Evicted and Rejected
The Disturbing Trend Facing Residents in Skilled Nursing Facilities

Also in This Issue:

- Is a Housing Crisis on the Horizon for Seniors?
- The Challenges of an Elderly Population with Progressive Disabilities
- Elder Law Day is Approaching. Plan a Successful Event with our Guide!
200 Evicted: The Disturbing Trend Affecting Nursing Home Residents by Robyn Grant and Lori Smetanka

204 Is an Affordable Housing Crisis Looming for Seniors? by Lisa Sitkin

212 Navigating Pension Benefits for Veterans and Surviving Spouses by Naomi Rodda

218 How to Live Forever: A Guide to Writing the Final Chapter of Your Life Story, reviewed by David Godfrey

220 It's Here: Read the Commission’s Guide on Planning for Elder Law Day, with an introduction by Louraine Arkfeld

225 The Challenges of Caring for a Growing Elderly Population by Joanne Lynn
Residents in Skilled Nursing Facilities Face Growing Concerns Over Evictions

By Robyn Grant and Lori Smetanka

A disturbing trend is becoming increasingly evident across the country: The eviction of vulnerable nursing home residents from their facilities, often without notice, preparation, or a safe and appropriate place to go. Consider the following cases reported by long-term care ombudsmen:

**After raising concerns** about an increase in the price of sodas in the nursing facility machines, and then asking a physician assistant who came to see him to leave his room, Mr. T was forcibly removed from his nursing home and discharged. He appealed the discharge and won but the nursing home refused to follow the hearing officer’s order to permit him to return. At the new nursing home where he was sent, he became increasingly distressed, depressed, anguished, and anxious. He worried that he would never be able to return to his former nursing home.

**Mr. R received a notice of discharge**, but the facility failed to notify his sister, who had power of attorney, the ombudsman, the Department of Health or the appeals officer as required by state and federal regulations. The nursing home social worker drove him to a motel and booked a room for him for three nights only, after which he was to check out. The resident had no money, no medication, no phone, and no one to help him transfer to/from his chair -- assistance he needed since one of his legs had been amputated.

**Residents receiving Medicare rehabilitation** in facilities belonging to one particular corporation were unexpectedly discharged when Medicare coverage ended. They were not given the option of remaining in the facilities and paying privately or through Medicaid if they still needed nursing home level of care. Shockingly, these residents were discharged to homeless shelters, storage units (in the middle of summer heat), unlicensed boarding homes where they reported they were assaulted and/or robbed, and even driven to and left in other cities.

Under federal law and regulation, there are only six permissible reasons for the transfer or discharge of a resident:

- The resident’s welfare and needs cannot be met in the facility
- The residents’ health has improved sufficiently so the resident no longer needs the services provided by the facility
- The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident
- The health of individuals in the facility is endangered
- The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility
- The facility ceases to operate

Regulations also mandate that residents be given written notice within certain time frames, have the right to appeal, and must be discharged in a safe and orderly way to a location that can meet their needs.

**CMS Rules**

When the Centers for Medicare and Medicaid Services (CMS) issued revised nursing home rules in 2016, it increased resident protections from eviction. For example, residents may not be discharged for nonpayment if they have applied for Medicaid and are waiting for a determination; nor may residents be discharged while an appeal of the discharge notice is pending. The revised rules also increased the documentation that must be made by
nursing facilities attempting to discharge by requiring that the reason for transfer or discharge be documented in the resident’s medical record and that appropriate information (as specified in 483.15(c)(iii)) be provided to the receiving provider of servicesiv. If the reason for discharge is that the facility is unable to meet the needs of the resident, CMS also now requires that the facility document in the medical record the specific need of the resident that cannot be met, what the facility did to attempt to meet that need, and the service available at the receiving facility to meet the needv.

Stronger protections were imposed because facilities were discharging people inappropriately and often illegally. In fact, since 2011, complaints regarding transfer/discharge handled by long-term care ombudsmen have risen from 8,882 to 10,071 in 2018. In each of these years, it has been the top complaint reported to ombudsmen.

Some of these discharges may be linked to a growing effort to maximize profitsvi. Facilities are incentivized to fill their beds with as many individuals whose stay is covered by Medicare as possible. Consequently, when a resident’s Medicare stay is up, some facilities move to discharge the resident instead of adequately informing them of their right to appeal the Medicare determination, or permitting those who are eligible to remain with Medicaid as the payor or to pay out of their own pocket.

Some residents with dementia or other conditions with challenging behaviors, vii such as agitation, combativeness, yelling out or wandering, are also being discharged by facilities that say they cannot meet the residents’ needs. Frequently, it is not that the facility cannot meet the resident’s needs, but that it takes more staff and resources to care for these residents, which impacts the facility’s bottom line. So nursing homes decide that the easiest course of action is to evict the resident, sometimes even by using a behavioral incident as a reason to send the resident to the hospital and then not allowing the person to return.

**Devastating Impact**

The consequences of inappropriate discharges can be potentially devastating, resulting in physical harm or decline, psychological suffering, and death. CMS even issued a memoviii that said: These discharges may result in residents being uprooted from familiar settings; termination of relationships with staff and other residents; and residents may even be relocated long distances away, resulting in fewer visits from family and friends and isolation of the resident. In some cases, residents have become homeless or remain in hospitals for months.

Long-term care ombudsmen, other advocates, residents and their families have filed numerous complaints with state survey agencies about lack of notice, invalid reasons for discharge, and discharges to unsafe locations over the years. Yet these facilities are only infrequently cited for violations, and when citations do occur, they generally result in very few meaningful penalties. In fact, some penalties are so inconsequential that there have been nursing homes that simply say they will “take the hit” rather than comply. Systemic and individual advocacy is clearly needed to protect the rights of residents facing discharge inappropriately or illegally.

