an attorney can help if you are having difficulty getting financial institutions or other third parties to honor a power of attorney.

Fraud

A power of attorney is a valuable tool in aiding an elderly individual, but in the wrong hands it can also be used to perpetrate fraud. There are steps you can take to minimize the potential for financial abuse:

- Choose the right person to act as your agent under a power of attorney. Make sure that the individual is someone you can trust.
- Be careful about what powers you give to an agent under a power of attorney. Make sure you 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, eg. power of attorney for the sale of real estate. Exercise great caution in granting the power to make gifts. Consider limiting or prohibiting self-gifting.
- You may consider appointing more than one person to act as your agent. If you choose to appoint more than one person, you have the option of allowing them to serve individually as your agent or have them act together. If your agents are to serve together, while this may be more cumbersome and less efficient due to your agents having to agree, it provides a system of checks and balances.
- To 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 or require bank statements to be sent to a friend or relative.

Health Care Provisions in a Power of Attorney

A power of attorney usually deals with financial matters, but can also address medical issues, or is commonly a separate power of attorney limited to healthcare matters. Under Pennsylvania law, a patient's expressed wishes concerning medical treatment will generally be upheld.

The law allows an agent, appointed by you in your power of attorney, to authorize

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. If one person is to act as your agent for your financial affairs and another as agent for your health care, you need to specify the separation of powers, or create two separate power of attorney documents.

A living will, described below, is a separate document which allows you to specify your intent regarding medical decisions in end-of-life situations. A living will is sometimes incorporated into a healthcare power of attorney, but is also commonly a separate document. You and your lawyer must be careful that these documents complement and do not conflict with one another. Finally, a power of attorney can, if you wish, give your agent the authority to make an anatomical gift of all or part of your body.

Health Care Power of Attorney and Living Wills (Advance Directives)

You have the right to decide the type of health care you want in the event you become unable to understand, make, or communicate decisions about medical care. Your wishes for medical treatment are most likely to be followed if you express those wishes in advance by:

1. naming a health care agent to decide treatment for you; and
2. giving health care treatment instructions to your health care agent or health care provider.

An advance health care directive is a written set of instructions expressing your wishes for medical treatment. It may contain:

1. Durable Health Care Power of Attorney, where you name a person called a "health care agent" to decide treatment for you. You have the option to name one person to serve as your health care agent or to name a group of people to serve jointly as your health care agents. If a group of people are chosen, you should also provide that should any of your named agents be or become unable or unwilling to serve or to continue to serve, then the remaining one(s) of them will continue to serve as the agent(s); and
2. Living Will, where you tell your health care agent and health care providers your choices regarding the initiation, continuation, withholding or withdrawal of life-sustaining treatment and other specific directions, if you wish. If you do not write down your wishes about your health care in advance, and if later you become unable to understand, make or communicate these decisions, those wishes may not be honored because they may remain unknown to others. A living will is also sometimes referred to as an "advance health care directive" or "advance medical directive."

You should give a copy of your advance health care directive (a living will, health care power of attorney or a document containing both) to your health care agent, physicians, family members and others whom you expect would likely attend to your needs.

The Living Will becomes operative only if you are unable to make and communicate your own decisions when you have an end-stage medical condition (which will result in death, despite the introduction or continuation of medical treatment) or if you are in an irreversible vegetative state and there is no realistic hope of significant recovery. A Living Will contains treatment instructions only under those circumstances.

Anyone of sound mind who is 18 years of age or older or who graduated from high school or has married may execute a living will at any time. The Pennsylvania law states that the document must be witnessed by two individuals each of whom are 18 years of age or older.

Other states may require that the living will is acknowledged by a Notary Public, though notarization is not required in Pennsylvania. (Only two witnesses are required.) Hospitals and nursing homes must by law provide patients with information concerning living wills. However, declarations are optional and no entity can charge a different fee for medical services based on whether or not a living will has been signed.

If a patient does not execute a Living Will, there is no presumption of the patient's intentions to consent or refuse life-sustaining treatment and there may be a need to go to court before life sustaining treatment can be removed.

Health Insurance Portability and Accountability Act (HIPAA)

Privacy requirements were enacted not too long ago under the Health Insurance Portability and Accountability Act (HIPAA). The purpose of this law is to protect the privacy of your healthcare records and information. HIPAA also enables you to access, inspect, copy and correct your health care information. This law applies 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. Your agent under power of attorney may obtain medical records and health information if specifically authorized to do so. It is therefore a best practice to include "HIPAA release language" in your healthcare power of attorney document. An elder law attorney will make sure this language is in your power of attorney.

Out of Hospital Do Not Resuscitate (DNR) Orders

Out of Hospital Do Not Resuscitate orders are now recognized under Pennsylvania law. 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 patient's wishes when a patient is experiencing cardiac or respiratory arrest and has both an Advance Health Care Directive (Living Will) and an out of hospital DNR order issued under the DNR Act.

Under the DNR Act, the EMS provider can withhold CPR upon observing an out of hospital order, bracelet, or necklace displayed with the patient. The EMS provider is not required to contact a medical command physician to secure approval and can follow the patient's wishes.

Physician Order for Life-Sustaining Treatment "POLST" Form

Pennsylvania has approved a POLST form. The use of a POLST form 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 preference 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 comfort care. Health care professionals can discuss options with seriously ill patients or their agents under their health care powers of attorney, document those preferences on a standardized medical form 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. Although the POLST is helpful, it is still important to have living will and healthcare power of attorney documents prepared in advance.

GUARDIANSHIPS

If someone is unable to make safe decisions about their health or finances they may need to have a legal guardian appointed by the Court to manage their financial and personal affairs. Dementia or other progressive mental, emotional or physical illnesses can rob people of the ability to make safe decisions about their personal or medical care and make them susceptible to financial exploitation.

To provide a decision-maker for people in these situations, Pennsylvania law allows the Orphans' Court to appoint a guardian of the person (for personal and health matters) and/or a guardian of the estate (for financial matters). Anyone interested in the person's welfare can file the petition seeking a guardian.

To be in need of a guardian (an "incapacitated person" under Pennsylvania law), a person must be found to be partially or totally unable to manage their financial resources or meet essential requirements for physical health and safety. In layman's terms they are unable to understand the consequences of their actions. Because a ruling of incapacity and appointment of a guardian involves the removal of important legal rights, stringent standards are in place to protect the alleged incapacitated person. Notice must be given to the alleged incapacitated person, proper medical testimony must be presented (at the more stringent clear and convincing evidence standard) and there is a right to legal counsel whether the person can afford a lawyer or not.

Hearing Before the Court

For someone to be declared an incapacitated person a petition is filed with the Orphans' Court alleging the reasons why the alleged incapacitated person lacks capacity. The petition may be a non-emergency where the individual is given a minimum of 20 days' notice of the hearing so they can hire their own counsel and prepare a defense. This is where the person is under no immediate threat of personal or financial harm. An emergency petition can be filed when there is an imminent threat of personal/medical/financial harm and a hearing will be scheduled in a few days or less to prevent the harm. The alleged incapacitated person is required to attend the hearing unless excused for medical reasons. While the law does not compel it, the current practice in Montgomery County is to ensure legal counsel for every alleged incapacitated person. So if the alleged incapacitated person does not have their own lawyer, the Court will appoint someone to represent them. To meet the legal standard, testimony by qualified persons experienced in assessing capacity is presented. This is usually a physician or psychologist, but can be a nurse or social worker if they possess the requisite experience. Just because a person meets the legal definition of incapacity does not mean they need a guardian. If a support structure exists outside of a guardianship (like having a responsible person appointed as your power of attorney) the Court may decline to appoint a guardian. The law prefers the least restrictive alternative if less severe remedies than a guardianship exist.

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 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 authorized to admit the person to a facility, even over that person's objections.

The appointed guardian has all powers set forth in the court order, usually including making every kind of decision with the exception of admitting the incapacitated person 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 long term care facilities. A guardian for the estate has the power to manage the incapacitated person's assets, buy and sell their property, collect their income and pay their bills. A guardian may not be paid from the incapacitated person's funds without the Court approving their bill.

Every guardian must file a detailed annual report with the Orphans' Court. A comprehensive power of attorney may make guardianship proceedings unnecessary and is less expensive and stressful than the court process. One may nominate a guardian in a power of attorney for the court's consideration in the event of a guardianship proceeding.

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 and conversations can involve intense emotions and sometimes contain conflict. Struggles may occur regarding an older adult's desire for independence and others' concerns about safety.

Mediation is a way for people 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 to better understand one another and make decisions. Private mediators can be retained by the parties to reduce conflict, arrive at negotiated solutions and reduce conflict, thereby healing families and avoiding the need for expensive litigation.

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. In Montgomery County there are two Social Security offices:

1700 Markley Street
First Floor
Norristown, PA 19401
800-772-1213

39 W. Ridge Pike
Royersford, PA 19468
866-964-7415

These local Social Security offices offer helpful and informative publications available free to anyone who requests them. Additionally, an attorney who works with Social Security benefits should be consulted in the event of any questions since the programs and benefits are quite complex.

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; file a claim for retirement or disability benefits; request a replacement Social Security card; find out how to 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. Beneficiaries can access much of this information by creating a "my Social Security account." Go to www.socialsecurity.gov/myaccount for more information. Note that Social Security no longer issues paper checks. See www.GoDirect.gov for more information.

Deadlines

Keep in mind that Social Security will give you a deadline to finish certain tasks, such as filing an appeal if you are dissatisfied with a decision. You must comply with its timelines or you will lose your right to appeal its decision. Typically, its deadlines are within 60 days; however, in some circumstances they may be shorter, so you must read notices 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. You can call your local Social Security office to make an appointment to meet with its staff in person so they can review your file with you. Take a friend, relative or Social Security attorney with you. People who are deaf or have difficulty hearing may call the Social Security office at 1-800-325-0778.

Written Explanation for Denial of Benefits

If Social Security denies your claim for benefits, you are entitled to a written explanation giving the reasons for the denial. If you do not receive a written explanation, ask Social Security to provide you with this documentation and consult an attorney concentrating in Social Security law to protect your rights.

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 it has posted to your Social Security account, you should take immediate steps to inform Social Security.

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: 1-800-431-2804. They maintain a national listing of attorneys who concentrate their law practices in Social Security matters. You may also wish to contact the Legal Aid office for your community or the Montgomery Bar Association Lawyer Referral Service at 610-279-9660.

Social Security Benefits

Following is a brief description of some of the benefits available through the Social Security Administration. The system provides benefits not only during retirement but also for survivors and dependents in case of death or disability. Keep in mind that these are not full descriptions of all of the eligibility requirements for each program and benefit. Some of the eligibility requirements are complicated and cannot be fully addressed in this handbook. When in doubt, contact the Social Security Administration and set up an in-person appointment to ask about your eligibility for benefits and consult an attorney working with Social Security benefits.

Retirement Benefits

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 increased 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 an attorney who is familiar with Social Security law before you make any decisions.

Social Security Disability Insurance Benefits (SSDI)

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 Social Security earnings record. This is a complicated program and you should visit your local Social Security office in order to apply. SSDI is not intended for a temporary condition; Social Security disability programs only cover total long-term or catastrophic disability. There is no such thing as a "partial" disability benefit program from Social Security.

