LEGAL GUIDES

by Middle Alabama Area Agency on Aging

M4A | ASSISTING ALL AGES AT ALL STAGES

DESIGNING A LONG-TERM CARE PLAN

This book was created in partnership with the | **Jan Neal Law Firm**

This publication was written by Jan Neal, Jan Neal Law Firm, LLC, for the Middle Alabama Area Agency on Aging/Aging and Disability Resource Center June 2017.

Middle Alabama Area Agency on Aging/Aging and Disability Resource Center can be reached at 209 Cloverdale Circle, Alabaster, Alabama 35007, (205) 670-5770, http://www.m4a.org.

Jan Neal can be reached at Jan Neal Law Firm, LLC, 207 N. 4th St., Opelika, Alabama 36801, (334) 745-2779 or 1-800-270-7635, http://janneallaw.com.

TABLE OF CONTENTS

The Bad News:
It Will Cost More Than You Think 1

The Good News:
There is Help..... 3

Medicare Helping
Care Recipients Stay at Home.....6

VA Helping
Care Recipients Stay at Home.....10

Long-Term Care Insurance Helping
Care Recipients Stay at Home.....13

Practical Considerations for Care at Home:
Income and Health Insurance Screening.....15

Reverse Mortgages.....16

Practical Considerations for Care at Home:
Family Paid Caregivers.....18

Practical Planning Considerations:
Authority Issues.....21

Independent Living in the
Long-Term Care Continuum.....22

Care in Assisted Living.....23

Care in a Nursing Home.....24

In Conclusion.....27

The Bad News:
It Will Cost More Than You Think

Long-term care is a necessary service for many senior and disabled persons, yet comprehensive and accurate information concerning long-term care can be difficult to find and is seldom comprehensive in nature. According to a May 2016 Forbes article by Richard Eisenberg entitled Americans' Estimates of Long-Term Care Costs Are Wildly Off, Eisenberg states:

"Here's a stunner: The average American underestimates the cost of in-home long-term care by almost 50%. That's just one of the surprising, if frightening, findings in the Genworth 2016 Cost of Care Study released today…"

A survey published last year, '2016 Long-Term Care in America', conducted by the Associated Press - NORC Center for Public Affairs Research at the University of Chicago, concluded that 38% of adults over the age of 40 mistakenly believe Medicare will pay for their future long-term health care needs. And according to Kaiser Commission on Medicaid and the Uninsured, only two out of ten older adults anticipate using Medicaid to finance their long-term care needs despite the fact that Medicaid is the largest public payer of long-term care services in the United States.

This booklet is being provided to address misconceptions concerning long-term care financing options and to address the lack of preparedness associated with finding suitable long-term care. It is hoped that timely information will prevent caregivers from being without accurate information to make informed choices. Often a caretaker finds himself or herself obtaining a crash course in long-term care planning at the very time a member of the family is desperately ill and in need of immediate long-term care arrangements. Needless to say, making arrangements in an emergency is less than optimal.

Becoming informed about long-term care resources before dealing with an emergency will make you an informed consumer when the time comes for you to make decisions about long-term care for yourself or someone for whom you care.

Long-term care is expensive. According to The Genworth 2016 Cost of Care Study, the median annual cost of Long-Term Care in the United States is as follows:

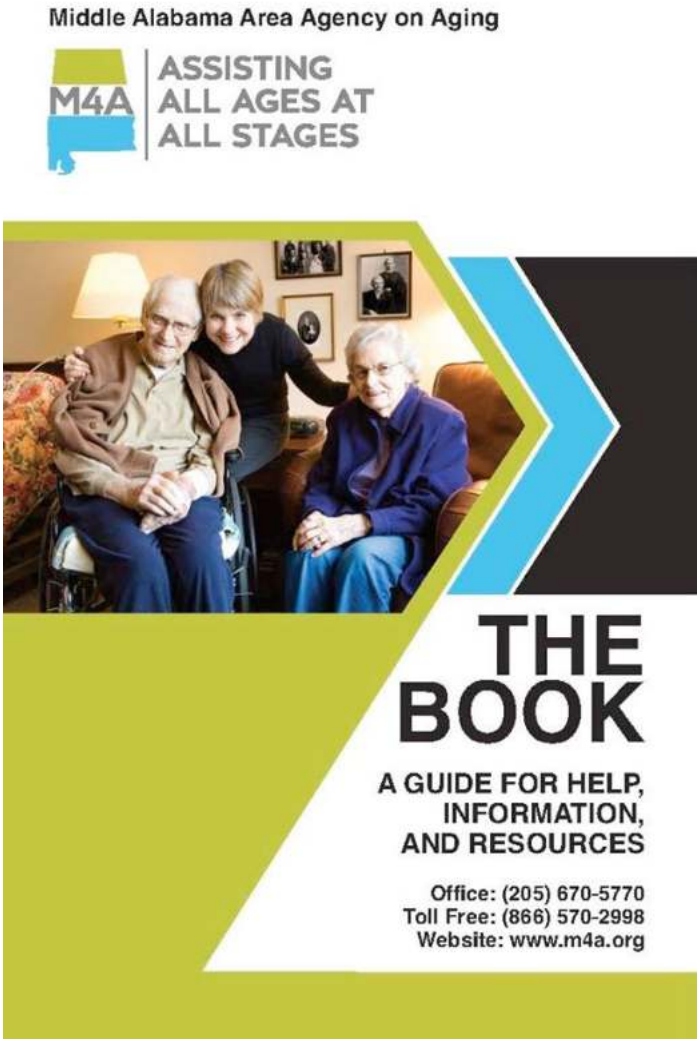
Adult Day Care	$17,680 per year/$1,473 per month
Assisted Living	$43,539 per year/$3,628 per month
Homemaker Services	$45,760 per year/$3,813 per month
In-Home Health Aide	$46,332 per year/$3,861 per month
Nursing Home (semi-private room)	$82,125 per year/$6,844 per month
Nursing Home (private room)	$92,378 per year/$7,698 per month

