



The Florida *Long Term Care & Nursing Home* Answer Book™

2016 Brevard County Edition



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The Realities of Long Term Care

When faced with the possibility of a loved one needing long term care, it is only then that most individuals, usually children or a spouse, actually realize the emotional, economic, and legal complexities of obtaining the appropriate care needed by their loved one. For a husband or wife, the realization that their spouse may need care beyond what they can personally provide is shocking. And the potential that their spouse may need a level of care only offered in a skilled nursing facility is devastating. For a child, the fact that their parent(s) can no longer care for themselves often triggers feelings of guilt, frustration, and anger. Moreover, the financial ramifications of long term care can be extremely frightening as well as confusing.

However, it is important to understand that all of these feelings and reactions are normal. It is also important to realize that the process of coordinating your loved one's care will be constantly changing. This is probably the biggest truth in the care giving journey and one that you should remind yourself of regularly.

For individuals who do not have the luxury of living in an area with a high senior population, the process of finding, coordinating, and paying for long term care can be quite a challenge. However, in Brevard County, we are fortunate to have an abundance of state and local agencies, community service organizations, and legal services that focus on the needs of seniors and their loved ones who must come to terms with the realities of long term care. From organizations that provide counseling to families whose loved one has just been diagnosed with Alzheimer's disease or dementia to those individuals who provide end of life care and support, the road to securing the appropriate care for your loved one may not be so daunting if you are armed with the right information and seek the assistance of professionals who deal with these issues on a daily basis.

The information contained in this book will hopefully answer some of your initial questions regarding long term care as well as give you an idea of the vast amount of resources that are available to you as you navigate your way through finding just the right care for your loved one.

Selecting a Nursing Facility

As stated before, nursing home care is not always the right choice for everyone. However, there are times when a full service nursing facility is the best option for you or your loved one. Locating an appropriate facility can be a daunting task and many find the transition emotionally draining. My hope is that the following pages will help to simplify the process for you. When faced with a long term care situation, there are decisions that must be made. Questions arise such as:

- Where do I begin?
- What services are available?
- What types of facilities are available?
- How much will it cost?
- How will we ever pay for this?
- What legal documents do we need?
- Who do we call for information?
- And the list goes on and on...



This portion of the book is an attempt to answer all those questions. So let's start with how to select a nursing home once placement has been deemed necessary.

STEP 1: EVALUATION

There are important considerations that need to be evaluated. These include the following:



- Needs and wants of the resident
- Medical needs of the resident
- Emotional needs of the resident
- Location of the facility
- Special Alzheimer's needs
- Costs
- Space and availability
- Payment arrangements
- Special equipment needs
- Special amenities
- Room size
- Noise
- Odors

Your physician will have a say in the type of medical care the resident must have. However, many times friends and family help determine the other evaluation factors. Form a list of which evaluation criteria are most important to you.

STEP 2: MATCHING THE EVALUATION TO A FACILITY

The next step is identifying a facility that meets those established criteria. The State of Florida Agency of Health Care Administration (AHCA) can provide a complete listing of the nursing home facilities located in this area. This listing can be obtained from:

www.floridahealthfinder.gov

Also found on this website are nursing home profiles which include any legal actions such as fines imposed on the facility and Florida AHCA Inspection Reports.

The federal Medicare agency has an excellent website for checking facility services, deficiencies and staffing ratios. That website address is www.medicare.gov. This website will also allow you to compare nursing homes.

Make sure that you contact each facility on your match list. Speak with an administrator, admissions person or staff. Discuss your situation with them. Ask questions — lots of them! Ask yourself if the staff was responsive, knowledgeable, courteous and friendly. You can save yourself a lot of time in the next step.

STEP 3: VISIT THE FACILITIES

If you followed step 2, you already know which facilities on the match list can be eliminated. Your next step should be to schedule a visit to the remaining facilities on your match list. I have provided a nursing home evaluation form on my website at www.floridaelderlaw.net. Fill these out during or right after your visit. These forms contain important criteria to look for in the facility.

Next, interview the staff. Be sure to make an appointment to meet with the key personnel in administration as well as those individuals who will provide the actual care to your loved one. Remember to ask the questions listed on the evaluation forms. This information will give you much needed insight.

Then, interact with the staff by participating in the facility's activities for a day. This will give you a feel as to how the day-to-day operations of the facility are conducted. You will experience what it will be like to be a resident at the facility first-hand.

Finally, make a return visit to the facility unannounced. Visit at a different time from your previous visit. Do you still have the same impression of the facility? Things can be quite different during off hours than during the middle of the day.

STEP 4: CHOOSE A FACILITY

Finally, choose the facility that evaluated and rated best on your match list, all things considered. Talk about the facility with your friends and loved ones. Ask people in the community at large and the medical community about your choice. Sometimes word of mouth can bring attention to facts that are not readily observable.