Supplemental Security Income Benefits (SSI)

SSI provides income to persons with disabilities who don't qualify for SSDI and persons whose benefit under SSDI is below the SSI benefit amount. Unlike SSDI, eligibility for the SSI program is based on your finances. To qualify, you must have modest means (low income and countable assets under \$2,000 if single and under \$3,000 if a couple) and be either medically disabled, blind, or 65 or older. However, this is not a benefit program to "supplement" your income. In other words, in addition to other eligibility requirements, you must meet strict 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 \$783 per month in income from SSD, retirement, a pension, or other sources, you will not be eligible for SSI benefits because Social Security will consider that you make too much money to qualify for SSI.

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, or 50 or older and disabled;
- a widow or widower at any age if they are caring for your child who is under 16 or disabled and receiving Social Security benefits;
- children if they are unmarried and under age 18;
- children under age 19 attending elementary or secondary school as full-time students;
- children age 18 or older and severely disabled (the disability must have started before age 22);
- parents age 62 or older, if they were dependent on you for at least half of their support.

Survivors can apply for benefits by calling Social Security at 800-772-1213. A person cannot apply online for survivors' benefits.

Benefits For a Divorced Spouse

A divorced spouse can receive benefits based on the Social Security earnings record of a former spouse if the marriage was of at least ten years' duration. Benefits paid to a divorced spouse do not affect the former spouse's benefits. 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 former spouse must be eligible for benefits; that is, at least 62 years of age and with enough work history to qualify for benefits, even if he or she is not actually receiving benefits. In order to receive benefits from the former spouse's Social Security earnings record, the divorced spouse must be at least 60 years of age and remain unmarried.

If the divorced spouse remarries prior to age 60, he or she will not be eligible for benefits based on the earnings record of the former spouse. However, if such remarriage terminates, the divorced spouse becomes eligible for benefits once again from the former spouse's work record.

If a divorced spouse has been married more than once and each time for at least ten years, benefits come from whichever former spouse's work record provides the highest benefit.

If you are considering divorce, or if you are a divorced spouse planning to remarry, consult with an attorney regarding the effect it may have upon your Social Security benefits.

Benefits to Divorced Widow(er)s

If you are divorced, even if you have remarried, at your death your ex-spouse may be eligible for benefits on your Social Security earnings record if you were eligible for benefits as of the date of your death. 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 his/her own earnings record; and
- not be currently married, unless the remarriage occurred after age 60, or 50 for disabled widow(er)s.

Income Tax on Social Security Benefits

To determine if Social Security benefits are taxable, the test is whether the individual's "combined income" (adjusted gross income combined with 50% of Social Security benefits, plus any tax-exempt interest) exceeds a base amount. For individuals, that base amount is \$25,000; for married couples filing jointly, the amount is \$32,000; for married couples filing separately, the amount is \$0. If combined income exceeds the threshold, up to one-half the Social Security benefits received will be included in taxable income.

For individuals with higher combined income (\$34,000 for single individuals or \$44,000 for a married couple filing a joint return), up to 85% of Social Security benefits received will be included in taxable income. Calculating the percentage of benefits included in taxable income can be complex; you may wish to consult a tax attorney for guidance.

Most pensions are not counted for purposes of calculating combined income. However, when one spouse works and the other is drawing benefits, the base amount can easily be exceeded. Form SSA 1099 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 a 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, including 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:

If you receive Social Security retirement, survivors' benefits, wages, or a salary over a specified exempt amount:

- You must report any changes in your address, or if you change your name via marriage or divorce.
- If you are under full retirement age, earnings over \$18,240 may affect your monthly benefit amount. The year you reach full retirement age, earnings over \$48,600 may affect your monthly benefit amount for months before you reach full retirement age.

These earnings thresholds are those in effect for 2020 and will be adjusted upwards in subsequent years. Social Security's website can provide information about the thresholds for years after 2020.

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

If you receive SSI disability benefits:

- 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 that someone else gives to you or the amount of money they give you to help pay your bills, unemployment, annuities, pensions, etc.
- You must inform Social Security if you move and provide it your new address.
- You must inform Social Security if there is a change in the number of people who live with you, if you get married, or if your marriage ends. For example, report if someone moves into or out of your home, or if someone who lives with you dies.
- You must inform Social Security if you enter or leave an institution such as a nursing home, hospital, shelter or penal institution.
- 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.

If you receive SSDI 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 SSDI benefits:

- You must report any changes such as change of address or marriage or divorce, or changes such as improvement of your medical conditions. Failure to report 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.
- 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.
- There are work incentives offered by Social Security to allow you to test your ability to work for at least nine months even after you receive disability benefits.
- *Trial work period* - The trial work period allows you to receive your benefits regardless of how much you are earning as long as you report your work and continue to have a disabling impairment. In 2020, a trial work month is any month in which your total earnings are \$910 or more. The trial work period continues until you have worked nine months within a 60-month period.
- *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 2020, earnings of \$1,260 or more (\$2,110 if you are blind) are considered substantial. Your free Medicare Part A coverage will continue if your SSDI 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 \$1,260 a month or your benefits will stop, unless you have extra work expenses as a result of your disability.

If you would like to return to work, Social Security's new Ticket to Work Program can help by providing you support to prepare for and maintain employment:

- Tickets will be mailed to people who receive Social Security Disability (SSDI) or Supplemental Security Income (SSI) benefits. Tickets can be used for vocational rehabilitation, job training and other employment support services. The program is entirely voluntary and beneficiaries are not required to go to work, but may attempt to do so.
- Ticket holders may contact an Employment Network established by Social Security to assist beneficiaries in planning for employment and working.
- Medicare Part A (Hospital) premium free coverage was extended for 4.5 years beyond the current limit for SSDI beneficiaries who work. Therefore, an individual does not have to choose between working and receiving health coverage, including Medicare Part B. SSA will not conduct a medical review of a person receiving disability benefits if that person is using a ticket. However, income benefits can still be terminated if earnings are above the allowable limits.
- Since 2002, individuals who have received SSDI benefits for at least 24 months will not be medically reviewed solely because of work activity. However, regularly scheduled medical reviews can still be performed and, again, benefits terminated if earnings are above the allowable limits. So, if you go back to work, you won't automatically lose your benefits if you earn under the allowable amount.
- If your benefits have ended because you have substantial gainful work activity, you can request that your benefits resume without filing a new application if you are unable to continue to work because of your medical condition. You can receive up to 6 months of temporary benefits that do not have to be repaid if you are found ineligible to receive disability benefits, as well as Medicare or Medicaid, pending SSA making a new medical determination. The medical condition must be the same as or related to your initial medical condition when benefits were granted. You must file your request to start your benefits again within 60 months of the month your benefits ended.

Resources

Social Security pamphlets include:

- "Understanding the Benefits" SSA-05-10024
- "Retirement" SSA-05-10035
- "Disability Benefits" SSA-05-10029
- "You May be Able to Get Supplemental Security Income" SSA-05-11069
- "Survivors 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 Or Have Low Vision - How We Can Help" SSA-05-10052
- "A Guide For Representative Payees" SSA-05-10076
- "When A Representative Payee Manages Your Money" SSA-05-10097
- "5 Things Every Woman Should Know About Social Security" SSA-05-10044
- "Working While Disabled: How We Can Help" SSA-05-10095

These are available by calling the Social Security toll-free number 1-800-772-1213 or through Social Security's 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 Centers for Medicare and Medicaid Services (CMS), under the U.S. Department of Health and Human Services.

Medicare originally consisted of only two parts, which is why Parts A and B together are often referred to as "Traditional" or "Original" Medicare. Parts A and B cover various health care services including hospital care and doctor visits. With Original Medicare, you are covered for any doctor and hospital in the country that takes Medicare. You do not need prior authorization or permission from Medicare or your primary care doctor. If you want prescription drug coverage with Original Medicare, in most cases you will need to join a standalone private drug plan offered under Medicare Part D.

Medicare does not cover all health care costs. You will need to pay premiums (except for Part A, which is premium-free for most people), as well as deductibles and co-insurance for many covered services. And many health services will remain uncovered.

Certain people who meet low-income or resource guidelines may be eligible to receive help with these costs.

Many people stick with Original Medicare while also purchasing a Medicare supplement insurance or "Medigap" policy to cover some of the costs and gaps in coverage. Others choose to enroll in a managed care plan under Part C, more commonly known as Medicare Advantage. These alternatives are discussed in greater detail in the sections which follow.

Eligibility and Enrollment

Most people become eligible to receive Medicare coverage 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 receive SSI benefits. Persons who need kidney dialysis or transplant may also be eligible in some circumstances.

However, do not assume you will automatically be enrolled in Medicare once you are eligible. Automatic enrollment only happens for those who are already collecting Social Security (or Railroad) Retirement benefits by their eligibility date, and only in Parts A and B (or Part A only for those who choose to decline Part B coverage).

If you are waiting to take Social Security retirement benefits until your full retirement age of 67, for example, you will need to actively enroll in Medicare. The Initial Enrollment Period (IEP) is a 7-month period starting three months before the month in which you turn 65. It continues during that birthday month and the three months following it. If your birthday falls on the first of the month, your IEP starts four months before and ends two months after the month of your birth. If you wait until your birthday month or later in your IEP to enroll, the start of your Medicare coverage will be delayed, for at least one and up to six months past your birthday month.

You will also have to actively enroll if you want additional or alternative coverage to that offered by Original Medicare. For Part D prescription drug coverage, supplemental "Medigap" insurance, or Medicare Advantage, you must actively choose and sign up for a plan.

Failure to enroll during the earliest enrollment period when you are eligible for the type of coverage you want can significantly increase your costs with late-enrollment penalties. It may also result in a gap where you have no coverage. Enrollment periods for each type of Medicare coverage are discussed generally in the following sections, however, the rules can be complicated. Legislation has been proposed to simplify the enrollment processes, but as of the date of publication of this Handbook has not been enacted. It is highly recommended that you start looking into your options for Medicare coverage at the earliest time feasible, preferably at least three months before your 65th birthday.

Several excellent resources to help you navigate your Medicare choices are discussed in the Resource section at the end of this section.

Original Medicare: 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, if you or your spouse worked for less than 10 years of covered employment you can purchase Part A insurance by paying premiums ranging from \$252/month to \$458/month in 2020. If your income is low, you may be eligible for assistance with those premiums.

When you are admitted to a hospital as an inpatient, you are required to pay a deductible – in 2020, the first \$1,408 of hospital costs -- for that benefit period. A benefit period (sometimes called a "spell of illness") begins when you are formally admitted to a hospital or skilled nursing facility and ends when you are discharged and have not received any further doctor or skilled nursing care for 60 straight days. After you pay that deductible, Medicare will pay all other hospital costs through day 60. For longer hospital stays, there are coinsurance charges of \$352 a day in 2020 for days 61 through 90. For a hospital stay beyond 90 days, you may choose to use up to 60 additional "lifetime reserve" days of coverage, with coinsurance charges of \$704 a day in 2020. You pay all costs after 90 (or up to 150) days as an inpatient. If you are admitted to a hospital again after 60 days in a row without skilled care, a new benefit period begins. Your 90 days of coverage per benefit period begins again, and you pay another deductible.

Note that Part A does not cover doctors' services while you are a hospital inpatient. It also does not cover hospital care you receive as an outpatient. Those are covered under Part B.

Part A covers costs such as general nursing, room and meals, medically necessary medications, and other hospital services and supplies. There is no Medicare coverage for a television or telephone in your room, personal care items like razors or socks, private duty nursing, or a private room unless medically necessary or it is the only room available.

The same coverage applies to hospital costs for a mental health inpatient at a Medicare-certified general or psychiatric hospital, as well as the same limits. Thus, mental health services you get from doctors and other health care providers while you are a hospital inpatient are covered under Part B, not Part A.