Alabama's costs fare slightly better than the average United States median, but are nonetheless staggering to consider:

Adult Day Care	$7,152 per year/$596 per month (if available)
Assisted Living	$34,800 per year/$2,900 per month
Homemaker Services	$36,612 per year/$3,051 per month
Home-Health Aide	$37,752 per year/$3,146 per month
Nursing Home (semi-private room)	$71,172 per year/$5,931 per month
Nursing Home (private room)	$75,192 per year/$6,266 per month

The challenge faced by many caregivers, especially those still working full-time, is accessing information about the range of prices in their individual communities. Prices and options can vary dramatically county to county, and there is no single state database of available prices. As an example, some counties have no adult day care services available at all, and the disparity between costs of assisted living can be dramatic, rendering families with no other option than to move a care recipient out of county and to other parts of the state. This is a stark reality that caregivers need to face before placements are needed. A tentative plan needs to be in the works here and now, not when a situation turns into a full-blown emergency. Understanding that an appropriate long-term care plan is often pieced together with multiple resources is critical, and that is why learning about the various options now is essential homework for a caregiver.

The Good News: There Is Help



The goal of this resource guide is to provide information to seniors and disabled persons and their caregivers about the various options for long-term care, how to qualify for benefits and programs to meet long-term care needs and where to find help while going through the process of arranging for long-term care. Here we will examine the different levels of long-term care and provide information on qualifying to receive and pay for these different levels of care.

The Alabama Department of Senior Services (ADSS) is the service and planning state agency that administers programs for senior citizens and people with disabilities. At the local level, The Middle Alabama Area Agency on Aging (M4A) is the designated Area Agency on Aging established to foster the development of a comprehensive and coordinated service delivery system for older adults living in Blount, Chilton, St. Clair, Shelby and Walker Counties. The

Area Agency on Aging is responsible for advocacy planning and provision of supportive services, nutrition services, and, where appropriate, the establishment, maintenance, or construction of multipurpose senior centers. Additionally, M4A administers a variety of home and community-based services to help older adults maintain independence with dignity in a home environment for as long as possible. Further, M4A is a designated Aging and Disability Resource Center (ADRC) formed to educate seniors and their families regarding services and benefits available to them by providing person-centered access to information through a single-entry point and help those seeking information about long-term services to plan for their care. M4A's ADRC provides access to options both public and private, thus helping seniors, persons with disabilities and caregivers make more informed choices regarding long-term care.

Recognizing that Long-Term Care Begins at Home

Long-term care begins at home for those who are able to make a plan of care to meet their needs while continuing to live in their own homes. The first step to accomplish this goal is to have a complete medical and social assessment to determine the services a person needs, and the second step is locating those services available through governmental programs at no additional expense as well as finding the money to pay for services that are not readily available through governmental programs. Persons who are able to remain at home usually piece together services from a number of sources, and this is why well-informed caregivers – family and professional – can make such a profound difference in the quality of life for a senior or disabled person. Since medical care is so expensive, no stone can go unturned to locate appropriate cost-free services and financial support for which a care recipient may qualify in order to pay for those services not otherwise provided through governmental programs.

Area Agency on Aging Services Helping Care Recipients Stay at Home

In approaching the challenge of funding long-term care it is important that every dollar saved or accessed is a dollar available to meet the needs of care. Often the challenge of meeting long-term care needs involves piecing together multiple programs and benefits to create a framework of comprehensive care. This is where the Area Agency on Aging becomes a vital partner in putting together a plan. Besides the long-term care assessment services provided by The Aging and Disability Resource Center (ADRC), M4A provides a number of services that can assist a person to stay in his or her own home.

Support For Caregivers: The Alabama Cares Program

The Alabama Cares Program is a federally funded program offering support to caregivers and grandparents who are raising their grandchild/children. Caregivers are supported with information on resources, education and services including Case Management, Counseling, Respite, and Supplemental Services such as incontinent supplies and nutritional supplements.

Medication Access:SenioRx

SenioRx helps eligible individuals 55 and older in applying for free and low-cost medications and nutrition supplements made available through pharmaceutical company programs. Eligible persons must have no prescription coverage, have chronic medical condition and meet certain income requirements. Wellness education is also provided. This program also provides drug coverage for persons eligible for Social Security Disability who have not yet met the 24-month waiting period before becoming eligible for Medicare.

Medicare Counseling: The State Health Insurance Program (SHIP)

SHIP provides individual insurance counseling, advice and assistance to Medicare beneficiaries regarding Medicare, Medicaid, long-term care insurance, supplemental health insurance, QMB, SLMB, QI and Medicare Part D prescription drug plans and low-income subsidies. During Open Enrollment comparisons are run to assist Medicare eligible people in selecting the best health and drug plan for their individual needs.

Home and Community Based Services: Medicaid Waiver Services

HCBS provide home and community-based services to older adults and persons with disabilities in their communities who are at risk of institutional care. Attention is given to client care, protecting the health and welfare of the client, and client free choices in providers and workers. Services available through this program include Case Management, Respite, Homemaker, Personal Care, Companion, Frozen Meals and Adult Day Health.

A Range of Services to Assist People in Need: Supportive Services

Supportive services are designed to provide a system of transportation; identification of potential clients; counseling, education, and representation and appropriate in-home assistance to clients. Programs available include Transportation, Outreach, Information and Referral, Homemaker, and Legal Assistance.

Health and Socialization Services: Nutrition Services

Nutrition services are provided to individuals 60 years of age or older who are eligible so that they receive Congregate, Home-Delivered and in few instances Frozen Meals five days a week in the planning and service area. In addition, center participants enjoy a variety of activities including exercise, educational programs, games, music, arts and crafts, volunteer opportunities, recreation, special events, and computer instructions in some locations.