STEP 5: RE-EVALUATE

After your loved one has been placed in the facility that you have chosen, remember to constantly re-evaluate the facility using the criteria that you established. Does the facility live up to expectations? Has the facility been placed on the watch list? Has management changed? Have any lawsuits been filed against the facility? Does the facility cater to the particular needs of the resident? Always remember that you can change facilities anytime you like. However, you must ensure that the resident has a space at another facility before doing so. Otherwise, if space is limited, the results could be disadvantageous.

Furthermore, when your loved one enters a nursing home facility, they should receive a "Patient's Bill of Rights". This document must be presented in writing to each resident. Take the time to read the handout the facility gives you so that you know what your rights are as well as those of the resident. If a problem should ever arise that you think warrants action on your part, please consult with the facility's administrator. If you do not get satisfaction, consult with an elder law attorney for a recommended course of action.

Lastly, you can consult the Medicare website at www.medicare.gov for a comparison of nursing homes and for the "Guide to Choosing a Nursing Home". You can also find a link and a PDF copy of this publication at www.floridiaelderlaw.net.

What to Do If You Do Not Have Time

If time is not on your side, I suggest contacting a geriatric care consultant in your area. These consultants have already done all the ground work and can match a facility to your needs. Geriatric care consulting is a growing field in Florida. There are many newcomers to the field. Make sure you retain one with the experience and qualifications that meet your needs.

Additionally, the Florida Department of Elder Affairs has established a CARES (Comprehensive Assessment and Review for Long Term Care Services) program

that can assist you in determining eligibility for nursing home care and other long term care services.

Getting Good Care in a Nursing Home

Now that you have placed your loved one in a nursing home facility, your role has changed. In many long term care situations, the initial long term care is provided for the patient in his or her home. As needs rise, alternate plans must be made and placement in a nursing home might become necessary. Once placed in a nursing home, the resident now comes under the care of the staff of that particular facility. This means that your role has now changed from a caregiver to a care advocate.

As a care advocate, you will need to convey the resident's particular needs to the facility's staff. The resident's medical needs may be conveyed by his or her particular doctor, but don't always rely on this. I have included a form called "Special Needs of" at www.floridaelderlaw.net that can be completed and given to the facility's staff that conveys not only your loved one's medical needs but also his or her personal needs. When a person is removed from their immediate surroundings (their home), it may be necessary to re-educate them and others as to what makes the person feel comfortable. You will need to convey this to the staff at the nursing home facility.

Shortly after the resident arrives, the staff of the nursing home facility will perform a baseline assessment of the resident. This becomes the yardstick against which the staff will measure the resident's progress. The staff will ask questions concerning the resident's medical, psychological, spiritual, personal and social needs. This is your opportunity to contribute. Supply the staff with the Special Needs Form mentioned above, adding any additional information that you feel they need to know. This will give them a clearer picture as to the needs of the resident as well as give you peace of mind that the staff will know how to care for your loved one.

Federal law requires that the nursing home stay result in improvement to the resident if possible. In the case where improvement cannot be accomplished, the facility must strive to maintain the status quo or slow the loss of functions. This is why the baseline assessment is important and why your input is needed. Furthermore, facilities must review the care plan every three months or if the resident's condition changes. All residents must be reassessed annually. At each of these intervals, care plan meetings are held. You can provide input at these assessments as well.

Finally, as a care advocate, you must monitor the status of the resident. You will want to ensure that your loved one is receiving the best and appropriate level of care. Attendance at the assessment meetings is essential as is regularly visiting the resident. In this manner, you can ensure that your loved one's needs are being met.

Alternatives to Nursing Homes

Nursing home care is not the right fit for everyone. Sometimes, a person needs assistance in some areas, but is still able to remain autonomous in a variety of others. There are many alternatives to nursing homes. Below is a listing of such services. The Florida Department of Elder Affairs through its Comprehensive Assessment and Review for

Long Term Care Services (CARES) program can provide a free assessment for nursing home eligibility and other community-based alternatives. The Long Term Care Ombudsman's office can assist you and provide information on long term care services.

Community Based Services

Retirement communities, continuing care retirement communities (CCRCs) and senior apartments are all examples of alternate community housing arrangements. Other community-based services include Meals-on-Wheels, homemaker and companion services, church sponsored elder services and the like. Most nursing homes and assisted living facilities provide respite care that can allow a caregiver to take a break. The stay is usually no longer than two weeks, but can give the caregiver the opportunity to recharge his/her batteries. Many other institutions provide senior services and activity centers

Continuing Care Retirement Communities

These "Care-for-Life" communities offer different levels of care depending on the needs of the residents. As a resident's care needs increase, the individual is moved through progressively advancing skilled facilities. CCRC residents are guaranteed care for the rest of their lives. Most charge entrance fees as well as monthly maintenance fees. The Florida Department of Insurance regulates CCRC contracts. The Florida AHCA licenses and inspects CCRC facilities.