Inpatient vs. outpatient

You may not have been formally admitted to a hospital as an inpatient, even if you are given a room or stay overnight. If you are in the hospital to have your condition monitored, or to determine whether you should be admitted as an inpatient, you may be on "observation" status and considered an outpatient. Emergency room care is also considered outpatient. This is extremely critical, because Part B, not Part A, covers your hospital care while you're an outpatient, and under Part B you will typically pay more for hospital care. For example,

you may have multiple copayments which together cost more than the Part A deductible, and higher prescription drug costs.

Even if you are admitted later as an inpatient, your observation status at the beginning of a hospital stay may affect whether Medicare will cover care at a skilled nursing facility. Let's say you were being "observed" during your first night in the hospital, and then were formally admitted for two more nights before discharge. Since Medicare only covers skilled nursing facility care if it follows three days in a row as a hospital inpatient, you will not be eligible for Medicare to cover your subsequent skilled nursing care. In 2020, Medicare has removed this three-day hospital stay requirement in certain circumstances where its feasibility has been affected by COVID19 public health emergency.

You can ask hospital staff whether you are formally admitted as an inpatient. The hospital must give you written notice if you are on observation status for more than 24 hours, which your doctor should explain to you in person.

Skilled nursing facility (SNF) care

If you receive inpatient skilled nursing or rehabilitation services in a Medicare-certified SNF within 30 days after leaving the hospital, where you were an inpatient for at least three straight days, Medicare Part A *may* cover the full cost for up to 20 days per benefit period, depending on your medical assessment. There is no guarantee of coverage for any time period since coverage depends upon your medical assessment. For days 21 through 100 in the facility, you will pay coinsurance of \$176 a day (in 2020). There is no Medicare coverage for skilled nursing facility care after day 100. However, if the coronavirus public health emergency has prevented you from leaving a SNF, thus ending a benefit period, and from starting a new benefit period by staying out of the SNF for 60 days in a row, Medicare will cover another 100 days of SNF care without you having to start a new benefit period.

Help with usual daily activities like getting in and out of bed, eating, bathing, dressing, and using the bathroom, is called "custodial care." Medicare does not cover custodial care by itself, for a SNF inpatient who does not also need skilled care. This, along with the Medicare limit for skilled nursing care of 100 days per benefit period, if even received, is why many people require Medicaid assistance for long-term care in a SNF.

Many professional staff and administrators of SNFs use the incorrect "improvement" standard to determine whether a patient needs skilled care that qualifies for Medicare coverage. The result is that patients who have "plateaued" or are "medically stable" or need "maintenance only" are often prematurely cut from Part A benefits. The correct standard requires only that the patient needs skilled services to prevent further deterioration or preserve current capabilities. If you believe that you or a family member's Medicare Part A coverage is about to be cut improperly, you may find help among the resources listed at the end of this article. The facility can also provide a telephone number you call to appeal the cut of services for the above reasons. You may also wish to contact your local Legal Aid office or the Montgomery Bar Association Lawyer Referral Service at 610-279-9660. 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, if you meet Medicare's definition of "homebound" and need skilled care within 14 days after leaving the hospital, where you were an inpatient for at least three days, Part A will cover certain medically necessary home health services. Also, people who are terminally ill can receive hospice care, which is usually given in your home by a Medicare-approved service.

If you need blood, you may have to pay for the first three pints each year, unless the hospital gets the blood from a blood bank, or you or someone else donates the blood.

All of the deductible and coinsurance amounts cited above are subject to an increase every year, typically by about three or four percent.

Part B – Outpatient Medical Insurance

In 2020 the standard Medicare Part B premium is \$144.60/month or higher, depending on your income. Your Social Security annual notice will tell you each year what your premium will be. Under Part B, you pay the first \$198 (in 2020) in medical costs each year if you are an individual with less than \$87,000 in income, or a couple filing jointly with \$174,000 or less in 2020. The deductible increases depending on your income. After reaching that deductible, Medicare will pay 80% of the Medicare-approved amount for doctors' services, other licensed health care providers' services, outpatient physical, occupational, speech, and mental health therapy, many lab tests, emergency and certain other ambulance services, and certain durable medical equipment. You are responsible for the remaining 20%. For outpatient mental health care, Medicare now pays the same 80% that applies to other Part B services, except that you may have to pay an additional copayment if visits with your mental health care provider take place at a hospital outpatient setting, or if you receive "partial hospitalization" mental health services at a community mental health center or hospital outpatient setting.

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

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 Part B 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 co-payment for most preventive-health services. If you are new to Medicare, you are entitled to a comprehensive "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.

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, in 2020 in response to the coronavirus public health emergency, Medicare expanded Part B coverage for "telehealth" or "virtual" services delivered by audio-visual (and in some cases, only audio) technology. Also, the preventive services covered by Medicare have expanded over the years.

Part B Late Enrollment Penalty

If you decline or fail to enroll in Part B coverage during your Initial Enrollment Period, you can enroll later during the General Enrollment Period (GEP) or, if you are eligible for it, a Special Enrollment Period (SEP). The GEP runs from January 1 to March 31 of each year. When you enroll in Part B during the GEP, your coverage doesn't start until the following July 1, so you may face a gap in coverage. You will also probably owe a late enrollment penalty: an increase to your Part B premium by 10% for every 12 months you were without

coverage. So, for example, you will pay a 30% higher premium if you delayed signing up for 3 years after your eligibility date.

You may avoid this penalty if you are eligible for the Medicare Savings Program (discussed in a later section), or if you qualify for a SEP. You can delay enrollment in Part B without penalty if you or your spouse are still working and you have coverage through the employer's or union's group health insurance policy. Your SEP will run for up to eight months after you lose your group health coverage or you or your spouse stop working, during which time you can enroll in Medicare without a Part B penalty. To avoid a gap in coverage, you should enroll the month before your employment or your group health coverage will end. Failure to enroll during your SEP will result in a lifelong premium supplement when you do enroll.

Additional Insurance for Part A and B

Medicare pays for many covered items, 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, if not 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's 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 is not 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 "Medigap" 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, when 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 obtain a Medigap policy later in your life.

Congress established 10 standardized Medicare supplement plans in 1992 and labeled them A through N, but some previously approved plans have been dropped from this alphabetic sequence. Plan F covers all the deductibles and coinsurance gaps of original Medicare and has been the most popular supplement policy; Plan C is similar. However, as of January 1, 2020, Plans C and F are not available to people who became newly eligible for Medicare on or after that date. If you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy one of these plans. Since 2010, insurance companies were no longer allowed to sell plans E, H, I and J to new enrollees (though if you already held one of these policies you were permitted to keep it.)

This leaves Plans A, B, D, G, K, L, M, and N if you became eligible for Medicare on or after January 1, 2020. Each letter plan provides a different variation on gap coverage, so that one variation may suit your needs better than another. Plans K and L, for example, pay for 50% or 75%, respectively, of Part A deductible and Part A and Part B coinsurance. Plans K and L also have yearly limits for your out-of-pocket costs. Medigap policies with the same letter name offer the same benefits, but the premium can vary. You can compare letter plans by choosing “How to Compare Medigap Policies” on the Medicare.gov website at <https://www.medicare.gov/medigap-supplemental-insurance-plans>.

The first time you can purchase a Medigap policy is during the six-month Medigap Open Enrollment period, which begins the month you meet both of the following: (1) you are 65 or older and (2) you are enrolled in Medicare Part B. During your Medigap Open Enrollment period, companies must sell you a policy regardless of your health status, and they are limited in their ability to exclude coverage for pre-existing conditions.

If you missed your Open Enrollment period, you may be able to buy a Medigap policy with similar protections regarding your health status, if you are 65 or older and you lost or ended certain other health insurance coverage. You can try to purchase a Medigap policy outside of these protected enrollment periods, but no company is required to sell you one, or to disregard your health status when setting price and coverage.

If you have Original Medicare with a Medigap supplement, you show the hospital or doctor your Medicare card and your Medigap insurance card when you receive service from them. The medical service providers 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. If you believe your health care provider is trying to collect such an excess charge, you should report this to and discuss it with one or more of the organizations listed in the “Resources” section, below.

If you have a Medicare supplement policy, it will help with your costs under Parts A and B; and if you want prescription drug insurance, you will enroll in a separate Part D plan.

Medicare Advantage

Formally Part C of the Medicare program, Medicare Advantage at first was composed of managed-care plans such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). However, it now includes several additional types of plans, known as Private-Fee-For-Service (PFFS) plans and Medical Savings Accounts (MSAs).

With Medicare Advantage, the federal government pays private health insurance companies a specified amount 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 make co-payments for most office visits. Most plans have also instituted co-pays for the more expensive health-care services such as hospital and skilled nursing stays, outpatient surgery, and ambulance

services. However, most plans provide some services (at varying levels) that are not covered by Original Medicare, such as vision care, hearing services, dental care, and fitness programs. And unlike Original Medicare, there will be an annual out-of-pocket limit (which varies widely depending on the plan) after which you will owe no further coinsurance.

To choose Medicare Advantage rather than Original Medicare, you will have to actively enroll. If you qualified for automatic enrollment in Medicare, you will need to remain enrolled in Part B and add a Medicare Advantage plan. If not automatically enrolled, you must actively enroll in Part B before adding Medicare Advantage. You have an opportunity to change your Medicare Advantage 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.

You will pay the standard Part B premium. On top of that, most Medicare Advantage plans charge an additional 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 – this 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. Referrals are typically 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 organization's network. 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. Some of the managed-care companies that serve Montgomery County have very large networks of service providers, covering the entire five-county region of southeast Pennsylvania, including Philadelphia, Bucks, Chester, and Delaware counties as well as Montgomery.

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, they will cover some services you receive out of network, but you will have to pay a larger 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 plan you are considering.

Even though networks are geographic-based, if you travel outside of your HMO or PPO network area, 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.

Among the newer Medicare Advantage plans, 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. Since 2012, many of the companies that offer PFFS plans have had quite limited numbers of doctors, and especially hospitals, that accept their payments.

The Medicare Medical Savings Account (MSA) arrangement has two parts. As with other Medicare Advantage plans, Medicare pays the insurance company a specified amount for your health care. The company uses part of that amount to pay your covered costs under a Medicare Advantage plan with a higher-than-usual deductible. The company then deposits the other part of that payment into your medical savings account for you to use to help pay

your health costs which may include the deductible. 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. Be aware that doctors or hospitals are allowed to decide, on a case-by-case basis, whether to accept the plan's payment terms.

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

Many of the HMOs serving Montgomery County also include Part D prescription drug coverage in their plans. If you by chance enroll in a separate Part D plan, you will be automatically disenrolled from your HMO – so be very careful of solicitations to join such “free-standing” Medicare prescription drug plans.

Medicare Advantage and Medigap supplemental insurance plans are mutually exclusive – you cannot have both at the same time.

To compare Medicare Advantage plans offered for your geographic region, you can visit the Medicare Plan Finder at www.medicare.gov/find-a-plan, or call 1-800-MEDICARE or 1-800-633-4227.

Medicare Savings Program

There are programs available to help those who are 65 and older or disabled pay for Medicare premiums, deductibles, and co-payments if income and assets are below certain limits. The Medicare Savings Program is called “Healthy Horizons” in Pennsylvania and is jointly funded by the state and federal governments. Various levels of assistance are possible, depending on your income, resources, and number of people in your household. You can visit the Medicare.gov website to learn more about the Qualified Medicare Beneficiary Program (QMB Program), Specified Low-Income Medicare Beneficiary Program (SLMB Program), and Qualifying Individual Program. Pennsylvania has added the Categorically Needy Program which provides additional benefits for those who qualify. For help with the application process contact APPRISE at 610-834-1040 and request a call back, or the Montgomery County Assistance Office at 610-278-3601. If you encounter any difficulty accessing this program, contact your local state legislator.