Competitively Priced Services for Pay known as Private Pay Program:

A variety of services competitively priced for those who have the ability to pay are available through M4A. Through the Private Pay Program person-centered care plans are established to meet individual and family needs including case management, homemaker services, meals, respite care, and medication review.

Medicare Helping Care Recipients Stay at Home

To access the services described here, you may contact the Area Agency on Aging through agency contact information provided at the front of this guide.

It is first important to understand that Medicare provides very limited long-term care assistance. It does not provide 24-hour care at home, meals delivered to the home, homemaker services, personal care or anything more than short term institutional long-term care in very limited circumstances. So it is important not to hang your long-term care expectations on Medicare. Still Medicare does provide a number of services that, along with other services, can help a person remain at home. These services include Home Health Care, Hospice and durable medical equipment.

In order to qualify for Medicare Home Health Care Services a Medicare recipient must meet certain requirements. All of the following conditions must be met for Medicare to pay for Home Health Care Services:

1. A doctor must determine that the person needs medical care at home and must provide a plan of care;

2. The patient must need intermittent (part-time) skilled nursing care (other than only drawing blood), physical therapy, speech-language pathology, or continued occupational therapy services when the patient's condition is expected to improve in a reasonable time period;
3. The home health agency caring for you must be certified by Medicare as approved by the Medicare program to provide care; and
4. The patient must be doctor certified as homebound, or normally unable to leave home without help.

The "homebound" requirement does not mean that a patient must be unable to ever leave home in order to qualify for Medicare Home Health Services. It does mean that leaving home is not easy and takes considerable effort. A homebound person can go out for medical treatment or can leave home for short and infrequent non-medical reasons such as going to the hairdresser or church services. Further, a "homebound" person can leave home for adult day care and remain qualified for Medicare Home Health Care Services.

When the Medicare recipient meets the four threshold requirements listed above Medicare will pay for the following Home Health Care Services:

Skilled Nursing Care, which includes nursing services that can only be performed safely by a licensed practical nurse or a registered nurse. These services can be provided on a part-time or intermittent basis.

Home Health Aide Services, which are services performed by an aide to support nursing services and includes personal care services such as bathing, toileting and dressing. While these services are performed by an aide who is not a licensed nurse, these services cannot be provided unless the patient is also getting skilled nursing services or other therapy.

Physical Therapy, Speech-language Therapy, and Occupational Therapy for unlimited times so long as a doctor indicates that these services are needed. Physical Therapy Services include exercise to strengthen the body or to restore movement that has been lost or teach a patient how to perform needed activities such as moving from a bed into a wheelchair. Speech-language Therapy are services to help a person regain or strengthen the ability to speak. Occupational Therapy is e xercises to help the patient perform usual activities by himself or herself, such as helping a patient learn how to dress or perform personal care such as shaving. Occupational Therapy can continue when ordered by the doctor even after skilled care is no longer needed.

There is no cost for Medicare Home Health Care services under Original Medicare, but the cost for durable medical equipment is 20 percent of the Medicare-approved amount.

Hospice Services are a separate health care system provided to care recipients who are certified by their doctors to be terminally ill with a life expectancy of six months or less. The service is usually provided at the patient's home, and the patient or his legal representative must opt to receive hospice services rather than the regular Medicare services.

Medicare services are normally provided to cure a patient of illness; hospice services are non-curative medical and

support services designed to help the patient and his or her family move through the dying process. After the patient elects Hospice Services, he or she selects a Medicare certified hospice provider from a list of all providers in the area, and a care plan is developed. Hospice services may include home care and inpatient care as needed, and a variety of services not otherwise covered by Medicare. For instance, respite care is provided to allow family caregivers time to get away and recuperate. Hospice uses a team approach with the patient and family working with social workers, nurses, doctors, clergy and volunteers to collectively carry out the care plan to meet the needs of the care recipient. Of particular benefit for patients and families support, the hospice team can be contacted 24 hours per day, seven days per week. It is important that the patient and caregivers recognize that once Hospice Services are selected, the hospice provider directs the location of medical care, and the patient calls the hospice provider (e.g. the nurse in charge of direct care) even in emergencies for assistance in dealing with the medical issue.

The election to accept hospice services is an election for up to two 90-day periods followed by an unlimited number of 60-day periods, and the benefit periods may be used consecutively or at intervals. Regardless to how the benefit periods are used, the patient must be certified as terminally ill at the beginning of any benefit period.

Durable Medical Equipment (DME) is provided by Medicare Part B and includes reusable medical equipment such as hospital beds, walkers, wheelchairs, seat lifts, home oxygen equipment, etc. In order for Medicare to pay, the particular equipment needed must be prescribed as medically necessary by the care recipient's doctor, and the equipment must be provided by a Medicare certified supplier.

Often some home modifications in conjunction with durable medical equipment provided by Medicare is the assistance someone needs to be able to remain living independently at home. For instance, some home modifications such as tub rails, stair glides and wheelchair ramps are not considered durable medical equipment, but if resources can be found to pay for these upgrades, it may make the difference in maintaining one's life at home as opposed to moving to a higher institutional level of care.

In-patient psychiatric care is covered by Medicare, though treatment facilities may be hard to find. There is a geriatric psychiatric unit at L.V. Stabler Memorial Hospital in Greenville (Butler County), Alabama, and the Acute Care for Elders (ACE) Unit at University of Alabama at Birmingham (UAB), which provides a multi-disciplinary approach to treat seniors in crisis.