Adult Day Care Centers

These facilities provide a minimum of care for the user. Usually the facility is a protected setting for leisure activities, meals and respite care for a portion of the day. These facilities are licensed and inspected by the State of Florida.

Adult Family Care Homes

Adult Family Care Homes provide an around-the-clock family living arrangement for up to five elder or disabled persons unrelated to the owner. The owner lives with the residents and provides room, board, and personal services for the residents. Services vary between Adult Family Care Homes. Adult Family Care Homes are licensed and inspected by the Florida AHCA as Assisted Living Facilities.

Assisted Living Facilities (ALF)

An ALF provides room, board, and personal services for the residents. The services offered by ALFs vary greatly. Some provide limited nursing or mental health services through special licenses. Others provide extended congregate care (ECC). ECC allows frail ALF residents to remain and age in the same facility rather than being moved around to various facilities. ALFs are licensed and inspected by the State of Florida.

Home Health Care Agencies

Home health care agencies provide medical services and supplies to patients in their homes. They can also provide medical care to individuals in assisted living facilities and other community settings. These agencies supply the gamut of medical services but can only provide medications prescribed by a medical doc-

tor. Home health care agencies are required to be licensed and inspected by the Florida AHCA.

Nurse Registries

A variant on home health care agencies is nurse registries. These agencies act as employment agencies for nurses or other health care workers. They can provide nursing care but not therapy or medical equipment services. However, nurse registries are not required to carry liability insurance. Nurse registries are licensed by the State of Florida and must display their registration number on all advertisements.

Homemaker and Companion Services and Agencies

By law, homemaker and companion agencies may not dispense medication or provide “hands on” help (such as bathing). However, they provide useful assistance with cleaning, cooking, visiting and such. They are required to register with the State of Florida and to include their registration numbers on all advertisements. I suggest enlisting the services of only those who have liability insurance and are bonded. Ask to see a copy of these documents prior to the engagement of services. These agencies are licensed by the State of Florida and thus complaints are listed with the State of Florida.

Hospice

Hospice care is given to terminally ill patients who have six months or less to live. The emphasis is on providing comfort to these individuals. These services are most likely to be rendered in the home of the individual. Hospice providers may also provide some grief counseling services. Hospice providers are licensed and inspected by the State of Florida.

Paying for the Costs of Long Term Care

Part of the estate planning process is not only ensuring that your loved one is protected in the event that long term care is needed, but also making sure that the well spouse is taken care of into their golden years. Many times people encounter certain health events that require them to procure some form of outside care, whether it is in the form of home health care or an assisted living situation. The most common question that I get asked about long term care situations is, “How do we pay for all this?” There are basically three ways to pay for the cost of a long term care event. They are the following:

1. Long Term Care Insurance

Most people facing nursing home stays do not have long term care insurance. This method of payment has only become popular in the last few years with the increased awareness of the public. If your loved one has long term care insurance, consider yourself lucky! Long term care insurance can go a long way towards paying for a long term care event and may keep additional options open to you (i.e. home health care). Just like most private insurance, you have to qualify. Thus, many individuals are unable to get or afford long term care insurance due to age or prior illness.

2. Self Pay

You can always pay for the costs of long term care by using your own funds. However, nursing homes cost roughly \$96,000.00 per year nationally. Locally, costs can generally run around \$8,000.00 - \$10,000.00 per month. Few people can afford to keep up this level of spending for an extended length of time.

3. Medicaid

Medicaid is a federally funded, state administered program that, among other things, can pay for the costs of a nursing home provided certain income and asset tests are met.

Since both the long term care insurance and self pay options are self explanatory, this portion of the book will deal primarily with persons who either have no insurance or cannot afford the costs of a nursing home. Veterans may have some benefits that pay for nursing home care. Consult with a veteran's benefits specialist. Additionally, Tri-Care for Life does pay for skilled nursing care, but not for the room, board, custodial care and certain other items associated with the nursing facility.

The Truth about Medicare

Many people often confuse Medicare and Medicaid benefits. Medicare, for the most part, is a federal program devoted to bringing health care to individuals over the age of 65. Medicare primarily focuses on hospitalization and physician services, but only provides payment for limited long term care services. However, there are certain restrictions that apply to Medicare. First, you must have had a hospital stay of at least three days prior to going to the nursing home for skilled rehabilitation. Second, you must be going into the nursing home for the same illness or condition for which you were in the hospital. Third, you must show a need for skilled nursing once you are in the facility for Medicare to keep paying and you must be receiving skilled nursing care.

If you meet the above criteria, Medicare will likely pay a portion of your nursing home stay. Again, however, there are limitations. Medicare will pay for the cost of the first 20 days in full. The next 80 days are covered, but require a \$161 (2016) per day deductible (roughly over \$4,725.00 per month that you must pay). In most cases, this can be paid by your supplemental Medicare insurance. After 100 days, Medicare will no longer pay any costs.