Part D – Outpatient Prescription Drug Insurance

Medicare pays private insurance companies to offer prescription drug coverage to everyone with Medicare. Even if you don't take many prescriptions now, you should consider joining a Medicare drug plan when you are first eligible since if you do not have other equivalent or “creditable” prescription drug coverage or get Extra Help, you will probably pay a lifelong late enrollment penalty if you join a plan later.

The two ways to get Medicare prescription coverage are:

1. If you are enrolled in Original Medicare or in a Medicare Advantage Plan that does not offer drug coverage, you can join a stand-alone Medicare Prescription Drug Plan under Part D.
2. You can join one of the many Medicare Advantage Plans that includes Medicare Rx drug coverage. You get all of your Part A, Part B, and Prescription Part D coverage through these plans. Either way, you must reside in the geographic service area of the Medicare drug plan you want to join.

Persons 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.)

Picking a Part D Plan

You can join switch or drop a Medicare drug plan when you first become eligible for Medicare or when you get Part B for the first time, and during Open Enrollment, between October 15 - December 7 each year (or at any time, if you qualify for Extra Help). How much you pay depends on your Medicare drug plan, and plan costs can change each year. Your actual plan costs vary depending on many factors, such as what prescriptions you take, if they are on your plan’s list of covered drugs for that year and what tier the drug is in, which pharmacy you use, and whether you get Extra Help paying your Part D costs. The monthly premium varies by plan. You pay this in addition to the Part B premium. If you have higher income, you may pay more for your Part D coverage. If your income is over \$87,000 for individuals or \$174,000 for married persons, you will pay an extra premium amount. To compare Part D plans you can visit the Medicare Plan Finder at www.medicare.gov/find-a-plan, or call 1-800-MEDICARE or 1-800-633-4227.

Prices for your Part D-covered drugs may change during the course of a year, as you advance through each of four phases of coverage. In the first phase, the “Deductible period”, you pay the full price (as negotiated by your particular plan) for your covered prescription, until you meet your annual Part D deductible. In 2020, no plan’s deductible can be higher than \$435. Deductibles vary by plan, and some plans have zero deductible.

After you’ve met your plan’s deductible, your plan begins to pay its share of your covered prescriptions, and you pay a copayment. This “Initial Coverage period” ends after the total costs you and your Part D plan have paid for your covered drugs reaches \$4,020 (in 2020).

The third phase used to be the start of a coverage gap, also called the “donut hole”. Once your Initial Coverage period ended, you had to pay a much higher share (originally 100%) of your plan’s cost for covered drugs. The Affordable Care Act started a gradual elimination of the gap, and it essentially ended in 2019. Now, once you enter the “coverage gap” phase, you pay 25% of the plan’s cost for covered drugs until you reach the end of this phase. You might still notice a difference in cost between the Initial Coverage and the gap periods if, for certain (more expensive) drugs, your 25% share comes to more than your co-pay would have during the Initial Coverage Period. Not everyone enters the gap period if their drug costs aren’t high enough.

The fourth phase is “Catastrophic coverage.” In all Part D plans, you reach this phase after you have paid out-of-pocket costs, during that year, of \$6,350 (in 2020). The threshold amount is just the amount you have paid – not (like in the Deductible period) the total costs you and your plan have paid. Once you have reached the catastrophic coverage period, you pay significantly lower copays or coinsurance for the rest of the year: the greater of 5% of the plan’s cost for the drug, or \$3.60 for generics and \$8.95 for brand name drugs, respectively, in 2020.

It’s important to know what’s counted in your yearly “out-of-pocket” costs. It includes any deductible you pay, all co-pays you make for your drugs in the “Initial Coverage” period, and all payments you make in the “coverage gap.” It also includes amounts paid by others including family members, most charities, and Pennsylvania’s programs (PACE, PACENET, SPBP, CRDP) to assist certain persons with prescription drug costs. It does not include the amount of your monthly premiums. If you can purchase prescription drugs (most likely generics) for less than what your plan requires as your co-pay, you might consider buying them “off-plan” – that is, without using your card.

All prescribers need to be enrolled in Medicare or have an opt-out request on file for your prescriptions to be covered by your Medicare drug plan.

Part D Late Enrollment Penalty

If you did not enroll in Part D during your Initial Enrollment period because you had other prescription drug coverage certified as “creditable,” you may be eligible for a Special Enrollment period for Part D. There are several different Part D SEPs depending on the circumstances, and not all will excuse you from a late enrollment penalty. The Part D SEPS generally last only two months after you’ve lost your previous drug coverage.

If you don’t qualify for a SEP, you can enroll in Part D (or change your Part D plan) during the Open Enrollment period from October 15 through December 7. You will probably have a late enrollment penalty that is added to your Part D premium. Tell your plan about any previous drug coverage you have had. The cost depends on how long you didn’t have other drug coverage. The penalty amount may increase each year.

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” – 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. If you qualify for Extra Help and join a Medicare drug plan you will get help paying your Medicare drug plan’s costs, have no coverage gap, have no late enrollment penalty, and have the chance to switch plans at any time. You automatically qualify if you have full Medicaid coverage, or get help from Medicaid to pay your Part B premiums or you get SSI benefits. Extra Help is a Medicare program to help people with limited income and resources pay prescription drug costs. If your annual income and resources in 2020 are below the following limits you may be eligible:

Single Person: income less than \$19,140 and resources less than \$14,610.

Married Person: Income less than \$25,860 and resources less than \$29,160.

If you think you are eligible for Part D’s Low-Income Subsidy, submit your application to Social Security at www.ssa.gov, or call Social Security toll-free at 1-800-772-1213, or visit your nearest Social Security office when they are open for in-person visits. They will notify Medicare if their review of your income and assets indicates that you are qualified for “extra help” with your prescription drugs. By the way, the assets considered do not include your home or car or burial insurance. Only “liquid” assets such as bank accounts, stocks and bonds, and mutual funds, are counted. Since eligibility is calculated using the Federal poverty level, the income requirements are subject to change every year.

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. **YOU MUST FILE AN APPEAL WITHIN 120 DAYS OF THE DATE YOU GET THE MSN IN THE MAIL.** 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 if you're asked to leave the hospital before you feel you are well enough to go, 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. Pennsylvania's QIO in 2020 is a company called Livanta, which can be reached at 1-866-815-5440, or TTY 1-866-868-2289

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. Choose "billing" at the first prompt; then depending on what has influenced you to call, choose "hospital stay" for Part A claims, "doctor service" for Part B claims, or "medical supplies" 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 speak with a customer service representative; and if you need help in another language, tell the representative.

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.

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. In Montgomery County, Apprise is staffed by trained volunteers supervised by RSVP – the Retired and Senior Volunteer Program. Call 610-834-1040 and leave a message on the Apprise line by pressing "1". 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 members 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. PHLP also publishes a couple of newsletters that are invaluable sources of information, especially for lower-income beneficiaries.

Resources

In addition to the organizations listed in the preceding section, the following resources can be extremely helpful for any Medicare-related question or issue you may have.

- The official U.S. Government Medicare Handbook, "Medicare & You 2020": order it by calling 1-800 MEDICARE (1-800-633-4227), TTY 1-877-486-2048 or order and/

or download it at Medicare's official government website, <https://www.medicare.gov>. This medicare.gov website has loads of information, including plan comparisons which you can narrow down to focus on your local geographic area or a specific health issue. You can call Medicare directly to apply over the phone or ask questions: 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048

- APPRISE Helpline: For free, confidential guidance on Medicare and related plans and programs specifically available to Montgomery County residents, call 610-834-1040 and leave a message requesting a call back, or visit the APPRISE website for Montgomery County, <https://www.rsvpmc.org>. For APPRISE guidance for Pennsylvania generally, call 1-800-783-7067 from 9 am to 3 pm Monday – Friday. Leave a message to receive a call back.
- Medicare Rights Center National Helpline: Call 800-333-4114, M-F. Counselors can answer your questions about insurance choices, eligibility and applications, Medicare rights and protections, payment denials and appeals, complaints about care, and Medicare bills. The Medicare Rights Center also operates a user-friendly interactive website: <https://www.medicareinteractive.org>, that can walk you through all sorts of scenarios to answer a wide range of questions about Medicare.
- Center for Medicare Advocacy: Their website, <https://www.medicareadvocacy.org> offers comprehensive Medicare information, with a focus on access to and quality of health care for older people and people with disabilities.
- Montgomery County Area Agency on Aging: Call 610-278-3601 during regular business hours and if the office is accepting in-person visitors, you can go to 1430 DeKalb St., Norristown, PA 19404.

MEDICAID

Medicaid is a combination state and federal program that helps pay for long-term care. Once an applicant successfully completes the application process, Medicaid will pay for nursing home costs, and certain home and community-based services. In most nursing home cases, the individual receiving Medicaid benefits must pay his or her income to the facility, less a \$45 allowance for personal needs, and less an allowance for the community spouse. A short-term resident in a nursing home, certified for 6 months or less, may also be allowed a housing allowance of 816.10/month in 2021 for up to 6 months.

Eligibility

Benefits are available only to individuals who meet these Medicaid eligibility standards. An applicant for Medicaid benefits must prove medical and financial eligibility. Montgomery County's Office of Senior Services 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. In 2021, single

applicants with income over \$2,382 must have total resources under \$2,400. Single applicants with income less than \$2,382 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 \$130,380, effective January 1, 2021. The minimum allowance is \$26,076, effective January 1, 2021. The community spouse is also allowed to have a certain level of income to avoid impoverishment, between \$2,155 (effective July 1, 2020) and \$3,259.50 (effective January 1, 2021) 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 where 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 long-term care benefits even if all of the other eligibility requirements have been satisfied. Gifts and certain other asset transfers (such as loans to family members) are subject to a 5-year look-back, and the penalty period begins to run when the Medicaid applicant is otherwise eligible for Medicaid but for the gift. Such gifts within that 5 year look-back cause one day of Medicaid ineligibility for every \$364.90 (2021 daily penalty divisor) given away. Aggregate gifting of \$500 or less in a given month is not penalized, but other gifts can cause major problems with Medicaid eligibility.

Several exceptions to the gifting penalties exist. For example, special exceptions in the law permit certain asset transfers to disabled children, siblings with equity interests in real estate, and certain family caregivers. Sometimes trusts can be used to protect assets, particularly for disabled individuals.

You and your attorney need to know and carefully follow the rules before making any asset transfers, or the Medicaid application will be denied, possibly leaving you or a family member personally liable for thousands of dollars in unpaid nursing home costs. “Selling” the family residence for \$1.00, for example, is considered a gift and causes Medicaid ineligibility unless an exception applies.

Transfers made exclusively for a purpose other than to qualify for Medicaid benefits should not cause a period of ineligibility, but you may need to prove certain facts “on appeal” to an administrative law judge before the exception will be allowed. Unless you have enough money or long-term care insurance to pay nursing home care privately for 5 years, see an attorney with specialized knowledge in Medicaid law before making any gifts or asset transfers. There are planning techniques that work, but Medicaid laws and regulations are strict and constantly changing. If gifts have been made, and a penalty period exists that creates undue hardship, there are often steps that can be taken to correct the problem of Medicaid ineligibility. A Medicaid planning attorney can provide guidance in this area. Medicaid planning without the advice of an elder law attorney is quite risky, and may not be in your best interests.