It can be very difficult to find help for patients with dementia, and often they end up in locked nursing home units because their family cannot care for them at home and do not know of any other options. The illusive nature of dementia is another part of the problem, and the lack of geriatric specialists in sufficient numbers results in seniors with very special needs often treated by general practitioners. Many general practitioners are good at treating the demented patient, but nothing can compare to specialized training with specific care plans created by psychiatrists, nurses and social workers who specialize in geriatric care for patients with cognitive deficits. Not all dementia is Alzheimer's Disease; other physical illnesses and medication interaction can cause dementia.

The L.V. Stabler geriatric psychiatric program's goal is to help patients return to as much independent living as possible. This is accomplished by in-patient structured plans of individual counseling, medication evaluation, group therapy, coordinated activities and family support. The 13-bed facility is for adults 55 years of age and older and admission is voluntary. Patients must meet clinical admission criteria. For more information call (334) 383-2247.

The Acute Care for Elders is a growing movement to address stabilizing and getting the senior back on the road to progress. The UAB ACE is a model used to reduce adverse outcomes in older adults with frequent interdisciplinary team rounds. The program is designed to recognize and manage geriatric syndromes and to improve processes of care, prescribing practices, physical functioning and patient and provider satisfaction. Analyses of ACE programs show that ACE units help reduce rates of restraint use and institutionalization.

To locate other geriatric in-patient treatment facilities, consult with a geriatric specialist for recommendation and referral.

VA Helping Care Recipients Stay at Home

The Veterans Administration offers benefits specifically for veterans and their dependents to help them cover the cost of attendant care. The pension benefits discussed here are either specifically tied to the veteran's or his dependent's low income or limitations in handling activities of daily life and need for help accomplishing those activities and IS NOT dependent upon service-related injuries for compensation. While these benefits are available for veterans and their dependents at home, in assisted living facilities and in nursing homes, information concerning these benefits is included here where we are examining resources to help a care recipient obtain the care he or she needs first at home.

Special Monthly Pensions are for veterans who served for 90 days or more during active wartime who were honorably discharged. They may qualify for benefits if their health care expenses leave them without adequate resources to live. Surviving spousal benefits are also available when the veteran is deceased. There are several types of benefits including New and Improved Pension (NIP), Housebound Benefits (HB) and Aid and Attendance (A&A).

Income and Asset (Net Worth) tests are performed to determine eligibility.

To qualify for New and Improved Pension (NIP) the veteran must have low income.

To qualify medically for Housebound Benefits (HB) the veteran or surviving spouse must need regular assistance, but does not have limitations as great as those who would qualify for Aid and Attendance.

To qualify medically for Aid and Attendance (A&A) the veteran or surviving spouse must need the assistance of another person to perform daily tasks, such as eating, dressing, undressing, taking care of bodily needs, etc.

To calculate income, qualifying medical expenses (exceeding $645 for NIP and $845 for HB and A&A) are deducted from the veteran's (or spouse's) income to calculate adjusted income. As an example, in 2017 a veteran with no dependents applying for Aid and Attendance who does not have $1,794.25 per month in adjusted income may be eligible for an amount to bring his or her income up to $1,794.25, referred to as Maximum Annual Pension Rate (MAPR). There are different minimum eligibility standards for the different categories of benefits and based on whether the veteran is alone or has dependents, widows, surviving children, etc., but that is how the income calculation works: Income minus qualifying medical expenses = adjusted income which is subtracted from the MAPR to determine the amount the veteran or spouse is eligible to draw to bring his or her income up to the MAPR.

Other MAPR monthly rates include:

Veteran without dependent	$1,075.59
Veteran with one dependent	$1,408.50
Housebound veteran without dependent	$1,314.42
Housebound veteran with one dependent	$1,647.50
A&A without dependent	$1,794.25
A&A with one dependent	$2,127.08

In January 2015 the Department of Veterans Affairs (VA) announced changes coming to agency regulations for calculating eligibility for these pensions that would adopt a new method of calculating countable Assets (Net Worth) and imposing penalties for transferring assets out of the veteran's name within three years of application. At this time, it appears that this regulation change has not been enacted, but the final rule was projected to be published in April 2017. When or if it is enacted, it will result in sweeping changes that will make the VA pension application process look more like Medicaid.

Currently to calculate Assets (Resources aka Net Worth) the VA has allowed the applicant to have $80,000 or less to qualify with the residence and automobile excluded, and transfers of assets creates no penalty.

Under the potentially more stringent Assets (Net Worth) rule that may become operable at any time, applicants who give away their property within three years of applying for benefits will be penalized. In other words, there will be a three year look back, and transfers can result in a penalty lasting as long as ten years, meaning that the veteran cannot draw benefits for the length

of the penalty. To calculate the penalty the amount transferred within three years of application will be divided by the monthly MAPR in effect at the time of the application to arrive at the number of months of penalty. The penalty will begin to run at the time of the transfer. Further, under the new rule allowable Net Worth will line up with Medicaid's community spouse protected amount of $120,900 (in 2017) and is calculated by adding all the resources not excluded plus annual adjusted income for the year. Under the new rule the principal residence and a "reasonable amount of land" around the house capped at two acres is excluded. As under the old rule, the automobile and household items would not count as long as they, too, are considered "reasonable."

Under the new rule basic living expenses such as food, clothing and shelter can be deducted from the year's income that is added into the Asset calculation to arrive at Net Worth.

To Apply: Contact the county VA Officer where the care recipient lives and ask about how the VA is currently calculating Assets particularly if property has been given away in the last three years. To locate your county VA Officer go to http://www.va.state.al.us/county_select.aspx.

Long-Term Care Insurance
Helping Care Recipients Stay at Home

Long-term care insurance was originally designed to protect purchasers from the catastrophic expense associated with long-term care in nursing homes. However, over time the public has clearly voiced a preference for home care over care in an institution. In response to that preference, long-term care insurance companies now offer a variety of in-home services to help individuals pay for services to assist a person with activities of daily living. In fact, most policies sold today are comprehensive policies that cover services in different long-term care settings including at home.