For example, the following situations are not covered by Medicare:

1. Someone who has Alzheimer's disease or dementia and requires constant supervision but no nursing services
2. Someone who is admitted to the nursing home directly with no hospital stay
3. Anyone in a nursing home facility after 100 days

There are more examples, but they are too numerous to list. If you do not qualify for Medicare or your Medicare benefits have run out, then you are left with only the last two options on our list, provided that you have no long term care insurance. If you cannot afford to self pay and do not have long term care insurance, then these next few pages will be very important to you.

Medicaid

Generally, Medicaid is a federally funded health care program for low income families with limited resources. All Medicaid long term care services are administered through the Statewide Medicaid Managed Care Program and the Medicaid application process is administered through the Florida Department of Children and Families. Currently, Medicaid is the long term care insurance of the middle class. Why? Basically, with nursing home stays running roughly \$96,000 per year, and the average stay lasting over two years, (Alzheimer's and dementia patients usually require much longer stays), an individual's modest nest egg of savings could be wiped out in less than a year. It does not have to be this way. Medicaid planning is essential long prior to the time you or a loved one needs nursing home care. You can protect a large portion of your estate with proper planning and legal instruments. If you did not do this, it's not too late! There are many ways an attorney can still help.



The Income Test

As discussed earlier, Medicaid is a benefit of last resort. As such, Medicaid is means tested with tests for income and asset eligibility. In order to qualify for Medicaid, you must pass both tests. The nursing home resident cannot have more than \$2,199.00 per month (2016) in gross income from all sources. If your income exceeds this amount, you may not qualify for Medicaid. However, there is a way to lower your income so that you will qualify: the Qualified Income Trust (QIT). There are a number of ways to fund the QIT. A QIT should be drafted by an elder law attorney, who can advise on the proper funding. If you fail to properly fund the QIT, it will cause Medicaid disqualification. However, there are catches, such as, upon the death of the recipient, the excess that is retained in the trust first goes to reimburse Medicaid for its expenses. Only after Medicaid is 100% reimbursed will the trust then distribute any remaining monies to heirs. If there is not enough in the trust to reimburse Medicaid, then Medicaid may file a claim against the probate assets of the recipient. We will discuss this in depth a little later.

If you need a QIT, please contact a local elder law attorney. One word of caution, if the recipient is incapacitated, then the spouse or attorney-in-fact (through the use of a durable power of attorney) may need to create and fund the trust.

Many durable powers of attorney do not contain provisions that allow the attorney-in-fact to do this. The Florida Department of Children and Families will enforce this rule. This is another reason why having your legal instruments drawn up by an attorney well in advance of a long term care event is crucial. Lastly, if the Medicaid recipient is married and the recipient is the major source of income for the couple, there are special rules that allow a community spouse (the well one) to take a portion of the institutionalized spouse's income, if needed, to make ends meet. This process is called spousal diversion, and could be integral to the well spouse being able to maintain his/her quality of life.

The Asset Test

If you qualify under the income test or can create a QIT, you must still pass the asset test. This test can be the most daunting and confusing. First, you must know the asset test limits. These vary between single and married persons. The reason for this difference is so that a survivor of a Medicaid recipient is not left destitute by the “spend down” (more on this in a moment). The asset test level for an individual is \$2,000 in countable assets and \$119,220 (2016) in countable assets for a community spouse who is not in a facility. For married couples, both persons must qualify under the asset test.

Second, you must understand the difference between exempt (non-countable) and non-exempt (countable) assets. Exempt assets **do not count** towards the asset test limits and non-exempt assets **count** towards the asset test limits. The following are exempt assets:

- Homestead residence
- One car of any value (a second car if it is over 7 years old but less than 25 years old and not a luxury car)
- Income producing property
- Life estates
- Burial plots for you and your spouse (\$2,500 each)
- Burial Account (\$2,500)
- Irrevocable Burial Contracts
- Household and personal belongings
- Life insurance if the face value is less than \$2,500
- The principal in certain annuities and IRAs or other qualified plans



There are some other non-countable assets, but for the most part, this is it! What this means is that checking and savings accounts, stocks, bonds, mutual funds, IRAs, 401(k) accounts, 403(b) accounts, and trust assets are all counted towards the asset test. In short, any asset that is not exempt and can be turned into cash is counted. Please see the Florida Administrative Code Section 65A-1.712 (SSI-Related Medicaid Resource Eligibility Criteria) for a more technical analysis.

What happens if you (and your spouse's assets) are over the asset test limits? You will have to “spend down” until you qualify. In other words, you will have to spend your own assets on you or your spouse's nursing home care until such time as your assets are below the asset test limits and you can qualify. Some call this the “Pre-Death Tax”.

However, there still are some things that you can do. Just as the income test had planning alternatives, so does the asset test. But first you need to know some other rules concerning the asset test.

The Look Back Period Or “Why You Can’t Just Give It All Away”

Many people simply try to give their assets away, most likely to their children, in an attempt to safeguard their estate. The Medicaid people have caught on to this. Many years ago, a popular planning technique was to transfer your assets into an Irrevocable Medicaid Trust. This technique attempted to move your assets out of your name and control so that they would not be counted towards the asset test.