Estate Recovery

Pennsylvania is required by federal law to seek reimbursement from the estates of certain deceased Medicaid recipients, including those over age 55 who received nursing home care or home and community-based long-term care services through the Aging Waiver Program. At present, recovery is generally 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 which do not designate beneficiaries. In some cases, advance Medicaid planning with an elder law attorney can reduce or avoid 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. Medicaid planning should not be attempted without the assistance of an elder law attorney specializing in Medicaid law.

MEDICAID BENEFITS FOR IN-HOME CARE

Seniors who wish to remain in their own home can access Medicaid long-term care benefits through the Waiver program. Many seniors would rather reside in their own home rather than in a nursing facility, making Waiver benefits a valuable resource.

The services provided through the Waiver program are similar to those in nursing homes. These services include custodial care, nursing care, adult day care, respite care, medical supplies, and meals. The program also pays for home medical equipment and minor home modifications, such as wheelchair ramps, stair glides, walk-in bathtubs, and safety bars. To receive funding for the services chosen, the service provider must accept Medicaid.

Seniors formerly would enroll in the Aging Waiver, which was available for applicants age 60 and older. The Aging Waiver is now part of the Community HealthChoices (CHC) waiver.

To begin the process of qualifying for Waiver benefits, the applicant contacts the statewide Independent Enrollment Broker (IEB), which is Maximus, at 1-877-550-4227, or is referred from a hospital, an LTC facility, physician, or the County Assistance Office.

Medical Eligibility

A Maximus representative schedules an in-home visit to determine whether the applicant medically qualifies for Waiver. To start this process, the applicant files a Medicaid application and Maximus sends a physician’s certification form (Form 1768) to the applicant’s doctor. The physician’s certification form is due within 86 days of the initial visit with Maximus. On the form, the physician determines the applicant’s diagnosis and recommends a level of care.

Additionally, Maximus refers the applicant to the independent Assessment Entity (the Area Agency on Aging). The AAA conducts an in-home visit within ten (10) days of receiving this referral and completes a FED (functional eligibility determination) to determine whether the applicant needs waiver services. The AAA sends the results back to Maximus. The FED identifies information regarding the applicant’s medical status, recent hospitalizations, and functional ability (ADLs and IADLs). Maximus then must follow up with the AAA and

physician to make sure the process progresses. Once Maximus receives the results, it sends them to the County Assistance Office.

Once medical and financial eligibility is achieved, a service coordination entity (SCE) will be used to develop a service plan through the Comprehensive Needs Assessment process. Benefits are then paid from a CHC MCO: AmeriHealth Caritas; Pennsylvania Health and Wellness (Centene); or UPMC for You.

Financial Eligibility

Financial eligibility is determined by the County Assistance Office (CAO), after it is contacted by Maximus. The CAO will make an eligibility decision within 30 calendar days of the date an individual submits an application, with a possible 15-day extension.

To qualify for CHC long-term care waiver, the applicant's income must be \$2,349 (1/1/2020) or below and available resources must be at \$8,000 or below. Resources count toward the \$8,000 if they are owned and can be spent by the applicant. Examples include bank accounts, investment accounts, life insurance with a cash value, and non-qualified annuities. Excluded resources that do not count against the \$8,000 include the primary residence up to \$595,000 in equity value, personal property, one motor vehicle, and a spouse's retirement plans.

The community spouse of a married applicant is allowed to keep a resource allowance based on a Resource Assessment. The spouse may retain half of the countable resources, subject to a maximum of \$128,640 (1/1/2020) and a minimum of \$25,728 (1/1/2020). The Resource Assessment is based on all resources owned by both spouses on the date the Form 1768 is completed. Another date may be used depending on whether the applicant spent a qualifying period of time in a nursing home. To achieve the \$8,000, the applicant can spend down on items of fair market value. Any gifting that occurred more than five years prior to the Medicaid application is disregarded. If gifting occurred within five years, and exceeded \$500 total in a month, then a penalty period based on the amount given away divided by the average monthly cost of nursing home care results. Exceptions to the gifting penalty include gifts to a spouse, as well as a child who is determined disabled under Social Security administration standards.

In a nursing home, a Medicaid recipient must pay a portion of his or her income to the nursing home, subject to certain deductions. No patient pay is due under the long-term care waiver rules.

If an applicant receives gross income of more than \$2,349 a month and seeks Medicaid waiver benefits, the applicant will not be eligible for the long-term care waiver. Instead, the applicant would have the option of applying for waiver spend down.

Under waiver spend down, the applicant must reduce his or her monthly income by paying for certain monthly medical expenses, including health insurance premiums, as well as expenses that are allowed and not covered by insurance. Unpaid medical expenses can be deducted if they will not be paid by anyone else, will not subsequently be paid by Medicaid, have the date and amount of the expense verified, and have not already been used as a deduction for Medicaid approval. Also, paid medical expenses can be deducted in the month of application or during a retroactive period. "For medical insurance premiums, the date of the expense is the date when the bill was paid," according to the Medicaid Handbook.

The type of Medicaid procedure for waiver spend down requires an income spend down under either Non Money Payment (NMP) or Medically Needy Only (MNO) rules.

The waiver spend-down in an MNO category involves assessing the applicant's income and expenses over a six-month period, while the NMP category involves looking at income

and expenses from month to month. The resource limits also differ from long-term care rules in that no \$6,000 disregard exists for the NMP category. Additionally, neither NMP nor MNO waiver spend down has a transfer penalty for gifting assets, nor a community spouse resource allowance.

For a married applicant for NMP waiver spend down, the income and resources of the community spouse are counted toward eligibility. For a married applicant for MNO waiver spend down, the community spouse's income and resources are not counted. If a recipient of Medicaid waiver spend down services later enters a nursing home, fair consideration and spousal impoverishment rules would then apply.

For an unmarried applicant for NMP, he or she must spend income each month on allowable medical expenses until the income is reduced to \$805.10. At that time, eligibility for the remainder of the month is achieved. If the applicant is married, the income of both spouses must be spent to \$1,208.30. For a single applicant, the NMP resource limit is \$2,000, while for a married applicant, the resource limit is \$3,000.

Under MNO, the CAO first counts the income in the month of application. That number is then multiplied by six, unless the source of income would end prior to the six-month period. If the income is above \$2,550, the applicant can reduce the countable income through allowable medical expense deductions. Additionally, a \$20 unearned income deduction is allowed. For medical expenses, the CAO reviews expenses paid in the month of application, as well as unpaid expenses charged or expected to be charged over the six-month period. The applicant becomes eligible for MNO once spending on medical expenses is equal to or less than the six-month MNO income limit.

An applicant for MNO has a resource limit of \$2,400.

PACE AND PACENET **(PHARMACEUTICAL ASSISTANCE CONTRACT FOR THE** **ELDERLY)**

Pennsylvania has established pharmaceutical assistance programs for low and middle income seniors age 65 and over. These programs are known as the PACE and PACENET Programs. The PACE and PACENET programs are based on the applicant's income from the prior year, and not on assets.

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, in 2020. 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. Once enrolled in the PACE program, a senior pays no more than \$6 per month for a generic prescription, and no more than \$9 per month for a brand name drug.

PACENET has higher income limits. The 2020 limits are \$27,500 for elderly singles and \$35,500 if married. Copays may be in the range of \$8 for generic prescriptions and \$15 for brand-name prescriptions. If you are enrolled in a Part D drug plan that has a signed agreement with PACENET, your copays 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. Whatever your Medicare Part D may not cover, PACE or PACENET will. If the Medicare

plan's copays are less than PACE'S, you will pay the lower amount. 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. Applications are available from your local area agency for the aging, pharmacy, your local legislator's office or on the Pennsylvania Department of Aging's website. The application form can be used for both the PACE and PACENET enrollment. If you have other questions about PACE or PACENET, call the Montgomery County Office of Senior Services or online at <http://pacecares.magellanhealth.com/>.

PENNSYLVANIA LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

The Pennsylvania Department of Human Services (DHS) provides a low income home energy assistance program to help low income families pay a portion of their winter heating bills. Although administered by DHS, 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 and how to apply, call the Montgomery County Assistance Office at 610-272-1752, or the LIHEAP Hotline at 866-857-7095.

PUBLIC BENEFITS

The Pennsylvania Department of Human Services administers several other programs which may provide benefits such as food stamps and medical assistance. For information contact the Montgomery County Assistance Office at:

1931 New Hope Street
Norristown, PA 19401
Phone: 610-270-3500

Also, consider visiting www.benefitscheckup.org. By accessing the website, you can receive information, addresses and telephone numbers for programs such as Supplemental Security Income, Medical Assistance (also known as 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 online 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 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, and 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." The Montgomery County Department of Veterans Affairs can be reached at 610-278-3285.

Veterans' Health Care Benefits

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 online 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 above. 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 inpatient and outpatient services. These include: limited nursing home care, adult day health care and homeless programs, preventative medicine services, primary care, surgery, mental health and substance abuse treatment, home health care, respite and hospice care, emergency care in VA facilities and drugs and pharmaceuticals.

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” injuries. “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.

Veterans’ Aid and Attendance Special Pension

The Veterans’ Administration offers a Special Pension or Aid and Attendance (A&A) benefit that is largely unknown. This Special Pension (part of the VA Improved Pension program) allows for veterans and surviving spouses who require the regular attendance of another person to assist in eating, bathing, dressing, undressing or taking care of the needs of nature to receive additional monetary benefits. It also includes individuals who are blind or a patient in a nursing home because of mental or physical incapacity. Assisted care in an assisted living facility also qualifies.

This most important benefit is overlooked by many families with veterans or surviving spouses who need additional monies to help care for ailing parents or loved ones. This is a “pension benefit” and is not dependent upon service-related injuries for compensation. Most veterans who are in need of assistance qualify for this pension. Aid and Attendance can help pay for care in the home, nursing home or assisted living facility. A veteran is eligible for up to \$1,911 per month, while a surviving spouse is eligible for up to \$1,228 per month. A couple is eligible for up to \$2,266 per month.

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.

NO-COST AND LOW COST LEGAL SERVICES

For individuals who qualify and meet program criteria, legal services can be obtained free through Legal Aid of Southeastern Pennsylvania (LASP). The Norristown office is located at 625 Swede Street, Norristown, PA 19401 and can be contacted at 610-275-5400. The Pottstown Office is located at 933 N. Charlotte Street, Suite 2-A, Pottstown, PA 19464 and can be contacted at 610-326-8280. An Advice and Referral Helpline is also available at 1-877-429-5994 and at lasp.org. The helpline is in service on Mondays through Fridays from 9:00 a.m. to 12:00 p.m. and 1:00 p.m. - 4:00 p.m. The helpline may refer you to a clinic, speak with you about your case, explain the procedures, offer suggestions on how you may represent yourself, or provide representation.

The types of cases handled by LASP include: public and private housing, consumer issues, bankruptcy, protection from abuse, custody, child dependency, welfare, social security, unemployment compensation, expungements and elder law. Except in the case of Protection from Abuse and some Elder Law cases, all clients must be financially eligible for free legal services. Income, assets and family size determine financial eligibility.

Even if you do not qualify for legal aid, you should still seek legal advice. You may qualify for discounted legal advice and representation through the Modest Means Legal Access Program (MMLAP) of the Montgomery Bar Association by calling 610-279-9660, option 201,

for referral to an attorney. The MMLAP is a joint project between the Montgomery Bar Association and Legal Aid through which the Bar Association attorneys offer reduced fees to qualified individuals.