With the majority of policies sold today being comprehensive policies, they typically cover care and services in a variety of long-term care settings to include at home skilled nursing care, occupational, speech, physical and rehabilitation therapy, and personal care. Some policies also cover homemaker services, such as meal preparation or housekeeping as well; adult day health care center; hospital and respite; assisted living; and other residential care facilities and nursing homes.

Consumers should be aware of limitations on coverage, such as prior hospitalization requirements, and pre-existing condition exclusions. It is important to thoroughly understand what is being purchased, so a good deal of homework is involved in examining long-term care policies. Be sure that the services purchased are not services that are already covered by Medicare.

There are incentives in the form of resource protection offered by Medicaid to a person who does purchase long-term care insurance.

For policies issued prior to March 1, 2009, Medicaid will not consider resources of a person equal to the amount of long-term care insurance benefit payments in determining Medicaid eligibility when the long-term care insurance policy has paid at least the first three years of nursing home care and/or home health care services.

For policies issued on or after March 1, 2009, Medicaid will not consider resources equal to the amount of benefits paid (dollar-for-dollar) by an Alabama Long-Term Care Insurance Partnership Policy (Partnership Policy) for long-term care services received in determining Medicaid eligibility and in estate recovery. The amount to be excluded will be above and beyond the standard resource exclusion provided under the Medicaid State Plan. To qualify for this exclusion, the individual must be covered by a Partnership Policy that has been certified by the Alabama Department of Insurance as a policy that covers a person who was a resident of Alabama when coverage first became effective under the policy. Medicaid will provide reciprocity with respect to long-term care insurance policies covered under other state.

Adult Day Care Helping Care Recipients Socialize and Caregivers Work

Adult day care (ADC) provides seniors who need supervision (e.g. someone with Alzheimer's) with supervision and care in a structured environment during daytime hours allowing the primary caregiver the freedom to work or take a break from caregiving duties. Adult social day care (ASDC) provides basic health services, meals and activities while adult day health care (ADHC) provides intensive health services for more fragile persons who would otherwise need skilled nursing care. Some centers offer both types of care. Alzheimer's Day Care (ADC) is also available at some facilities.

The average cost of adult day care is $758 per month in Alabama, and Medicare does not pay for this service. In Alabama, Medicaid Home and Community Based Waiver Services pay for adult day care when available, but without qualifying for that service which may have a waiting list. Contact M4A to obtain more information on the possibility of obtaining adult day care through Medicaid Waiver services.

Practical Considerations for Care at Home: Income and Health Insurance Screening

The cost of staying at home can be very expensive, and it is not unusual for a caregiver to be called upon to supplement the income of a care recipient. While many resources do exist to help, for an individual receiving long-term care at home, there are often critical services that must be purchased. An example is sitter services for the care recipient suffering from dementia. Home health care agencies can provide this service, but the cost is high, averaging around $16 - $19 per hour. Another shortage some care recipients face is insufficient funds to pay for prescription drugs, even with full drug coverage through Medicare Part D. The potential income shortfall is a compelling reason why locating any benefits for which the care recipient might qualify is an important part of developing a long-term care plan.

Veterans can receive health care through the VA system, so if funds are tight for a veteran, this is a resource to examine.

While there are many programs designed to supplement the income, or reduce the cost of essential needs for seniors, finding, understanding and applying for benefits can be complicated. Often caregivers feel like they do not have time to provide personal care because they are drowning in paperwork associated with efforts to obtain benefits for their care recipients.

Apart from the services offered at the Area Agency on Aging previously discussed there are multiple public benefit programs available to seniors and disabled persons with lower incomes or particular health conditions. Programs to supplement income and health care costs exist through accessed through the M4A Aging and Disability Resource Center. In particular there are Low Income Subsidies and Medicare Savings Programs designed to help lower income Medicare recipients pay for the cost of health care. The SHIP program can provide eligibility screenings.

Reverse Mortgages

Another source of income to consider is a reverse mortgage as a way for the person who needs care to convert the equity in his or her home to cash. A reverse mortgage is similar to a traditional equity line of credit, but with some big differences. Namely, the homeowner takes money against the home but does not have to repay the loan so long as he or she lives in the home, pays the property tax and insurance and keeps the property from deteriorating. The lender pays the homeowner in a lump-sum, monthly payment of a line of credit, and there are no restrictions on how the funds can be used. There are multiple types of reverse mortgages, but the type discussed here is a Home Equity Conversion Mortgage (HECM) insurance by the federal government.

Persons age 62 and older can qualify for a HECM, and if the home is jointly owned, all owners must 62 before the property is eligible to use a HECM. Unlike a traditional mortgage, when a homeowner applies for a HECM, he or she will not be required to provide an income or credit history to get the loan, and no monthly payments are due from the homeowner to the lender. Instead the lender makes payments at a given interest rate. Over time the loan amount increases, and when the last homeowner/borrower dies, sells the home or permanently moves out, the loan becomes due and payable. In that event the heirs of the homeowner can pay off the debt or the lender will sell the property to get back the money that was loaned.

The income from a HECM is non-taxable, but care needs to be taken that income not interfere with need based income such as SSI. A person who qualifies for SSI can have a HECM, but only if the payment is spent during the month it is received. If money remains in the name of the SSI recipient the following month, it becomes a resource. If it exceeds $2,000 for an individual or $3,000 for a couple, SSI eligibility will be lost.

It is very important that a person fully understand how a reverse mortgage works before getting one. The HECM is offered by private lenders but are government insured. This means that if a person outlives his life expectancy or the value of property drops, the person will continue to receive the payments promised, and the proceeds recoverable by the lender is limited to the home alone. To be insured by the Federal Housing Administration (FHA), the borrower must pay, as part of the loan financed, an insurance premium along with an origination fee, servicing fees, closing costs, etc. In order to fully comprehend what expenses will be charged against the property and eventually taken by the lender, the federal government requires the HECM borrower to meet with a reverse mortgage counselor. The cost of that consult is rolled into the loan along with the other upfront fees.