**Legal Services**

Representing residents who seek to appeal the proposed discharge is the single most important action legal services attorneys can take. Appeal hearings can be complicated and require a strong knowledge not just of nursing home laws and regulations, but of legal proceedings. This is particularly important since nursing homes are increasingly represented by corporate counsel at these hearings. Not surprisingly, from states that track discharge hearing results, it is evident that legal representation for residents significantly increases the likelihood of a decision in the resident’s favor. In the 2019 preliminary results of a questionnaire conducted by the National Consumer Voice for Quality Long-Term Care, 93 percent of

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**NURSING HOMES RECEIVE CONSIDERABLY MORE MONEY FOR RESIDENTS WHOSE STAY IS PAID FOR BY MEDICARE: THE AVERAGE REIMBURSEMENT RATE FOR MEDICARE IS $503 PER DAY AND FOR MEDICAID IT IS $206 PER DAY.**

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state ombudsmen responding reported that their program assists residents who seek representation in a discharge hearing to obtain legal counsel, and the same percentage referred residents to legal services programs. Yet efforts to secure legal representation are often unsuccessful. Only 16 percent of state ombudsman respondents indicated that residents were most often represented by legal services providers, while a combined total of almost 40 percent of respondents said that most often residents represented themselves or were represented by family or a friend. Residents facing these disturbing actions need legal services attorneys to step up and help them. In fact, their lives just might depend on it.

Below are seven tips to encourage and assist legal services attorneys in handling these cases.

1. **Become knowledgeable about federal and state nursing home laws, regulations, guidance and guidelines before the hearing.** Review federal and state law and regulations and the surveyor’s guidelines; state manuals, policies, or communications regarding requirements related to discharge; and any facility policies, admission contract, or other documents that explain facility and resident responsibilities.

2. **Challenge improper reasons for transfer or discharge.** Sometimes facilities act to discharge a resident for actions such as having violated their smoking policy or not complying with a “behavior contract.” Any reason other than one of the six permissible reasons is illegal.

3. **Argue that failure to meet any procedural requirements means the proposed discharge is invalid.** The transfer/discharge regulations set forth process requirements that the nursing home must meet in order to transfer/discharge a resident. These include, but are not limited to, the timing and contents of the notice, who is notified, changes in the notice, and location where the resident is to be transferred. The facility must comply with all provisions.

4. **Hold the facility to all required documentation.** The resident’s record must include the basis for the transfer/discharge, documentation by the resident’s physician or another physician depending on the circumstances, and when discharge is allegedly for the resident’s welfare, documentation must address specific information related to the need the facility claims it cannot meet. Documentation related to discharge planning must also be included. In addition, check to see that the documentation is accurate. For instance, does the resident’s record show that the facility actually took the steps it indicated it did?

5. **Argue that discharge is premature if the reason for the discharge stems from the failure of the nursing home to meet federal and/or state requirements.** For instance, if the facility says a resident with dementia is endangering the safety of others because she is wandering into other residents’ rooms, determine whether the facility has fully complied with provisions related to behavioral health services, competency of staff, dementia management training and care planning. If not, argue that the alleged endangerment is the result of the facility’s noncompliance, not the resident’s actions.

6. **Show that the location where the facility is proposing to discharge the resident is unsafe and/or inappropriate.** Facilities must have a discharge plan for the resident ensuring a smooth and safe transition from the facility that meets the resident’s health and safety needs. They must also sufficiently prepare and orient the resident to ensure the resident is discharged in a safe and orderly manner. Point out that a proposed discharge to a homeless shelter or motel will place the resident at risk.

7. **Hold an in-person hearing, with the resident present, if possible.** At times, the resident’s very presence can undermine the facility’s argument. In one hearing where the facility contended that the resident was a threat to others, the hearing officer could see that the individual, who was paralyzed from the neck down with virtually no ability to use her arms or legs, did not pose a danger.
It will take the concerted efforts of advocates, consumers, legal services providers, nursing home providers, federal agencies, and policy makers nationwide to end the suffering and distress of residents that stem from inappropriate discharges. Residents’ health and well-being depend on these critical advocacy efforts to bring about needed change.

Resources for those who represent residents:

- State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 11-22-17).
  file:///C:/Users/Admin/Desktop/Revised_Interpretive_Guidelines_with_Clickable_TOC.pdf
- Advocacy Tools and Successful Practices to Protect Residents from Nursing Facility-Initiated Discharges Webinar, September 25th, 2019
  https://ltcombudsman.org/library/advocacy-tools-and-successful-practices-to-protect-residents-from-nursing-f
- Training Materials on Transfer/Discharge and the Revised Nursing Home Regulations
  https://ltcombudsman.org/library/new-transfer-discharge-materials
- A Closer Look at the Revised Nursing Facility Regulations: Involuntary Transfer and Discharge

i 81 Fed. Reg. 192, 68688
ii 42 CFR 483.15(c)(1)(i)(E)
iii 42 CFR 483.15(c)(1)(ii)
iv 42 CFR 483.15(c)(2)
v 42 CFR 483.15(c)(2)(i)(B)
vii Modern Healthcare, Nursing homes turn to eviction to drop difficult patients. May 5, 2016.
viii CMS S&C 18-08-NH, Dec. 22, 2017

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AFFORDABLE HOUSING NEEDS PROJECTED TO GROW FOR SENIORS

By Lisa Sitkin

At a time when the shortage of affordable housing in communities around the United States regularly makes the headlines, another less visible housing crisis is also intensifying. The number of elderly people with “worst case housing needs” – defined as renters with very low incomes who do not receive government housing assistance and pay more than one-half of their income for rent, live in severely inadequate conditions, or both – is increasing rapidly.¹

Nearly 10 million households with an occupant over age 65 spend more than 30 percent of their incomes on housing; roughly 5 million of those households spend more than 50 percent.²

The growth in the population of Americans aged 65 or older – projected to reach nearly 73 million in 2030, and more than 83 million in 2050³ – will likely mean that senior households increasingly will be renters.⁴ And senior renters, many of whom live on fixed incomes, are particularly vulnerable to the risks posed by skyrocketing rents, stagnant housing production, and increasingly severe natural disasters.