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; and
- Adult day centers, which provide personal care and medication management for individuals who cannot be left alone during the day.

You can contact the Montgomery County Office of Senior Services at 1430 DeKalb Street, Norristown, PA 19404-0311; telephone 610-278-3601, for more information regarding these services.

Independent Housing Options

- **Continuing Care Retirement Communities (CCRC)** offer 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. For information on subsidized housing facilities contact the Montgomery County Office of Senior Services at 1430 DeKalb Street, Norristown, PA 19404-0311; telephone 610-278-3601.

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 Montgomery County Office of Senior Services 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** 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.

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 coverage gaps.

For lists of these facilities, contact the Montgomery County Office of Senior Services: telephone 610-278-3601; website www.montcopa.org/148/Senior-Services.

NURSING HOMES

A nursing home is a facility where residents receive around-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.

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 elder law 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 their 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. The Montgomery County Long Term Care Ombudsman can be reached by calling 610-278-3600.

Assisted Living Facilities 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, also known as assisted living residence (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 must be 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 both an assisted living facility and a personal care home is almost exclusively through "private pay" arrangements with the resident. VA benefits may be available if certain requirements are met. In general, however, neither Medicare nor Medicaid covers residency in an assisted living facility. 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 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?

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- 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 newly expanded Pennsylvania law, residents of an assisted living facility have the following rights among others:

- the right to a plan of care;
- 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 and access to a telephone;
- the right to leave and return to the home;
- the right to participate in, or refrain from, 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 according to specifically enumerated guidelines and procedures;
- the right to be free of chemical and physical restraints.

As with nursing homes, the Montgomery County Senior Services Ombudsman program applies to residents of assisted living facilities.

New regulations have been enacted pertaining to dementia units, and the training of staff. New regulations have also been enacted to begin the process of licensing personal care homes and assisted living facilities.

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,

certain levels 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 housecleaning, 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 elder law attorney, is advised to make sure the resident understands the terms. Some continuing care retirement communities offer unlimited health services in exchange for the entrance fee, while others require that residents pay additional fees 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 their 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 ensures 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 while they are receiving assisted living 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 the previous sections covering assisted living facilities and nursing homes for a description of these protections.

Nursing Home Licenses: Problems, Sanctions and Revocations

Although nursing home placement is a difficult decision, there are ways to help verify that you are placing your loved one in a secure environment. One useful tool is the "Nursing Home Compare" feature on the Medicare website, www.medicare.gov. This web site enables you to locate nearby nursing facilities and compare quality. Some nursing homes earned "five stars" under the government's ranking system, while others garner only one star, which indicates quality that is "much below average."

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 Pennsylvania Department of Health does not require that the reporter be a direct eyewitness; 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 health care providers. Employees with certain felony and misdemeanor convictions are supposed to be 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 report an incident of abuse or substandard care, call the Pennsylvania Department of Health's Complaint hotline at 800-254-5164 and select the appropriate option for hospital, nursing home, intermediate care facilities, personal care, home health care, or others. For immediate help, the Elder Abuse hotline is 800-734-2020 at the Montgomery County Office of Senior Services Protective Services department. The Ombudsperson can also be contacted at the Office of Senior Services at 610-278-3600 with non-urgent complaints about nursing homes.

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, 717-783-1550.
- "Home Away from Home: A Consumer Guide to Board and Care Homes and Assisted Living;" American Association of Retired Persons, 1-888-687-2277, 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 being 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, continence, 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 a personal care facility or an 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 expenses. Long-term care insurance sold by commercial insurance companies can be 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 about \$9,792.65 per month according to a 2017 study by the Pennsylvania Department of Human Services, but the actual cost of nursing facility care in Montgomery County slightly exceeds the statewide average. Assisted living costs are usually less than nursing home care, running approximately \$5,000 - \$8,000 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 are 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, personal care homes, 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’s 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 aides 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 policies 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 \$340 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 \$290.

Factors Affecting Costs

Most policies include a waiting period, sometimes called 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 is 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 ten 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. 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 LTC 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 "5% compound inflation," may be lower percentages (for example, 3% compound"). One or two carriers have an innovative option for inflation that is 30-40% less expensive, 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. 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, and 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 triggers.” 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 a 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 making the benefits when received likely not taxable, but also provides some level of assurance of standardized benefit triggers (needing assistance in 2 of 6 ADL’s or requiring supervision 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 impairments can do all or most of the ADL’s, but 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 coverage.

Newest Developments

Before 2006, only four states (New York, California, Connecticut, and Indiana) offered two types of long term care insurance plans, including a type called a “partnership plan.”

This plan allowed purchasers buying certain minimum benefit levels to legally shelter 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 all of these partnership plans are underwritten for health. Note that one does NOT have to wait for the availability of such plans in their state, and risk their eligibility; anyone purchasing a plan from this point forward will have the option of a penalty-free conversion to partnership-qualified plans for a period after they are first offered in each state. Also note that partnership plans typically do not cost more than non-partnership qualified plans. In Pennsylvania and most other states, the requirements for partnership qualification are met by almost all well-developed plans, most buyers should only consider partnership plans.

Consumer Tips

- Utilize a long-term care specialist (someone who is 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.

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- 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 deciding 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 no bargain and a waste of money.
 - Consider policies from at least two or more companies. No two long-term care insurance policies are alike.
 - 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 helpful 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 serves 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.
- Long Term Care Planning Guide, 9th Edition, 1999; by Phyllis A. Skelton.
- National Care Planning Council; www.longtermcarelink.net.
- Health Insurance Association of America; www.ahip.org; “Guide to Long Term Care Insurance.”

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- Long-Term Care Partnership Policies-Questions and answers about Pennsylvania's newest option for long-term care insurance. www.portal.state.pa.us/portal/server.pt/document/707193/ltc_partner_faq_pdf
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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. The Montgomery County District Attorney's Office has established an Elder Abuse Unit in order to address these cases. Call 1-800-734-2020 or use their online Crime Reporting Form at www.montcopa.org to Report Elder Abuse. They also have an Economic Crimes Unit to investigate and prosecute financial crimes.

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/or 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 MCOSS Protective Services: 1-800-734-2020. They may answer the telephone by saying "Public Safety."

In an emergency, call 911.

If You Are Abused

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 - Protective Services: 1-800-734-2020

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- Domestic Violence Hotline: 1-800-773-2424
 - Montgomery County Senior Services: 610-278-3601
 - Pennsylvania Department of Aging: 717-783-1550

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. To qualify for a PFA there must be a family relationship or an intimate relationship with the person you want to file for protection from or you must share a household with the person. You first file for a Protection From Abuse Order by going to the Protection from Abuse office located on the First Floor of the Montgomery Courthouse in Norristown between 8:30 but no later than 1:30 P.M. You can call that office at 610-278-1191. In addition, the Women’s Center of Montgomery County can help you file the necessary papers and will go with you to court. Call them at 610-279-1548. The 24-hour hotline number for the Women’s Center is 800-773-2424. The Montgomery County Emergency Operation Center number is 610-275-1222. The abuser may be arrested and if a court deems it appropriate imprisoned and/or fined. Senior Law Center is a non-profit organization that may also be able to assist you through the PFA process. They can be reached at 610-910-0210.

Zero Tolerance for Abuse

You should know that many organizations are working in Montgomery County 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 may get 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 them 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 a major life activity is 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. The 2009 amendments to the ADA expanded the definition of disabled to include any individual with an impairment of any bodily system (i.e. circulatory system for individuals with high blood pressure) and prohibiting the consideration of "mitigating measures" such as medication in determining whether an individual is substantially limited in their major life activities and thereby entitled to protection 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. Generally, 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. However, there are limits to how much an employer is obligated to do to accommodate a person with a disability.

First, 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, generally, 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. In addition, the nature of the business itself is a big factor. For instance, if a server 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. In 2011, the Equal Employment Opportunity Commission (EEOC), updated the regulations that the EEOC uses to interpret the ADA. They have stated that because of its new ADA regulations, it will be "much easier for individuals to meet the definition of "disability."

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 also 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 were 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 of these laws are very clear: 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 the 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 a 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." In addition, 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 it is 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 does not get resolved within their periods, you may have lost your right to make a claim. The Pennsylvania Human Relations Commission regional office serving Montgomery County is the PHRC Philadelphia Regional Office located at 110 North 8th Street, Suite 501, Philadelphia, PA 19107. They can be contacted at (215)560-2496. You can find more information, and an online complaint form, at their website, www.phrc.pa.gov.

CONSUMER PROTECTION

The Pennsylvania Attorney General's Bureau of Consumer Protection 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 investigates and mediates consumer complaints. The Pennsylvania Attorney General's Bureau of Consumer Protection is 215-560-2414.

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 immediately;
- 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 a salesperson or company representative tells you that they cannot deal with your complaint, ask for 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 pre-printed form with the PA Bureau of Consumer Protection, Strawberry Square, 14th Floor, Harrisburg, PA 17120 or at www.attorneygeneral.gov. Their hotline number is 1-800-441-2555. Their Elder Abuse Unit can be contacted at 866-623-2137. You can also contact the local Philadelphia office at 21 S. 12th St., 2nd Floor, Philadelphia, PA 19107; telephone 215-560-2414.

Avoiding Scams

The PA Office of the 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:

- Living Trusts/Annuities
- "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.

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- “Contests” - Make sure they are not 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.
 - The IRS, Social Security Administration, or any state or federal agency will never contact you through the phone. They will always mail you to get in contact with you. If you receive a call purporting to be from a government agency, it is most likely a scam. If you are unsure, you can always hang up, independently look for the agency’s telephone number and call them to see if they are actually trying to reach you.
 - “Grandparent” scams usually involve a person calling pretending to be a grandchild in trouble. They pretend that the grandchild has been arrested, in an accident, stuck in a foreign country, or some other dire situation that usually involves the need for the grandparent to send some quick cash. The scammer usually also makes up a reason why the grandparent cannot tell anyone else about the situation (for example, “Please don’t tell mom and dad, I’m embarrassed”). If you are unsure if you are being scammed, you can always call your grandchild or relative to confirm.

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. You may also contact your local police department to make a report, and they can determine if criminal charges may be appropriate.

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 received; 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. Many solicitations for charitable donations are fraudulent, so do your homework before writing a check. Do not give out your credit card number to strangers.

Some precautions when you are called for donations:

- You may be on “the list” of charitable donors that is sold and to telephone marketers and junk mailers. Some of these solicitations are bogus.
- Ask for written information, including the charity’s name, address and telephone number;
- Before making a donation, 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. If that is important to you, ask for a receipt for the amount of your contribution;

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- Be skeptical if someone thanks you for a pledge you do not remember making. Phone solicitations can be fraudulent.
 - Always refuse high pressure or dire appeals. No legitimate organization should pressure you for your gift

Mail Fraud or Identity Theft

Mail fraud is illegal but it remains a perfect means for a con artist to try to trick you.

Do not respond to sweepstakes or contests that ask for money or your credit card. If you think you are a victim of mail fraud you can write or visit the postal service website at www.usps.com and submit a Mail Fraud Report, or call the US Postal Inspection Service at 877-876-2455, or call your local police department. If you think you are a victim of theft of your personal information or identity, you should call your local police department.

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. These are different times, and unfortunately, there are many scammers contacting senior citizens. Other tips include:

- Never agree to any offer until you have seen it in writing;
- Never pay for a prize over the phone. It is a definitely a scam;
- 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. Scammers call anyway.