The reverse mortgage market is constantly evolving at this time due to the shifting home values, so it is very important that consumers interested in these types of loans to obtain current information before entering the market to apply for a HECM. Additional information about reverse mortgages is available online to the web site of The American Association of Retired Persons (AARP) at:
https://assets.aarp.org/www.aarp.org_/articles/money/financial_pdfs/hmm_hires_nocrops.pdf

Practical Considerations for Care at Home: Family Paid Caregivers

When a care recipient makes arrangements to receive the care he or she needs at home, that care should come with a realistic consideration of future potential declining health and the need for institutional care. With that in mind, it is important to keep in mind that should nursing home care be needed, the long-term care patient will most likely need to qualify for Medicaid to pay for institutional care. Since Medicaid will look back five years to examine the applicant's financial transactions, there are issues of which the care recipient and caregivers need to know BEFORE nursing home Medicaid is needed. For each $5900 worth of uncompensated value given away (as of 2017) within five year of Medicaid applications, a transfer penalty of one month of ineligibility may be imposed. This can result in terrible circumstances for a senior needing nursing home care, having less than enough resources to pay for care and ineligible for Medicaid.

Often families work together to keep a spouse and/or parent at home, and, in so doing, family members may provide a large amount of the caregiving services or hire someone to provide intermittent services. A frequent example is bathing, dressing, toileting, cooking, help with eating and sitters to protect a dementia patient from wandering. Caregivers need to understand

that Medicaid has highly specific rules about payments made for personal care services, requiring a legally enforceable written agreement for personal care services to be provided in exchange for anything of value. If a legally enforceable written agreement is not executed, money paid for personal care services is presumed to be a transfer of assets subject to a transfer penalty. To avoid a transfer penalty the following requirements must be met:

- At the time of the receipt of the services, the services were recommended in writing and signed by the applicant's physician, as necessary to prevent the admission of the applicant to a nursing facility and the services may not include the providing of companionship and related services;
- At the time of the receipt of the services, the applicant was not residing in a nursing facility;
- At the time of the receipt of the services there already existed a written and signed agreement executed between the applicant and provider for the specific service(s) rendered; and
- At the time of the receipt of the services, the transfer of the consideration (money and/or property) to the provider relative occurred.

The agreement required by Medicaid must fully describe the type, frequency and duration of the services being provided to the applicant in such a way that they can be documented when provided; and the amount of consideration (money and/or property) being received by the provider/relative. Further, the payment for services must be comparable to the usual and customary rates in the local area. Services provided must be documented with time sheets and attendance logs, and payment to reimburse a care provider for purchases must be proven by receipt.

While Medicaid can enforce this rule for any paid caregiver, the agency is more likely to enforce the rule if the care provider is a paid family member. In some situations, Medicaid will accept a certified statement by a paid non-family caregiver. It is the best practice to always take this rule seriously and contact Legal Assistance services if payment will be made to any caregiver since without such an agreement there is a possibility that the eventual Medicaid application within five years will result in transfer penalties.

It is not at all unusual for caregivers in their 60's to be providing care for parents who are in their 80's or 90's. Often caregivers have not reached full retirement age, and if they have taken early retirement at age 62, caregiver earnings my result in loss of retirement benefits. Full retirement for those born between 1943 and 1954 is age 66; and for those born in 1955-1957 times ranging from 66 years and 2 months to 66 years and 6 months. The earned income limit is $16,920 (in 2017). For caregivers who have not reached full retirement age in 2017, their Social Security Retirement benefits will be reduced one dollar for every two dollars earned over $16,920 ($1,410 per month). For caregivers who do reach full retirement age during 2017, Social Security will deduct $1 for every $3 earned above $44,880 until the month the caregiver reaches full retirement age. This is an important consideration for the paid caregiver in long-term care planning. After reaching full retirement, there is no reduction of benefits for earned income.

When planning for long-term care for parents this Social Security earned income reduction can be a major consideration.

If a senior or disabled person resides in the home of another, and money is paid to the caregiving family, it is important to document any money paid as either caregiving charges with a written caregiver agreement in place and/or to charge an amount for room and board in the form of a pro-rata share of mortgage, utilities, groceries, etc. Do not just pay an arbitrary amount for care.

Often grown children will pay expenses for parents such as moving expenses. Logically it seems that the children could reimburse themselves for those expenses. Medicaid will consider repayment of those expenses a gift subject to a transfer penalty unless a promissory note evidences the debt. Do not pay expenses for a care recipient without documenting the debt if you want to be reimbursed.

Another financial problem caregivers frequently run into is providing explanations to Medicaid for checks written for cash. Seldom do individuals keep receipts for cash spent. Keep records for cash purchases when possible, and keep checks written for cash to a minimum.

Practical Planning Considerations: Authority Issues

Authority issues can sneak up on a caregiver. He or she can move right along performing the jobs that need to be done, and, suddenly, out of nowhere, an insurmountable problem appears. Property has to be sold or a lien given to Medicaid or an income trust created to qualify a care recipient for Medicaid. If no one has legal authority to perform these acts, that legal authority has to be acquired. If the care recipient has dementia or is too sick to execute a power of attorney to name a legal representative, the family has no choice but to file for a guardianship or conservatorship in the probate court where the care recipient lives. The process of having a court appoint a guardian (to make decisions over the body) and a conservator (to make decisions about the finances) can be costly because the petitioner must pay a filing fee, attorney's fees, publication fees and purchase a bond. While these expenses can be reimbursed from the estate of the care recipient, often there are not enough resources in the estate of the care recipient. Further compounding this problem is the fact that once a guardianship/conservatorship is established, the probate court retains jurisdiction over the care of the person who needs protection, and the guardian and conservator must account to the court every three years to show all money received and spent on behalf of the person who needs protections, and the bond required by the court has to be paid every year until the guardianship/conservatorship is terminated by the court – usually at the death of the individual being protected.