Resources for housing and supporting our aging population are scarce in relation to the scope of the problem. As of 2016, only 36 percent of renters aged 62 or over who qualified for some form of federal rental assistance were actually receiving it.⁵ Since the number of older renters earning 50 percent or less of their area median incomes (the threshold at which those aged 62 or over are generally eligible for federal rental assistance), is expected to reach over 7.5 million by 2035, nearly 5 million very low-income seniors would still remain unassisted – even if subsidies could be expanded to maintain that percentage.⁶ The number of homeless older adults (55 and over) is projected to grow from 170,000 in 2017 to 225,000 by 2026, with the fastest growth among those 65 and over.⁷

Urgent Need for Advocacy

There is an urgent need for more advocacy to increase funding for subsidized housing coupled with supportive services now and in future years. In the meantime, though, it is very important to understand what resources are currently available and help low-income seniors access and retain those resources.

In August 2019, the National Center on Law and Elder Rights (NCLER) hosted a webinar on elder subsidized housing to provide advocates and providers working with seniors with basic information about the federal subsidized housing

² Joint Ctr. for Hous. Studies of Harvard University, Housing America’s Older Adults (2018).  
⁴ Id. at 8.  
⁶ Id.  
⁷ Dennis P. Cullhane et. al., The Emerging Crisis of Aged Homelessness (2019) at 18.
programs available to seniors. The webinar drew nearly 1,300 attendees, suggesting a knowledge gap about existing programs among those who need to understand them. This article aims to address that knowledge gap by providing a basic overview of the major federal affordable housing programs available to seniors and a summary of resources that advocates and providers can consult when a senior client needs assistance obtaining or holding onto subsidized rental housing.

The Programs

The federal government subsidizes rental housing through a variety of different programs. For seniors, these include:

- Public housing, in which the rental properties are government-owned
- Programs that provide financial support for tenants renting from private owners, which include Section 8 (tenant-based and project-based), Section 202 and Section 811
- Rural housing programs
- Low-Income Housing Tax Credit (LIHTC) program

What follows is a basic overview of each of these programs. For more in-depth information about these programs, including information about income and rent calculations, tenants’ rights and reasonable accommodations, consult HUD Housing Programs: Tenants’ Rights (the “Green Book”), published by the National Housing Law Project.

Public Housing

Public housing, which was established in 1937, is the federal government’s oldest subsidized rental housing program. Properties in the program are funded by the Department of Housing and Urban Development (HUD) and owned and managed by local public housing authorities (PHAs) with oversight from HUD.

All public housing residents must have incomes at or below 80 percent of area median income (AMI), and at least 40 percent of new admissions in any year must have incomes at or below 30 percent of AMI. Local public housing agencies can also establish local preferences for certain populations, such as the elderly, persons with disabilities, veterans, full-time workers, domestic violence victims, or people who are homeless or at risk of becoming homeless.

Rents for residents of public housing are generally set at 30 percent of their monthly adjusted income and cannot exceed the higher of that figure or: 10 percent of their monthly gross income, their full welfare shelter allowance, or a local public housing agency’s established minimum rent of up to $50. Tenant incomes are calculated at the time of admission to confirm eligibility and set the tenant’s rent contribution. Reviews are conducted periodically thereafter.

About 1 million households are living in public housing units around the country, but the inventory is dwindling rapidly due to decades of underfunding and an accelerated push to privatize or demolish deteriorating properties. Public housing is open to all tenants who qualify, including elderly tenants. Public Housing Agencies (PHA) are permitted to designate a public housing development or a portion thereof as elderly-only, disabled-only or mixed elderly and disabled as long

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9 State and local subsidized housing programs are beyond the scope of this article.

9 NCLER hosted another webinar covering eviction issues and reasonable accommodations in October 2019. The recording and materials from that webinar can be found at https://ncler.acl.gov/.

10 Throughout the rest of this article, I use the terms “senior” and “elderly” to refer to people 62 years of age or older, since that is the threshold used in the relevant federal laws and regulations.

11 To purchase a subscription to the Green Book, go to https://www.nhlp.org/products/green-book/.


15 For more information about the loss of units from the Public Housing program, see the Green Book, Chapter 1, Section 1.10.1 and Chapter 12.
as they obtain HUD approval. According to HUD data, roughly one-third of all public housing households include at least one member over age 62.

**Section 8: Tenant-Based Assistance**

The Section 8 Housing Choice Voucher Program (HCV), the largest HUD housing program serving low-income families, provides subsidies for units that tenants rent in the private market. HCVs are administered by PHAs. Each agency has a cap on the number of vouchers it is authorized to administer.

Tenant-based vouchers are reserved for residents with incomes of no more than 50 percent of AMI, although those with incomes up to 80 percent AMI may qualify under certain circumstances. PHAs must reserve 75 percent of their vouchers for those with incomes below 30 percent of AMI. Of some 2.2 million voucher households across the country, 27 percent are headed by a person age 62 or older.

A voucher holder must locate a unit in the private market. The PHA then determines whether the rent the landlord is asking is “reasonable” with respect to market comparables, whether the lease conforms to federal requirements and, by inspection, whether the unit meets federal housing quality standards. If the unit is approved, the tenant and the landlord enter into a lease that must include a federally-mandated lease addendum, and the PHA and the landlord enter into a housing assistance payment (HAP) contract that sets out the landlord’s obligations with respect to the voucher program and specifies the portion of the total contract rent the PHA will pay to the landlord each month.

Voucher tenants pay income-based rents set at 30 percent of monthly household income but can pay up to 40 percent of monthly household income if the contract rent exceeds a rent level called the “payment standard” set by the PHA. The PHA pays the difference between the total contract rent and the tenant’s contribution.

Tenant-based vouchers can help low-income households afford modest housing in their communities; however, due to funding limitations, only about one in four needy renters receives assistance. Demand for vouchers is so high that a majority of PHAs don’t even have open waiting lists, and when eligible applicants do manage to get on an open waiting list, they often wait years to receive a voucher. Moreover, tenants frequently have trouble locating units to rent because of limits on the subsidy amounts PHAs will pay and because private landlords often discriminate against voucher holders.