Do Not Call Lists

Under this new law, those who tele market 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.donotcall.com) or by telephone: (1-888-777-3406, Option 2). 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.

Complaints about prerecorded calls can be filed with the FCC by calling 1-888-225-5322; 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, D.C. 20554. Pre-recorded calls are illegal if made to residential phone lines. Exceptions include calls from tax-exempt nonprofits or from companies with which you already have an established business relationship.

Online Scams

Online scams also are abundant in today's age. For the most part, the same rules apply so beware of being misled. Be wary of people you meet online, even if they seem well

intentioned and friendly at first. If they begin to ask you for money, even if they claim it's for the noblest of causes, that is a red flag. For additional information about online scams, contact the National Fraud Information Center, Consumer Assistance Service at 1-202-835-3323 or visit their website at www.fraud.org.

Resources

The U.S. General Services Administration Consumer Information Center publishes annually a comprehensive "Consumers Resource Handbook" 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. Additionally, the Consumer Financial Protection Bureau (CFPB) enacted by legislation in 2008, answers questions about consumer financial products or services, investigates, and addresses complaints. The telephone number is 1-855-411-2372 or contact www.consumerfinance.gov.

Grandparents' Custody and Visitation Rights

In the past, Pennsylvania custody laws permitted 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 considered 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 permitted visitation by grandparents where the parents of the child are unmarried. However, recently, the Pennsylvania Supreme Court declared this is no longer the law as that piece was declared to be unconstitutional. There is a movement to correct the law.

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 cases of a grandparent to include that the granting of rights should not interfere with the parent-child relationship.

Grandparents may also petition for either partial custody or 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 his parents.

A grandparent may want to gain full custody of a grandchild and can bring a case to court to do so 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 grandparent 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;
3. They must also have assumed the role and responsibilities of a parent to the grandchild for the last year, or due to the child being declared a dependent child by the court, or

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 this situation.

The purpose of this section is to protect grandparents 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.

In all cases in which the grandparent is seeking visitation or custody, the grandparent 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 under this law where the parents are not deceased, separated or divorced and the children never resided with the grandparent. Another exception to the rights of grandparents is that grandparents' rights do not apply if a person other than a stepparent or grandparent has adopted the child, even if the grandchild resided with the parent, a parent is deceased, or the parents are divorced or the parents are separated.

Recent cases in Pennsylvania have stated that grandparents have a favorable position among other third parties, (such as state agencies, or others), in custody disputes, and have standing to petition for physical and legal custody from a natural parent, providing the above conditions have been met.

At any stage, an agreement can be reached between the parents and grandparents, instead of proceeding further in the legal system.

Drivers' Licenses

Having a driver's 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 court's determination of incapacity 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 the Montgomery County Court of Common Pleas. 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 60 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 locally by 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. The Pennsylvania Department of Transportation Medical Reporting Unit can be reached at 717-787-9662 with questions.

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 small fee. You must bring proof of identification such as a birth certificate, your old driver's license and your Social Security card.

Handicap Parking

If you are disabled and need a special parking placard, you should 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; www.dmv.state.pa.us. In order to obtain a parking placard you must have a disability as defined by the Pennsylvania Department of Transportation (PennDOT) and be certified as having a disability by a physician.

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 _____, 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.

Personal Record Checklist:

- 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 and health insurance cards;
- Social Security records and communications;
- Bank account, brokerage and mutual fund statements (5 years);
- Business and partnership agreements;
- Stock option and pension fund agreements;
- Five years of complete financial records should be saved at all times;
- Save written verification of any closed accounts, liquidated certificates of deposit, and stock or bond sales, for the past 60 months (5 years);
- Save written verification of any gifts made in the past 5 years;
- Password and login credentials for online accounts and digital assets.

APPENDIX A: PUBLIC LIBRARIES IN MONTGOMERY COUNTY

Abington Free Library
1030 Old York Road
Abington, Pa 19001
215-885-5180

Roslyn Branch of the Abington Free Library
2412 Avondale Avenue
Roslyn, PA 19001
215-886-9818

Cheltenham Township Library System

Glenside Free Library
215 South Keswick Avenue
Glenside, PA 19038
215-885-0455

East Cheltenham Free Library
400 Myrtle Avenue
Cheltenham, PA 19012
215-379-2077

Elkins Park Free Library
563 East Church Road
Elkins Park, PA 19027
215-635-5000

La Mott Free Library
7420 Sycamore Avenue
La Mott, PA 19027
215-635-4419

Free Library of Springfield Township
1600 Paper Mill Road
Wyndmoor, PA 19038
215-836-5300

Horsham Township Library
435 Babylon Road
Horsham, PA 19044
215-443-2609

Huntingdon Valley Library
625 Red Lion Road
Huntingdon Valley, PA 19006
215-947-5138

Indian Valley Public Library
100 E. Church Avenue
Telford, PA 18969
215-723-9109

Jenkintown Library
460 Old York Road
Jenkintown, PA 19046
215-884-0593

Lansdale Public Library
Susquehanna Avenue & Vine Street
Lansdale, PA 19446
215-855-3228

Lower Merion Library System

Ardmore Free Library
108 Ardmore Avenue
Ardmore, PA 19003
610-642-5187

Bala Cynwyd Library
North Highland Ave. and Old Lancaster Rd.
Bala Cynwyd, PA 19004
610-664-1196

Belmont Hills Public Library
120 Mary Watersford Road
Bala Cynwyd, PA 19004
610-664-8427

Gladwyne Free Library
362 Righters Mill Road
Gladwyne, PA 19035
610-642-3957

Ludington Public Library
5 S. Bryn Mawr Avenue
Bryn Mawr, PA 19010
610-525-1776

Penn Wynne Library
130 Overbrook Parkway
Wynnewood, PA 19096
610-642-7844

Lower Providence Community Library
50 Park Lane Drive
Eagleville, PA 19403
610-666-6640

Narberth Community Library
Windsor Avenue
Narberth, PA 19072
610-664-2878

North Wales Memorial Library
233 Swartley Street
North Wales, PA 19454
215-699-5410

Pottstown Public Library
500 High Street
Pottstown, PA 19464
610-970-6551

Union Library Company of Hatboro
243 S. York Road
Hatboro, PA 19040
215-672-1420

Upper Dublin Public Library
805 Loch Alsh Avenue
Fort Washington, PA 19034
215-628-8744

North Hills Community Library
212 Girard Avenue
North Hills, PA 19038
215-884-4760

Upper Merion Township Library
175 W. Valley Forge Road
King of Prussia, PA 19406
610-265-4805

Upper Moreland Free Public Library
109 Park Avenue
Willow Grove, PA 19090
215-659-0741

William Jeanes Memorial Library of Whitemarsh Township
2391 Harts Lane
Lafayette Hill, PA 19444
610-828-0573

Wissahickon Valley Public Library - Blue Bell
Main Library, 650 Skippack Pike
Blue Bell, PA 19422
215-643-1320

Wissahickon Valley Public Library - Ambler
209 Race Street
Ambler, PA 19002
215-646-1072

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District Center
1001 Powell Street
Norristown, PA 19401
Main telephone: 610-278-5100 x0
Reference telephone: 610-278-5100 x2

Conshohocken Free Library
301 Fayette Street
Conshohocken, PA 19428
610-825-1656

Perkiomen Valley Library at Schwenksville
290 Second Street
Schwenksville, PA 19473
610-287-8360

Royersford Free Public Library
200 S. Fourth Avenue
Royersford, PA 19468
610-948-7277

Upper Perkiomen Valley Public Library
350 Main Street
Red Hill, PA 18076
215-679-2020

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APPENDIX B: CONTRIBUTOR BIOS

Michelle C. Berk, Esquire

Michelle C. Berk, Esquire is an Elder Law, Estate planning, Estates Administration and Disabilities law attorney at the Law Offices of Michelle C. Berk, P.C. She is proud to continue to Co-Author and Co-Edit the Montgomery County Elder Law Handbook since its inception in 2001.

Michelle is Chair of the Elder Law Committee of the Montgomery Bar Association and a former Director of the Bar Association. She also authors and edits the Guide to Legal Issues for Pennsylvania Senior Citizens published by the Pennsylvania Bar Association.

She is a member and presenter to the Pennsylvania Association of Elder Law Attorneys, (PAELA) and serves on its Legislation Committee, the Elder Law Institute and a member of the National Association of Elder Law Attorneys (NAELA), Academy of Special Needs Planners, (ASNP), National Organization of Social Security Claimants Representatives, (NOSSCR) and a Fellow of the Montgomery Bar Foundation.

She is a frequent presenter and provider of continuing education to seniors, the elder care community and organizations, Bar Associations, the Alzheimer's Association, geriatric social workers and nursing home administrators and civic organizations and a Mediation trainer. She is a member of the Board of the Montgomery County Office of Senior Services Advisory Council, Elder Access to Justice Roundtable, and Visiting Nurse Association. She received a B.A. in International Relations from the Maxwell School of Syracuse University in 1978 and her J.D. from Delaware Law School in 1981.

Liz Brendze, Esquire

Liz Brendze, Esq. is an elder law practitioner based in Narberth, PA. She established Liz Brendze Elder Law after experiencing firsthand the financial and emotional strain of caring for loved ones in declining health. A graduate of Brown University and University of Virginia School of Law, for many years Liz practiced law in other areas before turning to elder law. She now helps clients of moderate means make the most of the resources available for their own or loved ones' care.

Robert C. Gerhard, III, Esquire

Mr. Gerhard is a shareholder in the Montgomery County elder law offices of Gerhard & Gerhard, P.C. located in Jenkintown, Pennsylvania. He is the author of the law treatise Pennsylvania Medicaid Long Term Care 2021 (Seventeenth edition), the Pennsylvania Medicaid Long-term Care Lawsourc, and is co-author of Elder Law in Pennsylvania (Fifth edition). Mr. Gerhard is certified as an elder law attorney (CELA) by the National Elder Law Foundation and a fellow of the American College of Trust and Estate Counsel (ACTEC). He served as chair of the Montgomery Bar Association's Elder Law Committee for 15 years, and is past-chair of the Pennsylvania Bar Association's Elder Law Section. Mr. Gerhard is a member of the Montgomery County and Philadelphia Estate Planning Councils, the National Academy of Elder Law Attorneys, and the Pennsylvania Association of Elder Law Attorneys. He received his law degree from the Dickinson School of Law and earned his tax law degree from the Villanova University School of Law. Attorney Gerhard teaches numerous continuing education courses for attorneys and long-term care professionals. His articles can be found on www.paelderlaw.net.

Don Graves, RICP®, CLTC®, CSA

President of the Housing Wealth Institute

Adjunct Instructor at The American College

Business Development Leader - Mutual of Omaha Reverse Mortgages

Don is an adjunct instructor of retirement income at the American College of Financial Services where he created content for the Retirement Income Certified Professional (RICP) curriculum. Recently, he was recognized as one of the American College's 11 Retirement Income Alumni you need to read.

He also serves as a consultant and trainer for Retirement Funding Solutions—a subsidiary of Mutual of Omaha Bank—where he focuses on providing financial advisors with education on the newly restructured reverse mortgage and its potential benefits for clients in retirement.

He is also the president of the Housing Wealth Institute—creating educational content on Housing Wealth. His primary goal is teaching financial advisors how to have educated conversations about the reverse mortgage and how/when to appropriately incorporate them in retirement income plans. He accomplishes this through webinar/seminar trainings as well as his two books: *Housing Wealth – An Advisor's Guide* and *The Retiree's Guide to Housing Wealth*. He has been quoted in *Forbes Magazine*, featured on PBS-sponsored shows and is considered one of the nation's leading educators on incorporating housing wealth into retirement income planning.