In February of 2006, the Federal government radically altered Medicaid qualification with the passage of the Deficit Reduction Act of 2005 (DRA 2005). The Deficit Reduction Act of 2005, which became effective in February 2006, created “look back” periods of 36 months (pre 02/08/06) or 60 months (post 02/08/06). Although Florida did not officially adopt and enforce the 60-month look back period until November 1, 2007, the “look back” period is now five years (60 months) for everyone. What this means is that if you have transferred assets to anyone other than your spouse for less than fair market value within 60 months of applying for Medicaid, you will be denied Medicaid benefits and subject to an exclusionary period. The exclusionary period is equal, in months, to the dollar amount of the transfers divided by the average cost of a month of nursing home care [currently \$8,346 (9/2015) in Florida]. It is important to note that prior to DRA 2005, this number was rounded **down** and the exclusionary period was calculated from the **date of the gift**. It is also important to note that this new law only applies to any transfer of assets after November 1, 2007. So, if you have transferred any assets for less than fair market value **after** November 1, 2007, Medicaid will sum up the total of the transfers and divide by \$8,346.00. The resulting number is the **number of months that you are disqualified from receiving Medicaid benefits from the time you apply for Medicaid**. While it is impossible to know who will experience a long term care event five years before it happens, do not transfer any assets. This includes gifts to your children, a charity, or a church. Consider that you could be in a nursing home and private pay for three years (roughly \$288,000.00) and still be denied a month’s worth of Medicaid benefits because you gave your church \$8,000.00 four and a half years ago! Furthermore, DCF will no longer round down. This means any gift, no matter the value, will result in a disqualification period.

To clarify, transfers include adding children’s names to the title of assets such as with a deed, removing your name from the title of an asset, or simply giving your children a check.

Example: Doris adds her adult children, Timothy and Danielle, to the deed to her house within five years (60 months) of applying for Medicaid. The house is worth \$132,000.00. Providing Doris remains on the deed as well and resides in the house, her portion would be exempt (homestead). However, the portion transferred (\$88,000.00 or 2/3 of \$132,000.00) would not be exempt providing that the children did not reside with her and provide care for her. Thus, Doris would be denied benefits for a period of 10.54 months (\$88,000.00/\$8,346.00) from the time of application. Remember, the homestead is not counted; it is exempt. So there is no need to transfer it to your children.

Will I Lose My Home?

Under the pre-DRA Medicaid rules, your homestead is an exempt asset of exceptional value. Under Florida law, "homestead" is defined as a half acre in a municipality and 60 acres in an unincorporated area. Under the new law, if you are married, an unlimited amount of equity in your homestead is exempt. If you are single, up to \$552,000.00 of equity in your homestead is exempt. The rest of the homestead equity is a countable asset. But what if you move out of your homestead and into a nursing home? Will your house remain exempt? In short, maybe! Under Florida law, your house can remain your homestead, even if you do not reside in it and if you have the intention of returning to it. Thus, a nursing home resident should always state that they intend to return to their home no matter what their condition. Many misinformed people have lost their homesteads because people have told them that they need to sell them. This is not true! In fact, under the Florida Probate Code, a homestead can even be passed to a spouse and descendants free from creditor's claims. Remember, however, that you cannot rent the house. If you do, it becomes clear that you do not intend to return to it. Additionally, please remember that your homestead is probably one of your biggest assets and thus probably your biggest EXEMPT asset!

What You Need to Know About Medicaid Estate Recovery

The Omnibus Budget Reconciliation Act of 1993 required the States to establish Estate Recovery Units. Florida has established a recovery unit. Its purpose is to file claims against the estates of deceased Medicaid recipients to recover the outlays Medicaid made on behalf of the recipient. I have personally seen claims filed for as little as \$34.00. Thus, if a Medicaid recipient dies in Florida with assets that pass via a will or intestate (without a will), the State of Florida Medicaid Recovery Unit will file a claim against the estate for the full amount of payments made on behalf of the individual during his lifetime. It is important to note that as of January 1, 2002, all estates are required to file a copy of the estate's inventory with the Florida Medicaid Recovery Unit. What you should know is that under Florida law, your homestead is exempt from creditors claims (including the Medicaid Recovery Unit) if left to a spouse or descendants. There are some other exemptions under the Florida Probate Code. Consult with an elder law or estate planning attorney for more information.

What does this mean to the Medicaid prospect? A common planning technique for married persons is to transfer all the assets into the well spouse's name. Under the Medicaid rules, inter-spousal transfers do not count as transfers for disqualification purposes. Then, the estate planning documents of the well spouse should leave everything to the couple's children.

The Medicaid Estate Recovery Unit will not file a claim if any of the following are true: (1) there is a surviving spouse, (2) there is no probate in which to file a claim, (3) the Qualified Income Trust (QIT) proceeds satisfy all Medicaid claims, or (4) the recipient was under age 55.