**Section 8: Project-Based Assistance**

Under Project-Based Section 8, which was established in 1974, HUD enters into housing assistance payment (HAP) contracts with private owners of multifamily properties to serve low-income tenants. Incomes of new residents must be no more than 80 percent of AMI, and 40 percent of residents must have incomes below 30 percent of AMI. Because of additional set-aside and targeting rules enacted by Congress and HUD, it is nearly impossible for tenants with incomes higher than 50 percent of AMI to gain admission.

Of the roughly 1.2 million Project-Based Section 8 households, 49 percent include at least one person aged 62 or older. Owners of project-based Section 8 developments that were originally designed primarily for occupancy by elderly families may provide an admissions preference for elderly families.

Although Congress has not authorized or appropriated funding for construction of new 22 Note that as long as the contract rent is in line with the local rental market, there is no specific rent cap or restriction in the voucher program, i.e., voucher landlords are able to charge market rent to tenants using vouchers.

23 For more information about how payments standards work in the HCV program, see the Green Book, Chapter 1, Section 1.4.3.

24 Another form of Section 8 project-based assistance is the smaller Project-Based Voucher program. For information about that program, see the Green Book, Chapter 4, Section 4.2.4.3.


Project-Based Section 8 projects, an increasing number of public housing and other federally-subsidized properties are being converted under the Rental Assistance Demonstration (RAD) program.27 Rents are income-based, with tenants paying 30 percent of their monthly adjusted income for rent and utilities, and HUD paying the owner the difference between the contract rent and each tenant’s portion.

Beginning in the late 1990s, HUD delegated the responsibility of administering Project-Based Section 8 assistance to third parties, called “Performance-Based Contract Administrators” (PB-CAs). PB-CAs, which can be state housing agencies or nonprofits controlled by PHAs, will often be the first point of contact for advocates seeking to enforce HUD regulations and policies against a Project-Based Section 8 property owner.

Supportive Housing Programs for the Elderly and Persons with Disabilities

Two targeted multifamily programs, Section 202 and Section 811, serve the elderly and persons with disabilities by funding privately-owned affordable housing with supportive services. These programs have been through several iterations since the first Section 202 program in 1959, so older properties (generally those developed before 1990) may still operate under prior HUD rules and regulations.

The Section 202 program has helped to expand the supply of affordable housing with supportive services for the elderly by providing capital advances, operating subsidies and rent subsidies. It provides very low-income elderly tenants (those with incomes below 50 percent of AMI) with options that allow them to live independently and with support services such as cleaning, nutrition, health services and transportation. There are currently about 1.2 million Section 202 units.28 Congress has not appropriated any funds for new Section 202 projects since 2012, but funding continues for rent subsidies.

The Section 811 program provides funding for supportive housing for people with disabilities. There are currently about 33,000 Section 811 units, and 22 percent of those are occupied by households that include at least one elderly person.29 Rents in most Section 202 and Section 811 projects are income-based (30 percent of monthly household income). Some older projects may still have budget-based rents based on operating costs of the property, but in most cases, rental assistance is provided to allow residents to pay income-based rents.

Rural Housing Programs

The United States Department of Agriculture (USDA) operates housing programs through the Rural Housing Service (RHS), an agency within the Rural Development (RD) division of the USDA. RHS staff in Washington, D.C., establish the rules and policies for operating the housing programs through regulations, handbooks and other notices. The primary RHS programs serving the elderly are the Section 515 direct loan program and the Rural Development Voucher Program.

Owners of Section 515-financed properties receive loans from RHS in exchange for a commitment to maintain the properties as affordable for a set period of time. The program, which originated with the Senior Citizens Housing Act of 1962, has produced over 500,000 housing units. Currently, there are nearly 14,000 developments with over 410,000 units. Residents in some but not all of these properties also benefit from rental assistance payments that allow for income-based rents. Some Section 515 developments are restricted to elderly households and households with a person with a disability. More than 60 percent of Section 515 housing is occupied by tenants from these two groups.

The Rural Housing Voucher Program provides vouchers to residents of Section 515 developments who face rent increases related to the early termination of affordability restrictions on the properties.

27 For more information about the RAD program, see the Green Book, Chapter 1, Section 1.10.1.


29 Id.
The Low-Income Housing Tax Credit Program

The Low-Income Housing Tax Credit Program (LIHTC) was created by the Tax Reform Act of 1986 to finance the construction, rehabilitation, and preservation of affordable housing for lower-income households. Although housing tax credits are federal, each state has an independent agency that decides how to allocate the state’s share of the federal tax credits. The LIHTC program is responsible for adding or preserving an estimated 2.3 million affordable rental units. In 2018, Congress increased the LIHTC allocations by over 12 percent, so those numbers are expected to grow.

The income level targeted by LIHTC alone is much higher than most HUD or Rural Housing Service multifamily housing programs. The applicable rent-setting formula is based on AMIs instead of on tenants’ actual incomes, so without further subsidy, tax credit rent restrictions provide only a moderate level of affordability. However, many residents in LIHTC units benefit from additional forms of rental assistance such as Section 8 vouchers. Households that include at least one elderly member make up about 26 percent of all LIHTC households. Maximum rents for LIHTC units are set at 30 percent of household income for a tenant earning at the top of the relevant AMI category (usually 50 percent or 60 percent of AMI, but sometimes as high as 80 percent or as low as 30 percent). Unlike the Section 8 and Public Housing programs, these rents are flat rents and do not vary with an individual tenant’s income.

Admissions

The admission rules governing public housing, Section 8 programs, and HUD-assisted and subsidized housing, are specific to each program and can even vary for different developments. Further, unlike eligibility rules for other public benefits, the admission rules for federally-subsidized housing are not uniform within a state or county. Therefore, it is important to determine the applicable rules and procedures for each program and housing provider, which may be found in statutes, regulations, and handbooks. Detailed information about admissions to HUD programs is available in Chapter 2 of the Green Book.

Eligibility

For all of the HUD-assisted housing programs, a person must be at least 62 years of age to qualify as "elderly." An elderly family may include two or more elderly individuals living together, or one or more elderly persons living with one or more live-in aides. An elderly family may include children.