All of the complications of the guardianship/conservatorship system can be avoided by execution of an advance directive. This is the reason why one of the most important things a care recipient can do is to make appropriate advance directives so that the person of his or her choice will have necessary authority to handle the business and health care decisions for the care recipient without depleting the resources of that person's estate when the resources are needed to pay for long-

term care. A durable power of attorney is a document that can name a person to handle financial decisions, routine medical decisions and end of life decisions. The person making a durable power of attorney can name the same person to handle all functions, or he or she can name different people to handle the different functions. In that manner, the durable power of attorney is an extremely flexible document that can be crafted to each individual person's wishes.

Many people have living wills. A living will is a document that addresses end of life decisions when a person's condition is terminal or he or she is permanently unconscious. The living will has been amended by law to be called an Advance Directive for Health Care, and it is longer and permits the maker to name a surrogate decision maker or not. These powers can also be written into a durable power of attorney. The Advance Directive for Health Care also allows the maker to designate specific care he or she might want if his or her condition should be terminal or if he or she should be permanently unconscious. The living wills created prior to the emergence of the Advance Directive for Health Care remains valid even though all these old documents do is inform the physician to allow the patient to die with dignity and not be kept alive by artificial means.

Independent Living in the Long-Term Care Continuum

Often seniors will opt to downsize, sell their home and live independently in independent senior living facilities where recreation and community are focused values. Usually such facilities offer outstanding activities, and neighbors close in age, but no direct assistance other than the services previously described herein through the Area Agency on Aging and Medicare or privately purchased. There are multiple types of independent living communities, but these facilities share the common feature of limiting resident admissions to age 55 and older. The various types of independent living communities include subsidized senior housing, senior apartment complexes, retirement communities and continuing care retirement communities. Recognize that persons living in these types of communities still have ultimate control over their own lives and maintain independent home environments. Home based services can be provided in these communities just like in any home environment.

Subsidized senior housing is subsidized by the U.S. Department of Housing and Urban Development (HUD) and are available for low-income seniors. A person may move to subsidized senior housing to pay rent based on his or her income and to eliminate the high cost of living in a home they have had for many years that now is too hard to keep up. The senior would enjoy lower utilities, elimination of yard maintenance, homeowner insurance and property tax. The savings would free up funds needed to be able to pay for long-term care assistance with activities of daily life.

Senior apartment complexes can include community services as part of the rent charged. These services might be recreational programs, transportation and meals served in a communal dining room. While these services are not medical assistance, sometimes the community services are just the small amount of help a senior needs to continue to be able to live independently.

Retirement communities are usually considered single-family housing units of some description. The units might be condominiums, townhouses or single-family houses. While there is no defined requirement, retirement communities are generally places where individuals purchase a unit and pay additional monthly fees to additional services such as recreation, clubhouses, pools, etc.

Continuing Care Retirement Communities (CCRS's) are facilities that provide access to independent living, assisted living and skilled nursing facilities in one community. As a person ages and needs more care he or she can move to the next level. This can be a good arrangement for a married couple so that each can receive the care he or she needs while still living close together.

Care in Assisting Living

Assisted Living Facilities are medically based care communities. From the outset, it is important to recognize that Medicare and Medicaid do not pay for assisted living facilities and there are some restrictions on who can live in these facilities. For many years assisted living facilities were not regulated in Alabama, but regulations were passed in 2001 following several well publicized cases of injury and death to persons living in Alabama assisted living facilities. The Alabama Department of Public Health is the agency responsible for regulating these facilities in Alabama.

Alabama regulations recognize two levels of care. They are the traditional Assisted Living Facilities (ALF) and Specialty Care Assisted Living Facilities (SCALF). Both levels offer assistance with activities of daily living, medications, community meals and help with bathing or dressing if needed, but the SCALF level of care has staff trained to work with residents who suffer from dementia, and they have architectural features to assure the safety and health of the residents who have diminished capacity. There are 306 assisted living facilities licensed in Alabama with 97 of those licensed for SCALF services, representing approximately 32 percent of Alabama's assisted living facilities licensed to provide SCALF services to some 2,720 residents.

Assisted Living Facilities (ALF's) must evaluate whether or not the facility can meet the needs of those applying for admission, and, generally, the ALF resident should not be "cognitively impaired" to where he or she cannot care for his or her own needs or direct others to do so when inability to care for his or her own needs arise from physical disability. Further, the ALF r esident should not be a person with a level of dementia at risk for wandering since ALFs are not required to be locked facilities. Residents must be able to understand the unit dose medication system in use by the facility in order to live in an ALF.

Many people who would like to receive care in an ALF or SCALF cannot live there due to the cost of care not covered by Medicare or Medicaid. The cost of ALF and SCALF varies from facility to facility, and SCALF is more expensive than ALF, but as a general rule of thumb, ALF/SCALF care is half to 60 percent of the cost of nursing home care. The state median charge is approximately $2,900 per month for ALF.

There are a number of assisted living facilities in the M4A region. For more information about what is available, contact the M4A Area Agency on Aging.

Care in a Nursing Home

It is never too early to begin exploring the options to pay for nursing home care because nursing home care frequently catches families by surprise. According to Medicaid, the average cost of nursing home care in Alabama in 2016 was about $5900 per month, and the cost far exceeded that amount in urban areas of the state. It is not unusual to see care over $6,000 per month. At that rate a person will privately pay over $70,000 per year for nursing home care.