What is Medicaid Planning?

Medicaid planning is based on formulating legal strategies to let you qualify for Medicaid and yet still preserve some of your hard-earned assets. There are a variety of strategies that may work for you. In the Income Test section, we outlined how a QIT may work for reducing a recipient's income down so that they may qualify. Certain assets may not be countable towards the asset test if properly planned. You should consult with an elder law attorney instead of trying to formulate your own plan. Medicaid is a complex and oft confusing area. This is truer now more than ever. The passage of the **Deficit Reduction Act of 2005** greatly reduced the allowable planning options.

There are a variety of techniques that are still available. These should not be attempted without the guidance of an elder law attorney. The federal government has now made this area of the law so complicated that it is well beyond the understanding of most social workers and other applied health professionals. Additionally, every family's situation is unique and requires an individual assessment. What might work for your situation might not work for someone else; so it is very important to discuss and take into consideration your total planning picture.

The Statewide Medicaid Managed Care Program

In Florida, as of August 1, 2013, all Medicaid long term care services are administered through the Statewide Medicaid Managed Care Program. Services are available at a nursing home or in a home and community based setting (at home or in an assisted living facility). To qualify the applicant must be at nursing home level of care for Nursing home coverage or "at risk" of nursing home placement for home and community based services. Initial application is done through the Senior Resource Alliance. For home and community based services, there is a waiting list that is based on medical need. There is no waiting list for nursing home assistance. Once an applicant is released from the list, the application must be made through the Department of Children and Families for income and asset verification. Then, one of four Medicaid approved companies must be selected to deliver the services. If the applicant is at home, the services are delivered there. If the applicant is at a nursing home or assisted living facility, the services will be delivered there. However, the facility must have a contract with the Medicaid approved company selected by the applicant. With assisted living services, the applicant must pay for room and board which are at a reduced rate. With nursing home services, the applicant must generally pay their income to the facility.

Alternatives to Medicaid

Sometimes the costs of a nursing home situation can be paid for by alternate means. In some cases, an individual can pay for the costs provided that their assets are invested differently. The easiest way to pay for the costs of a nursing home or home health care is through insurance. The National Association of Insurance Commissioners has published a pamphlet entitled "A Shopper's Guide to Long-Term Care Insurance". This pamphlet can be obtained by calling (816) 783-8300 or can be downloaded from:

http://www.naic.org/documents/prod_serv_consumer_ltc_lp.pdf

There are a variety of other products that pay for the costs of long term care. Some products incorporate life insurance with a long term care rider that will pay the face amount of the policy towards long term care and/or a death benefit. That way if you do use it, you don't lose it. Other products link annuities to long term care benefits. Some annuity products pay out set sums for life given an initial investment sum. Other products will actually do an underwriting based on your health situation and usually require less "up front" money if you are ill. These companies "bet" that you won't survive to receive all the payout. However, if you do survive longer than the company expects, then they continue to pay for your life expectancy.

Almost all of the above products will pay the costs of nursing home and assisted living facilities. These products can be a life saver if you are looking for a way of coming up with a fixed sum of money each month. And some of these programs even accept you if you are already ill and in a facility. Be sure that the company you are dealing with has a high credit rating so that there will be little risk of losing your investment due to the company's failure. Consult with an Elder Planning Specialist with regard to all these products. Remember most brokers and insurance sales people are locked into only providing the products that their company offers. So shop around or go with an independent agent.

VA Benefits

Most veterans are familiar with the Veteran's Administration (VA) program for service connected disability. However, one of the best kept secrets is the VA program for non-service connected disability pension or "Aid & Attendance" as it is commonly called. Aid & Attendance is a program available to veterans or their dependents regardless of whether the veteran's disability was service connected. The program gets its name from the requirement that the veteran or their dependent (including spouse) must need the "aid and attendance" of another for their care. This program can be a real life saver when the veteran or their dependent is in need of home health care, assisted living, or nursing home care.

To qualify, the following requirements must be met:

1. The applicant must be a wartime veteran (38 USCS section 1521j) or a dependent of a wartime veteran. Basically, the veteran must have served at least one day during wartime and have been discharged under any condition other than dishonorable.
2. The applicant must be determined to be "permanently and totally disabled". Generally, a letter is needed from the applicant's physician stating that the applicant has an incapacity that requires care or assistance regularly to protect the applicant from danger in their daily environment.
3. As a general rule of thumb, the net worth of the applicant cannot exceed \$80,000. The home and a car are not counted. VA has now adopted a sliding scale for the asset test based on the age of the applicant. The older the applicant, the less assets they may have. Unlike Medicaid, (at the time of this writing) the VA does not impose a "look back" period or penalty in connection to asset transfers. However, VA applicants should expect to see a dramatic policy change in 2016, when the VA is expected to implement

a 36 month “look back” period and penalties for appropriate transfers. If the applicant needs Medicaid in the future, remember that any transfer to qualify for aid and attendance may still have repercussions in the form of penalty or disqualification periods for Medicaid eligibility. Consult with an elder law attorney for information about Medicaid.