Because these definitions are statutorily based, PHAs and private owners do not have discretion to modify them. The statute does not require that the two or more elderly individuals be related by blood, marriage or operation of law. The public housing and Section 8 statute defines a “near-elderly” person to be an individual who is at least 50 but below 62 years of age. This definition may have significance locally with respect to waiting list preferences and if the PHA designates developments for the elderly.

Designated Housing for the Elderly

The designation of a family as elderly means that the family is eligible for housing available to the general family population and for housing designated for the elderly. For public housing developments designated as elderly-only or in which elderly residents are preferred over non-elderly disabled applicants, the PHA’s designated housing plan may also provide for admission of near-elderly families.


32For a discussion of live-in aides, see the Green Book, Chapter 2, Section 2.2.3.11.
For the Project-Based Section 8 program, owners of developments designed primarily for occupancy by elderly families may give a preference in occupancy to elderly persons. An owner may skip over non-elderly applicants to take elderly applicants who applied later as long as the required number of units reserved for non-elderly people is met.

For Section 202 developments, owners are permitted to restrict occupancy to elderly families in accordance with the rules and agreements governing occupancy in effect when the project was developed. In limited instances, if an owner is temporarily unable to lease all units to eligible families, the owner may request HUD approval to rent to families that do not meet age and income eligibility requirements.

Although the Fair Housing Act protects families with children from discrimination, certain housing for elderly persons is exempt from the familial status provisions. These provisions do not apply to properties that are intended for and solely occupied by persons 62 years of age or older and to certain properties that are intended and operated for persons who are 55 years of age or older. In addition, the familial status provision does not apply to federal housing that HUD determines is specifically designed and operated for elderly families.

Despite these exemptions, HUD Handbook 4350.3 provides that owners may not exclude otherwise eligible elderly families with children from elderly properties or elderly/disabled properties.33 Additionally, HUD’s Public Housing Occupancy Guidebook states that “[t]here is nothing in the definition of elderly family that excludes children,” and that grandparents with custody of grandchildren could comprise an elderly family.34

### Identifying Local Housing Providers and Affordable

**HUD:** Owners may not exclude otherwise eligible elderly families with children from elderly properties or elderly/disabled properties

### Rental Inventory

Many of the programs discussed above work in tandem with one another and/or with state or local housing programs. While information about state and local subsidized housing programs is beyond the scope of this article, advocates working with seniors who are trying to access affordable housing need to identify and understand the programs in their own communities as well as the federal programs to serve their senior clients.

To maintain a list of assisted housing in their communities, advocates will need to utilize several different resources:

- The National Preservation Database combines data from HUD, USDA, several other federal programs and from three states (Connecticut, Massachusetts and Florida). It is searchable by address and includes a number of important characteristics of each listed property, including type of subsidy, number of units and owner.
- Listings with PHAs’ contact information are available online. Keep in mind that some rental markets may be served by more than one PHA.
- HUD’s website provides information on the number of units in different programs managed by each PHA.37 Information about other subsidized projects is also available on the HUD website,38 but HUD’s information can be incomplete or outdated, so it will usually be necessary to contact housing providers directly to obtain, for example, information about the characteristics of the units at a given property.
- Information on housing projects and programs managed or owned by a PHA

33 HUD Handbook 4350.3, ¶ 3-23.
34 HUD Public Housing Occupancy Guidebook, § 2.2.
35 See [https://preservationdatabase.org/about-the-database/](https://preservationdatabase.org/about-the-database/). Free registration is required to access the database.
36 See [https://www.hud.gov/program_offices/public_indian_housing/pha/contacts](https://www.hud.gov/program_offices/public_indian_housing/pha/contacts)
37 Id.
38 See [https://resources.hud.gov/#](https://resources.hud.gov/)#
should also be available in its annual and five-year plans.

- HUD maintains an inventory of privately-owned HUD-subsidized properties that serve the elderly and people with disabilities, but the information there is out of date.
- Information about subsidies for rural properties, searchable by location is also available online.
- For properties in the LIHTC program, information should be available through the state agency administering the LIHTC program, but information about LIHTC income limits and maximum rents in a given jurisdiction are also available through an online calculator maintained by Novogradac & Co., a private entity that provides resources and consulting services to LIHTC developers. The National Preservation Database described above also includes information about properties financed through LIHTC.
- Local agencies, including state, county and/or city housing departments and housing finance agencies and non-profit affordable housing developers are also important resources for identifying affordable housing programs and providers.

**Relevant Laws, Regulations and Guidance**

Public Housing tenants’ rights are derived from numerous sources, including federal and state constitutional doctrines, the United States Housing Act, other federal legislation, the annual contributions contract (ACC) between HUD and the PHA, HUD regulations, handbooks and notices, state law, PHAs’ policies, and the lease. The primary guidance from HUD regarding the Public Housing program can be found in HUD’s *Public Housing Occupancy Guidebook* (June 2003).42

The major sources of tenants’ rights under the HCV program are the authorizing statute, HUD regulations, guidebooks and notices, the PHA’s local Administrative Plan, the ACC between HUD and the PHA, the HAP contract between the PHA and the landlord, the lease between the tenant and landlord, and state and local law. HUD’s primary guidance is in the *Housing Choice Voucher Guidebook* (which is currently undergoing a major revision).43

The Project-Based Section 8 program is governed by the authorizing statute, HUD regulations, guidebooks and notices, owners’ policies, HAP contracts between HUD and the owner, the lease, and state and local law. HUD’s primary guidance is in *HUD Handbook 4350.3: Occupancy Requirements of Subsidized Multifamily Housing Programs*.44

The current Section 202 and Section 811 and related rental assistance programs, along with some of the older Section 202 properties, are governed by a unified regulation, 24 C.F.R. Part 891, which sets forth residents’ rights and owners’ responsibilities. HUD has also published several handbooks related to these programs.45

All the USDA housing programs are authorized by Title V of the Housing Act of 1949, which is codified at 42 U.S.C. §§ 1471 through 1490t. Program regulations for the Section 515 program can be found in 7 C.F.R. pt. 3560. The regulations for the Rural Development Voucher Program are at 78 Fed.