Medicare covers only a limited amount of nursing home care and only if a person meets specific requirements. Medicare will pay for the first 20 days of care provided the patient has a three- day prior hospitalization and is admitted to a nursing home within 30 days and requires skilled care. While the Medicare literature will indicate that Medicare pays for up to 100 days of nursing home care, the truth is that if the patient continues to have skilled care ordered by the doctor, on day 21 a co-payment of $164.50 per day begins. That means that in a month even with Medicare paying, the patient will pay over $5000 per month in co-payments. Under the best of circumstances Medicare will pay for only 20 full days of care and another 80 days if, and only if, skilled care continues to be ordered, and will pay for only about 1/3 of the cost of care while the patient pays $164.50 per day. After 100 days Medicare pays nothing.

As you can see, qualifying for Medicaid to pay for nursing home care quickly becomes an important concern for those who will need nursing home care on a long-term basis.

In order to qualify for Medicaid to pay for long-term care a person has to be medically sick enough and have income and resources low enough. The income limit in 2017 is $2,205, and if income exceeds $2,205 a Medicaid Qualifying Income Trust (MQIT) can resolve the problem of excess income. The resource limit is $2,000, but recognize that there are some types of property that can be excluded. For a married couple Medicaid considers what the couple jointly and individually owned on the “snap-shot” date (when the person entered long-term care, which might be when he or she entered a hospital from which a placement was made to a nursing home). The home is protected for the spouse who will remain at home, and besides the home, he or she is allowed to keep the first $25,000. If joint assets exceed $50,000, the spouse who will remain at home can keep one-half up to a limit of $120,900.

After Medicaid is awarded, a budget is prepared to determine the personal liability the resident must pay from his or her income. The resident can keep $30 for his or her personal needs allowance, enough money to pay for unreimbursed insurance, and is allowed to send home to the spouse at home enough of his or her income to bring the income of the spouse at home up to $2,003. The rest of the resident’s income is paid to the nursing home as his or her personal liability, and Medicaid pays the difference in that amount and the nursing home charges.

Another option for nursing home care is the Veterans Administration that has a federal and state program addressing health care needs of veterans. There are four VA nursing facilities in Alabama: Bill Nichols State Veterans Home in Alexander City; William F. Green State Veterans Home in Bay Minette; Floyd E. "Tut" Fann State Veterans Home in Huntsville; and Col. Robert L. Howard State Veterans Home in Pell City. In the VA system State VA and Federal VA contributes toward the rate leaving the veteran responsible for the remainder. Actually, this VA system is highly affordable nursing home care option after the state and federal government provide subsidies.

The VA is required to provide nursing home care to any veteran who needs nursing home care because of a service-connected disability, has a combined disability rating of 70 percent or more or has a disability rating of at least 60 percent and is deemed unemployable or has been rated permanently and totally disabled. Other veterans in need of nursing home care will be provided services if resources are available after the priority groups are served.

Information about nursing homes and their performance levels can be found at the www.medicare.gov web site with a tool called Nursing Home Compare. It can be located at http://tinyurl.com/2d7alxc.

It is a violation of federal law to require the family of patients to sign up to be guarantor on the bill. To protect him or herself from personal liability, the individual should sign all documents, particularly the nursing home contract, as follows: Mary Smith by John James, power of attorney. The caregiver should never sign just his or her own name.

For help with Medicaid issues you may contact the Area Agency on Aging and ask for help from the Legal Assistance services provided by the Area Agency on Aging.

Patients with dementia are an isolated population in nursing facilities out of necessity. If a patient wanders, for he or she to be protected, placement is appropriate only in a nursing home that has a locked unit to prevent the patient from wandering out of the facility and risking injury.

A very important service for the patient and family members is the Long-Term Care Ombudsman, an individual who investigates complaints from patients and their legal representatives, concerning care in nursing home facilities. The Ombudsman for the Middle Alabama Area Agency on Aging can be contacted for assistance at the agency contact number provided at the beginning of this resource guide.

In Conclusion

Planning for long-term care requires a great deal of knowledge about different resources to piece together a plan that will work for a particular care recipient in a particular location. It is hard work, but you are not alone. According the U.S. Census Bureau:

"Between 2012 and 2050, the United States will experience considerable growth in the older population. In 2050, the population aged 65 and over is projected to be 83.7 million, almost double its estimated population of 43.1 million in 2012."

And according to The Population Reference Bureau:

"The number of Americans ages 65 and older is projected to more than double from 46 million today to over 98 million by 2060, and the 65-and-older age group's share of the total population will rise to nearly 24 percent from 15 percent."

And

“The aging of the baby boom generation could fuel a 75 percent increase in the number of Americans ages 65 and older requiring nursing home care, to about 2.3 million in 2030 from 1.3 million in 2010.”

And

“Demand for elder care will also be fueled by a steep rise in the number of Americans living with Alzheimer’s disease, which could nearly triple by 2050 to 14 million, from 5 million in 2013.”

These are staggering numbers that reveal how important long-term care issues are now and how the importance of these issues will grow in the coming decades. Imagine a population consisting of almost one-fourth needing long-term care. Imagine, at a bare minimum, one child/grandchild and his or her spouse for each senior needing care. Even with such a modest projection, over half of the population would be struggling with long-term care issues by 2060.

While finding long-term care now is an urgent need for those with aging and disabled family members, eventually this need will be shared by an even greater portion of the population. Home and community based care will likely become more necessary as greater numbers of seniors need assistance with activities of daily life while governmental budgets shrink. This is the time to learn as much as possible, work together, coordinate resources and plan creatively for the challenge of today and tomorrow.

Are you or someone you care about residing in a nursing home but want to live back in the community?

Alabama's *Gateway to Community Living* program allows eligible people currently living in a nursing home to move back to their community and receive the services and support they need at home.

Let us help you take the first steps to regaining your independence.

GATEWAY
to community living

Contact your local Area Agency on Aging at
(800) AGE-LINE or 1-800-243-5463

Gateway to Community Living is an initiative of the Alabama Medicaid Agency.