4. The income limits are based on whether the veteran or the surviving spouse is applying. Countable income is all income attributable to the veteran (38 CFR sections 3.262 and 3.27 1). Unreimbursed medical expenses can be deducted from the veteran’s income (Manual M21-1, aprt IV, sec 16.3 1b[6][a]).

The maximum pension amount available to the veteran or their dependent is \$2,120.00 per month (2015). The formula for calculating the pension amount would be the maximum pension rate minus current monthly income plus unreimbursed medical expenses. Aid and attendance payments do not count as income for Medicaid qualification purposes. However, if the applicant is in a nursing home and receiving Medicaid, by law the pension amount is reduced to \$90 a month.

As with all federally funded programs, the eligibility requirements for Aid & Attendance are subject to change. Due to the significant increase in applications for Aid and Attendance over the last two years, it is likely that it will become harder to qualify for benefits.

Legal Incapacity Planning

Everyone should have a plan in place as to what their wishes are and who is to carry them out in the event of incapacity. Incapacity has many guises. Incapacity can result from a stroke, a heart attack, Alzheimer’s disease, dementia, psychoses, mental illness, coma and many other conditions. Below are the essential legal documents that are needed to protect the legal rights of yourself and your loved ones if an incapacity event should occur.

The Durable Power of Attorney: This document allows for an individual to name a person (called an agent or attorney-in-fact) to manage the individual’s financial affairs and execute legal and financial documents on behalf of the individual or maker. Unlike a regular power of attorney, the durable power of attorney survives the incapacity of the maker. Thus, the attorney-in-fact can manage the financial affairs of the maker after he or she has become incapacitated. As you can see, the durable power of attorney is a very powerful document as it is a license to sign your name. It should always be kept in a safe place and only given out when it is absolutely necessary. In most cases, the durable power of attorney is effective upon signing.

If you do not have a durable power of attorney, consider the consequences. Upon your incapacity, a spouse or loved one will not be able to access any asset titled in your name alone or sell an asset with your name on it. While most couples believe that all their assets are jointly titled, they never consider that to sell a jointly owned car requires the signature of both owners. Thus, if one spouse is incapacitated, the well spouse may be unable to sell the second car for much needed funds. Additionally, consider that pensions, social security, IRAs and 401(k) accounts are all only titled in one spouse’s name. Individuals with revocable living trusts need

to review their trust documents to find out when the successor trustee(s) can take over in the event of incapacity of the initial trustee (grantor). In certain cases where there is no power of attorney in place, a costly guardianship proceeding may be necessary to access an incapacitated person's assets. Guardianship proceedings are discussed more in depth at the end of this section.

There have been two significant changes in law with regard to durable powers of attorney that should be noted to make sure that your power of attorney is valid and most importantly, accomplishes your wishes.

The first change occurred in October 1995 and was a dramatic change to previous law. ***Any person currently having a durable power of attorney executed prior to this date needs to have the document redone.***

Effective October 1, 2011, Florida's new durable power of attorney statute became law. Under this new law, durable powers of attorney now require that the maker execute the document in the presence of two witnesses and that the individual's signature also be notarized. This change clears up some ambiguity with the prior statute. Out-of-state durable powers of attorney will now be honored if they are valid in the home state at the time of execution. However, this may not fully address all issues with out-of-state documents. Florida has some very picky durable power of attorney interpretation statutes that can still cause headaches for the agent trying to legally conduct business and financial transactions for the maker.

Additionally, the new durable power of attorney statute requires that the maker give specific authority to his or her agent for all powers or it is assumed that the agent does not have those powers. Broad grants of authority, like "to do everything the grantor can do" are invalid. The new statute also includes special language for banking and investment transactions so that there is now some degree of certainty in those areas. For certain powers to be authorized, the maker must now initial or sign next to certain powers in the document. These powers involve changing beneficiaries and other estate planning transactions.

Financial institutions now have up to four days to review a power of attorney document presented to them. This period can be extended for certain causes and can be a source of frustration for those persons trying to carry out routine and necessary banking transactions. It is probably a good idea to provide your bank or other financial institution with a copy of your durable power of attorney prior to when you expect to have to use it. The bank can review it and you can be assured that it will be honored when the time comes for it to be used.

The new statute also enumerates how the courts are to view conflict of interest transactions and provides for certain court remedies. Conflicts of interest not only apply to the agent but now apply to the "affiliates". Special language is now required to allow "self-dealing".

Another change to the previous law on durable powers attorney is the fact that agents acting under a durable power of attorney can now be paid and reimbursed for expenses provided that they fall into the category of "qualified agents". "Qualified agents" include family members, trust companies, attorneys, and accountants. Not considered as qualified agents are professional guardians and geriatric care managers.