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39 See https://www.hud.gov/program_offices/housing/mfh/hto/inventorysurvey
40 See https://rdmfhrentals.sc.egov.usda.gov/RDMFHRentals/select_state.jsp
41 See https://ric.novoco.com/tenant/rentincome/calculator/z1.jsp
42 See https://www.hud.gov/sites/documents/DOC_10760.PDF
43 See https://www.hud.gov/program_offices/housing/mfh/hto/inventorysurvey
44 See https://www.hud.gov/program_offices/administration/hudclips/handbooks/hsgh/4350.3
45 See HUD, *Section 202 Supportive Housing for the Elderly* 4571.3, REV-1 (Apr. 9, 1993); HUD, *Supportive Housing for the Elderly—Conditional Commitment—Final 4571.5* (July 21, 1992); HUD Section 811 Supportive Housing for Persons with Disabilities 4571.2 (June 1991); HUD Supportive Housing for Persons with Disabilities—Conditional Commitment—Final Closing 4571.4 (June 7, 1994); HUD Handbook 4350.3, ¶¶ 1–2 through 1–3.
LIHTC is governed by its authorizing statute in the Internal Revenue Code, by Treasury regulations, and by IRS rulings. In addition, each state’s allocating agency is required to develop a Qualified Allocation Plan (QAP) that lays out the rules for that state’s LIHTC program. A list of state allocating agencies is available online. The Novogradac website also includes extensive information about the LIHTC program.

Additional Resources

- National Housing Law Project at [www.nhlp.org](http://www.nhlp.org).
- National Low-Income Housing Coalition at [www.nlhlc.org](http://www.nlhlc.org).

About the Author:

Lisa Sitkin is a senior staff attorney with the National Housing Law Project in San Francisco. She provides technical assistance, training and resources to attorneys representing low-income homeowners and tenants. She has conducted workshops and trainings on mortgages, foreclosures, loan modification and foreclosure rescue scams. She helped to draft a bill that ultimately became the California Homeowner Bill of Rights. She has been practicing law since 1997.

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47 26 U.S.C.A. § 42.
48 See [https://www.novoco.com/](https://www.novoco.com/).
Jim, a 72-year-old Vietnam Veteran, was barely making ends meet on a monthly fixed income of about $2,000 in 2015. He’d spent the better part of the decade pursuing VA pension benefits and was denied three times. Jim, a lighting technician in the television and film industry, retired early on permanent disability at age 62 due to significant hearing loss caused by his military service.

In Vietnam, Jim loaded bombs onto fighter jets that were taking off from the aircraft carrier where he was stationed. He also witnessed the gruesome accidental death of a fellow soldier working right beside him—a memory he still vividly recalls more than 45 years later.

However, Jim was reluctant to include a mental health issue as part of his claim; he didn’t want to be labeled.

Jim came to our Community Services office at the MPTF (Motion Picture & Television Fund) in California to seek help with pursuing a service-connected disability claim for hearing loss, tinnitus and post-traumatic stress disorder (PTSD). After a year of paperwork and medical exams, Jim was awarded an 80 percent combined disability rating. A year later, this was converted to a full 100 percent rating, more than doubling Jim’s monthly fixed income in perpetuity. Jim no longer feels anxiety when routine bills arrive. He says this benefit has changed his life.

Sadly, Jim’s story is not unusual when military veterans, their surviving spouses, and their families seek VA benefits. This article is intended as an introduction to service providers who assist veterans and surviving spouses as part of their practice. The laws governing VA claims preparation and representation are stringent. Non-accredited individuals are permitted to assist one individual with one claim and cannot charge a fee. Despite these
restrictions, advocates for these clients can play a critical role in educating and empowering them to pursue and secure these essential monetary benefits.

**Types of Pension Benefits**

Three basic types of pension benefits are available to non-military-retired older veterans and their surviving spouses:

**Service-Connected Disability Compensation** is available to veterans who have sustained injuries or developed illnesses that can be linked directly to military service. This monthly pension benefit is not means-tested. The award amount is contingent upon the combined severity of the veteran’s disabilities, which are rated on a scale from 0-to 100 percent by the VA. Veterans rated at 30 percent or higher receive an additional supplement for dependents. Veterans rated above 70 percent who are unable to work may be eligible for conversion to a 100 percent rating. Veterans rated at 50 percent or higher are eligible for free VA health care; those rated at 100 percent are eligible for free VA dental care as well.

**Dependents Indemnity Compensation** is available to the surviving spouse of a veteran who died while on active duty or as a result of service-connected issues. This monthly pension benefit is awarded as a flat rate and is not means-tested. Surviving spouses receiving this benefit also are eligible for free health care from the VA.

**Non-Service Connected Pension** is available to veterans and surviving spouses who meet income and asset guidelines. The benefit is intended to augment the fixed income of clients who are living near or below the poverty level; it is known as low-income pension (veterans) or death pension (surviving spouses). Clients who meet income and asset guidelines, and require the assistance of another person to complete daily living activities due to frailty, cognitive impairment or severe visual impairment, are eligible for improved pension benefit (veterans) and improved death pension benefit (surviving spouses). This benefit is often referred to as **Aid and Attendance**.

Aid and Attendance funds can cover costs for residential care facilities, adult day health care, or in-home caregivers. These pension benefits are terminated when the client requires skilled nursing care covered by Medicaid/Medi-Cal in California. The award amount is contingent upon the client’s income versus countable care expense ratio. All non-service connected pension benefits are means-tested. The veteran also must meet discharge status and dates of service requirements to qualify.