Doreen L. Hespell

Ms. Hespell is an Administrator with the Montgomery County Office of Senior Services and has been with the Office for thirty four years. She received a Bachelors Degree in Social Work and works to bring awareness to the needs of Older Adults.

Rebecca A. Hobbs, Esquire, CELA

Rebecca A. Hobbs is a Principal with the law firm O'Donnell, Weiss & Mattei, P.C. with offices in Pottstown and Phoenixville, Pennsylvania. She focuses her practice on elder law, special needs planning, estate planning, estate and trust administration, and Veteran's benefits. Rebecca is Certified as an Elder Law Attorney (CELA) by the National Elder Law Foundation as authorized by the Pennsylvania Supreme Court. Rebecca received her Bachelor of Arts degree in English with a minor in Political Science from Eastern University. She received her Juris Doctorate from Regent University School of Law. She is licensed to practice in both Pennsylvania and New Jersey. Rebecca is an accredited attorney for the preparation, preservation and prosecution of claims for veterans' benefits before the United States Department of Veterans Affairs. In 2020, 2019, 2018, and 2017 Rebecca was selected for inclusion by the Pennsylvania Super Lawyers as a Rising Star in the field of elder law. As the National Director of ElderLawAnswers, she hosts a monthly Podcast and Webinar on elder law and marketing topics. She is an active member of the National Academy of Elder Law Attorneys (NAELA) and the Pennsylvania Association of Elder Law Attorneys (PAELA). She is an Editor on the Editorial Board for the NAELA Journal. As a member the Pennsylvania Bar Association (PBA), she serves as a Liaison for the Young Lawyers Divisor to the Elder Law Section Council. Rebecca is also a member of the Montgomery County Bar Association and is a Co-Chair of the Elder Law Committee.

B.J. Hoffman, CPA, CFE

B.J. Hoffman is a tax partner with Citrin Cooperman with over 25 years of experience in the areas of audit, tax, and litigation support. He serves clients in a wide range of industries, including closely held entities in staffing, health care, and franchising, as well as law firms. He devotes a substantial amount of time to the area of trust and estate income taxation, as well as international taxation. As a Certified Fraud Examiner, B.J. provides litigation support and forensic expertise to law firms. BJ Hoffman can be reached at bjhoffman@citrincooperman.com.

Eric Ladley, Esquire

Eric Ladley, Esq. is a Certified Elder Law attorney with Montco Elder Law, LLP. He focuses his practice in the areas of Estate Planning, Long-Term Care Planning, Estate Administration, and Guardianships. Attorney Ladley is certified as an Elder Law Attorney ("CELA®") by the National Elder Law Foundation. He also is accredited by the Veterans Administration to represent Veterans and can prepare, present and prosecute claims before the Department. Eric is a frequent presenter to the public and to organizations about topics related to Veterans Benefits, Estate Planning and Long-Term Care. Attorney Ladley graduated from George Washington University, with a major in Political Science and a minor in journalism, and from The Penn State Dickinson School of Law, where he worked in The Elder Law Clinic.

Michael L. Mauger Esquire

Mr. Mauger is a 2010 graduate of Elizabethtown College, where he received a B.A. in English, before earning an M.A. in English from West Chester University in 2013. He is a 2018 graduate of the Villanova University Charles Widger School of Law, and has held positions at the Clinic for Asylum, Refugee & Emigrant Services, the Office of Chief Counsel, Immigration & Customs Enforcement, and at a local private practice. Mr. Mauger has experience in estate planning & administration, business planning & corporate counsel, and real property counsel & litigation. He will focus his practice in corporate and commercial law at the Firm.

Mr. Mauger is a member of the American Bar Association, the Chester County Bar Association, the Federalist Society, the Philadelphia Lawyer's Chapter, the Montgomery County Bar Association, and the Pennsylvania Bar Association. He is also actively involved in the Pottstown Human Relations Commission and the Pottstown Borough Land Bank. He currently resides in Pottstown, PA with his family.

Susan E. Piette, Esquire

Susan E. Piette, Esq. is a Principal of the firm of Hamburg, Rubin, Mullin, Maxwell & Lupin, PC. Susan concentrates her practice in the areas of estate planning, elder law, guardianships and estate administration. She also regularly assists families with family wealth management and business succession planning by focusing on client values, inter-family dynamics, and the type of legacy they want to leave behind.

Every family is different, and Susan is committed to providing clients with unique estate planning services that meet their specific needs. She has guided hundreds of clients in creating customized estate plans with asset protection and complex distribution patterns. Her focus also includes a special emphasis on the senior population and those individuals with long term care Medicaid needs where she works diligently to appropriately protect their assets for their families from long-term care costs while qualifying them for Medical Assistance (Medicaid) long-term care benefits.

Dedicated to taking care of you and your loved ones to provide a comprehensive plan and peace of mind for you moving forward, Susan is passionate about her ability to help clients be protected and prepared. She is very compassionate and sensitive to the needs of her clients, regularly meeting with her elderly clients at their home or in their nursing home residence. Susan is known for thoroughly and sensitively counseling seniors and their families on frequently asked elder law questions such as “What happens if I outlive my money?”, “Can ‘they’ take my house?”, “How can I protect and preserve my assets for my children?”

In addition to her estates practice, Susan has extensive expertise in municipal law, land use, zoning and real estate matters, and she utilizes her background in contracts, regulations, compliance, negotiations and committee and board interaction to assist her clients in analyzing and implementing their estate and long term care plans. Susan received her undergraduate and law degrees from the University of Illinois.

E. Nego Pile, Esquire

E. Nego Pile received his J.D. from Temple University Beasley School of Law and his B.A. in Philosophy from Trinity College in Hartford, Connecticut. Prior to law school, Nego was selected by the Council on Legal Education Opportunity to be a Thurgood Marshall Fellow during the summer of 1995 at the University of Pittsburgh School of Law. Today, he provides legal counsel for clients throughout Pennsylvania and New Jersey primarily in matters relative to estate planning, elder law, special needs planning, personal injury law, and real-estate law.

An active member of the Pennsylvania and Montgomery Bar Associations, Nego recently completed a three-year term as Board Member of the latter group. He also volunteers with the Montgomery Bar Association Civics Education Program, which brings civics education to Norristown-area middle schools. Through the PBA Minority Bar Committee’s Community Outreach Subcommittee he regularly participates in panel discussions on various legal topics of significance to Philadelphia residents. Besides all this, Nego volunteers with the Montgomery Child Advocacy Project, providing legal representation to local children who are victims of abuse and neglect, and with the Philadelphia Volunteers for the Indigent Program, for which he has handled real estate and probate cases.

Lucy Qiu, Esquire

Lucy Qiu is the staff attorney at SeniorLAW Center’s Montgomery County Office. She focuses on seeking justice for victims of financial exploitation and abuse. She routinely represents seniors in protection from abuse cases and matters in orphans’ court, and advocates for victims in and outside the courtroom. Prior to SeniorLAW Center, Lucy worked in the Economics Crimes Unit at the Montgomery County District Attorney’s Office. Previously, Lucy has worked in commercial bankruptcy as an associate at Reed Smith. Lucy is a graduate of Boston College Law School and Columbia College.

Erin Saulino, Esquire

Erin Saulino, Esq. spent fifteen years in financial regulation. She started working at the Philadelphia Stock Exchange as an Investigator for Foreign Currency, Equity and Options Trading, quickly working her way up to Director of Options Trading Investigations. Later, she was in charge of Options Trading Investigations at NASDAQ PHLX, and then Associate Director in Options Regulation at FINRA, the Financial Industry Regulatory Authority. At

FINRA, she focused on best execution, Reg SHO, market access, customer complaints across the various options exchanges.

Continuing with her passion for helping people, Erin followed her dream of opening her own practice so that she could advocate for the those that could easily be taken advantage of, the elderly and those with special needs. As well as helping people prepare for getting older, and plan for the future; Erin is an advocate, a volunteer, she is outspoken for those issues which she cares about deeply. She is active with her children's sports teams, Girl Scouts, and local community issues.

Erin grew up in Lafayette Hill, and graduated from Plymouth Whitemarsh High School. She then went on to receive her B.A. from The George Washington University, and studied abroad in Aix-en-Provence, France for a year. While working at the Philadelphia Stock Exchange, she went to law school at Widener School of Law in Delaware. She is licensed in both Pennsylvania and New Jersey. Erin currently lives in Plymouth Meeting with her husband, two young children and their two basset hounds, Ovi and Jay Jay.

Anna Sappington, Esquire

Located in Jenkintown, Anna Sappington has been an active member of the Montgomery Bar Elder Law Committee since 2009 and has spoken before the Committee on topics relating to special needs trusts and guardianship. She practices in the areas of special needs planning, estate planning and administration, guardianship, and elder law. Anna is the author of the legal treatise Pennsylvania Special Needs Planning Guide: A Handbook for Attorneys and Trustees of Special Needs Trusts, currently in its third edition.

Margery J. Schneider, Esquire

Margery J. Schneider, Esq. is a sole practitioner in estate planning, estate administration, and fiduciary taxation located in Wynnewood, Pennsylvania. She is licensed to practice law in Pennsylvania and New Jersey. She regularly writes articles and presents seminars on estate planning and transfer taxation. She is a graduate of Wellesley College (B.A.), the University of Chicago (A.M.) the University of Michigan (M.B.A.) and Temple University Beasley School of Law (J.D., L.L.M. in Taxation).

Robert Slutsky, Esquire

Robert Slutsky, Esq. is the proprietor of Slutsky Elder Law with offices in Plymouth Meeting, Malvern and Radnor, PA, has practiced Elder Law since 1992. Mr. Slutsky advises clients on Long Term Care Planning, Medicaid and Asset Protection Planning, Guardianships, Wills, Trusts, Powers of Attorney, Estate Administration, Special Needs Planning, General Estate Planning and Real Estate Matters. In addition to his private Elder Law practice, Mr. Slutsky has been solicitor for the Montgomery County Office of Senior Services, the Area Agency on Aging for Montgomery County, since 1999. In addition to his private practice, Mr. Slutsky has also represented a multitude of non-profit and for profit elder services organizations. A 1992 graduate of the Dickinson School of Law, Mr. Slutsky resides in Plymouth Meeting with his wife and two sons.

IN MEMORIAM

Kathleen M. Martin, Esquire, CELA

Following a long battle, Kathleen M. Martin, Esquire, passed away on Sunday, June 28, 2020 during the preparation of this edition. Kathy was an esteemed and respected member of the Montgomery County and state-wide legal community, and a leader in Elder Law, as one of the first Certified Elder Law Attorneys in Pennsylvania. She also made a tremendous impact locally with her involvement in so many community organizations, such as Girl Scouts, YWCA, Berks Visiting Nurses, TCN Network, the Chester County Night School, and many more. Kathy has been a major contributor to the Elder Law Handbook since its inception and we acknowledge and appreciate her support of the Montgomery Bar Association and the Elder Law Handbook.

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Chaired the Montgomery Bar Association Elder Law Committee for over 15 years

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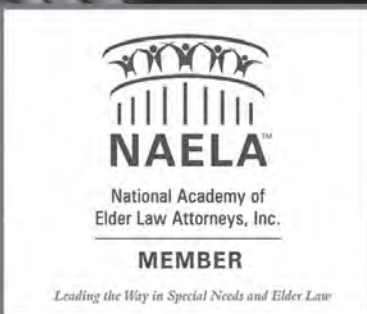
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