This omission may lead to needless guardianship proceedings so that persons in this category can get paid for their services.

Lastly, it should be pointed out that some of the statutory changes only apply to durable powers of attorney executed after October 1, 2011. These generally deal with execution requirements and necessary language clauses

The Designation of Health Care Surrogate: In this document, the maker designates an individual or health care surrogate to make health care decisions on behalf of the maker should he or she become incapacitated. The designation of health care surrogate is similar to the durable power of attorney document except that it applies only to health care decisions and not financial affairs.



If an individual is unable to give informed consent due to incapacity, the hospital or doctor will look to the health care surrogate to make the decisions on behalf of the incapacitated individual. If you have not executed a health care surrogate document, Florida Statute provides a pecking order of individuals who can make decisions for you. First is your guardian and second is your health care surrogate. Next is your spouse followed by your children, then your parents followed by your brothers and sisters. In the case of couples who live together and are not married, this can be a major source of friction between families. Second marriages are potentially problematic as well. Note that the first in line is a guardian. This may not be your spouse! Only a circuit court judge can select a guardian for you.

The Living Will: The living will protects loved ones and health professionals from having to make hard decisions or even going to court should the maker suffer from a variety of incurable and costly medical ailments such as terminal illness, brain damage, and coma. The living will spells out the wishes of the maker with regard to medical treatment, life support, and palliative care should these ailments or conditions occur. In doing so, this document protects loved ones and valuable estate assets. The Florida Statutes were amended in 2001 to carry new definitions for “end-stage condition”, “terminal condition”, and “persistent vegetative state”; terms normally used in a living will.

If you have not executed a living will, then your wishes may have to be proven from statements that you have made in the past. Putting your wishes in writing protects you and your loved ones. And keep in mind that before a living will can be utilized, two physicians must certify in writing that certain conditions exist.

The Declaration of Pre-Need Guardian: If a guardianship proceeding is initiated, the declaration of pre-need guardian spells out who the maker wants as his or her guardian. In this document, the maker designates a guardian of the person (for healthcare issues) and a guardian of the property (for financial issues). The designation of pre-need guardian allows the court to know the maker’s wishes as to the choice of guardian and creates a legal presumption in favor of that person. The only person who can select and appoint a guardian for you is a circuit court judge.

If you have not executed a Declaration of Pre-Need Guardian and more than one

person seeks to be your guardian, a contested guardianship could occur. Do not rely on the judge to make the choice you want. Put it in writing!

Each of the above documents has a special form and witness requirements (including a notarization for some). Consult with an elder law attorney for the preparation of the documents. As I mentioned in the Medicaid Income Test section of this book, certain language should be included in a durable power of attorney. Changes were made to this language in October of 2011. If you have a durable power of attorney, please check and make sure you are covered. Additionally, if you have recently relocated from out-of state, consult with a Florida elder law attorney to make sure your documents are valid in Florida.

All of these documents should be kept in a safe place. A copy of the designation of health care surrogate and living will should be placed in your medical records so as to notify your health care providers. Prior to executing legal documents, a durable power of attorney should be recorded in the county records. Finally, the pre-need guardian declaration may be kept safe with the court.

Guardianship

Guardianship is a lengthy and expensive process whereby a circuit court judge selects a person to manage your health care (guardian of the person) and financial decisions (guardian of the property). The first step in a guardianship is to determine whether an individual is incapacitated. A special medical, psychological and geriatric care examining committee will examine the Alleged Incapacitated Person (AIP) and report back to the court. The court will also appoint an attorney for the AIP during this process should the AIP not have one. If the court finds that the AIP is wholly incapacitated, the court will strip them of their rights and vest them in a plenary guardian of the person and property. Some AIPs are found to only be partially incapacitated. In that event, only a limited number of rights may be vested in the guardian. If two or more individuals seek to be guardian, then the guardianship becomes contested and a trial must take place (unless they are co-guardians). As you can imagine, this is quite time consuming and costly. Finally, once a guardian is appointed, annual accountings and guardianship reports to the court are required.



The court will also appoint an attorney for the AIP during this process should the AIP not have one. If the court finds that the AIP is wholly incapacitated, the court will strip them of their rights and vest them in a plenary guardian of the person and property. Some AIPs are found to only be partially incapacitated. In that event, only a limited number of rights may be vested in the guardian. If two or more individuals seek to be guardian, then the guardianship becomes contested and a trial must take place (unless they are co-guardians). As you can imagine, this is quite time consuming and costly. Finally, once a guardian is appointed, annual accountings and guardianship reports to the court are required.

The documents listed in the previous section can be utilized without a formal court process and can save the AIP much time and costs. A guardianship can be avoided! However, if a guardianship is needed, consult with an elder law attorney for assistance.

Preparation can save you and your family much stress. Your health and your loved ones are your most priceless possessions. Don't delay in protecting your investment! It is never too early to start planning and remember, you are not alone!

WILLIAM A. JOHNSON, P. A.

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