**Major Barriers to Accessing Benefits**

Some people face many obstacles in navigating the notoriously complicated VA system, however, these hurdles often can be overcome with the support of a committed service provider. Here are a few common obstacles:

Clients who are unable to locate the veteran’s military discharge paperwork (DD214 form) must order it from the National Archives. Unfortunately, a 1973 fire at a large VA storage facility destroyed a significant percentage of military discharge paperwork from World War II through the Vietnam Era. If the veteran’s paperwork was destroyed, the National Archives may be able to provide an alternative certification of service. However, clients with cognitive impairment may not be able to provide the necessary information needed to complete the request form. Barriers also can arise for surviving spouses if the deceased veteran never shared important basic details of his/her military experience.
The “VA System” usually is cited as a major obstacle for anyone who wants to secure pension benefits. As is the case with many government agencies, current VA policies and practices often create inefficiencies and unintended consequences that adversely impact the very clients meant to be served. One current inefficiency is the lack of communication and integration between two internal VA systems—health (VHA) and benefits (VBA). For example, a veteran who has received hearing aids from VHA may not be referred to VBA to initiate a claim for a hearing loss pension.

**Large Caseloads, High Turnover**

The lack of consistency of Veterans Services Officers (VSOs) is another major stumbling block. These individuals can prepare claims and represent clients by virtue of their employment through the VA or other accredited organizations. However, large caseloads, pressure to meet weekly claims filing quotas, and low pay often result in high turnover. Some claims invariably fall through the cracks in these situations, resulting in delays or lost paperwork. After months of work, some clients even have been notified that they must re-start the process from the beginning. Availability of VSOs can also be very problematic. Many large VA facilities employ a “first-come, first-serve” policy regarding VSO appointments. Frail and/or cognitively impaired older clients are even more disadvantaged under this policy as they are unable to arrive in the early morning only to wait several more hours for a same-day appointment to file or follow-up on a claim. Fortunately, smaller VA offices and other accredited service organizations often allow their VSOs more flexibility to set dedicated appointment times.

The veteran’s own perceptions and experiences can create one of the biggest challenges. Clients with negative associations regarding their military service may be unwilling to file a claim if it will require interaction with VA systems. Some veterans are under the mistaken impression that filing for pension benefits may preclude another veteran “who needs it more” from receiving monies. Veterans with service-connected mental health issues often are concerned about being forced to take psychotropic medications and/or being labeled with a stigmatizing diagnosis if they disclose their struggles.

**Eligibility Screening**

Current legislation strictly prohibits non-accredited individuals from assisting multiple clients with claim preparation and representation, however, service providers still can play an integral role in empowering clients to pursue these benefits. Asking simple screening questions to determine eligibility, assisting clients in ordering documentation, dispelling common myths, and providing longer-term support to veterans who need time to resolve concerns about acknowledging or claiming certain service-connected conditions are essential interventions in facilitating the eventual award of these monies.
Top Screening Questions to Determine VA Pension Eligibility

- Did the veteran actively serve in one of the five main branches of the military?

In most cases, pension benefit qualification is contingent upon the veteran’s active duty service in one of the five main military branches (Army, Navy, Air Force, Marines, Coast Guard). National Guard or Reserve service does not meet eligibility guidelines unless the veteran was injured during training or activated for duty by the federal government during a qualifying period of war.

Do you have the veteran’s military discharge papers (DD214 form)? The DD214 form is a requirement to file any type of pension claim. Clients who do not have this document face additional delays or even may be unable to pursue benefits if service cannot be confirmed.

- What is the veteran’s discharge status?

A veteran’s dishonorable discharge status will exclude a client from benefit qualification. However, any discharge status except dishonorable will qualify a client for non-service connected pension. Veterans with discharge status including honorable, medical and general are eligible for service-connected pension. In certain cases, discharge status can be upgraded. Clients who require a discharge upgrade should be referred to an attorney or community-based legal advocacy group that specializes in this work.

Service-Connected Conditions:

- Does the veteran have any injuries, chronic illnesses or mental health conditions that could be service-related?

Commonly awarded service-connected conditions for older veterans include hearing loss, tinnitus and PTSD. Physical injuries or degenerative conditions not originally documented during military service are difficult to substantiate and are often denied by the VA. Certain illnesses are considered presumptive for Vietnam Veterans exposed to Agent Orange. Pension claims for presumptive conditions often can be fast-tracked if medical records, either from the VA or a private physician, are readily available. A list of these conditions can be found on the VA’s website.

- For veterans already service-connected, have any rated conditions worsened or have new primary or secondary service-related conditions developed?

Ratings for previously established individual service-connected conditions may be increased if symptoms have worsened over time. Additional ratings can be granted to increase the veteran’s overall combined rating if a new primary (Type 2 Diabetes, secondary to Agent Orange exposure) or secondary service-related condition (peripheral neuropathy, secondary to Type 2 Diabetes) develops.
Death Indemnity Compensation (DIC):

- Was the surviving spouse married to the veteran for at least one year at the time of the veteran’s death? Has the surviving spouse remarried? Does the surviving spouse have the necessary supporting documentation?

DIC benefit eligibility includes certain marriage requirements; in most cases, remarriage disqualifies a surviving spouse. The marriage license, the veteran’s death certificate and the veteran’s military discharge papers (DD214) are required to file for DIC benefits.

- Was the veteran receiving service-connected compensation or in the process of filing a service-connected claim at the time of his/her death?

DIC benefit eligibility requires an established service-connection that more than likely contributed to the cause of death. Surviving spouses may be able to claim DIC if the veteran had a pending service-connected claim at the time of his/her death.

Aid and Attendance

- Does the veteran or surviving spouse require the assistance of another person in completing at least two activities of daily living (ADLs)?

In addition to the typical definitions of ADLs (dressing, bathing, feeding, etc.), the VA considers ambulation difficulties, the need for medication management assistance, and cognitive impairment requiring supervision for the client’s safety as qualified conditions. If the veteran is caring for a spouse with Aid and Attendance qualifying needs, the benefit will be awarded as a small supplement to a 30 percent or higher service-connected rating. Clients who require assistance with independent activities of daily living only, such as housekeeping, meal preparation, transportation, etc., likely will not qualify for this benefit and should be monitored over time for functional decline.

- Do total VA countable assets fall within current guidelines, and has there been a transfer of significant assets within the last three years?

In October 2018, the VA formalized asset limits and instituted rules regarding look-back periods for asset transfers similar to Medicaid/Medi-Cal guidelines. The client’s primary residence is excluded. The projected 2020 maximum asset amount is approximately $129,094; annual household income is included in this calculation.

- Does the client meet monthly income guidelines? Alternatively, does the client show a countable care expense versus income ratio that brings monthly income within current guidelines or creates a deficit?

The 2020 monthly maximum Aid & Attendance income guidelines are $1,230 (surviving spouse); $1,912 (single veteran); and $2,266 (married veteran). However, allowable care expenses such as health insurance premiums, incontinence supplies, prescriptions, in-home caregiver costs, adult day health care fees, and residential care facility rent can be subtracted from a client’s total monthly income.
The Impact of Pension Benefit Awards

The impact of pension benefit awards is transformative for older veterans, their surviving spouses and their families. Service-connected benefits augment the veteran’s fixed income and increase overall financial stability. Low and middle-income veterans living only on Social Security who are granted a 100 percent service-connected rating have the potential to see fixed monthly income double or even triple. Surviving spouses who are awarded DIC benefits can mitigate the often financially devastating reduction of Social Security benefits when a partner dies.

For clients who are awarded Aid and Attendance benefits, this extra income can mean the difference between remaining in a preferred setting or facing premature institutionalization. Adult children who had to stop working or scale back hours due to caregiving responsibilities can be paid a stipend as in-home caregivers. Clients who were facing relocation from an assisted living facility to a convalescent home due to exhaustion of funds may be able to afford to remain in a less restrictive level of care for a longer period of time. Veterans (but not surviving spouses) may be eligible for up to one year of retroactive monthly benefits.

Taking on the task of facilitating VA pension benefits for this vulnerable population is not for the faint of heart. It is often labor-intensive, confusing and frustrating. It requires perseverance and tenacity, many of the same skills that these older veterans and their spouses employed while serving our country during times of conflict. However, there is no question that receiving a benefit award is life-changing. In addition to the practical outcome of providing additional financial stability, these awards can offer a space for emotional healing. They serve as a form of confirmation and recognition of sacrifice. By choosing to incorporate this work as part of our practice, we also repay them and truly thank them for their service.

About the Author:

Naomi Rodda is a licensed clinical social worker and VA accredited individual claims agent based in Burbank, California. She has presented at the local, state and national level on facilitating VA pension benefits. She currently serves as director of the Community Services office at MPTF (Motion Picture & Television Fund).

Helpful Links:

Ordering Military Service Records:
https://www.archives.gov/veterans

Presumptive Conditions for Agent Orange Exposure:

2020 Service-Connected Compensation Table:
https://www.benefits.va.gov/COMPENSATION/resources_comp01.asp

Non-Service Connected Pension Qualifying Services Dates:
https://www.va.gov/pension/eligibility/
How to Live Forever: A Guide to Writing the Final Chapter of Your Life Story

By Kimberly Best

Book reviewed by David Godfrey, JD, senior attorney, ABA Commission on Law and Aging

Your legacy is more than the Mustang convertible, the Florida condominium, or the possessions from a past generation that you leave behind. What’s most important is how you are remembered by loved ones and friends -- and this book explains how to live the last chapter of life in a way that enables you to “leave your legacy with purpose.”

For many families, the last illness of a loved one is a time of confusion and conflict. In How to Live Forever, author Kimberly Best offers sage advice and tips based on her work first as a registered nurse, and later as a mediator focusing on family conflict and elder care. She shares her insight working with families at critical junctures to inspire us to focus on relationships, and on resolving questions and conflicts, in our final stages of living.

This 122-page book begins with a simple overview of the importance of putting our legal affairs in order well before they are needed. The basic tools of financial planning and decision-making are explained, along with the basics of wills and trusts. A helpful checklist that may be needed or considered at or near the end of life is provided.

Families are often torn apart by not knowing what health care decisions to make on a relative’s behalf, or by conflict over the choices that are made. Best explains that effective planning assures families that the care a relative receives or doesn’t receive reflects that individual’s beliefs and values. Thought-provoking questions about end-of-life wishes are provided to help readers start a conversation with loved ones.
A Celebration of Life

Another chapter explores the trend toward a celebration of life, with a focus on the how a well-planned send-off can help the survivors at a very difficult time. Again, Best provides useful questions for readers to consider, such as:

- Who will be in charge of executing your wishes?
- What, if any, type of religious preference do you have for the ceremony?
- What type of funeral service/end-of-life celebration do you want?

In the chapter titled, *Telling Your Story*, Best puts forth ideas on how to develop, tell, record, or otherwise document this. “Stories live forever,” she writes, “so stories make us immortal.” The richness of these stories and recollections can be very healing for surviving family members. The author offers ideas and questions to help readers develop their stories for survivors to remember when they have passed on.

Resolving Conflict

Best uses the last several chapters of her book to focus on resolving family conflict through communication tools and mediation. Tapping into her expertise, she offers guidance to help mend broken relationships and improve communication while encouraging respect, understanding and forgiveness. The ideas in these chapters would easily translate to any family counseling or mediation.

I recommend this book to people who work with adults facing or nearing the final chapter of life, and to families with loved ones who choose to plan ahead, live fully, and pass on without regret. The book is written well and accessible to readers without specialized training. Each chapter has practice tips, checklists, or thought-provoking questions to ponder. The book is a fast read and compact for all of the tips, tools, and resources it offers.

A Personal Note: When my Aunt Edith died unexpectedly at age 57, her husband and son found a stack of letters in her desk drawer addressed to loved ones to be opened in the event of her death. Those very personal messages offered strength and reassurance to her family at a very difficult time. The letters are a very significant part of the final chapter of her life story.

--David Godfrey

For more information on advance planning, check out the ABA Commission on Law and Aging *Toolkit for Health Care Advance Planning*.

For *Advance Directives: Counseling Guide for Lawyers*, click here. This guide is designed to assist lawyers and health care professionals in formulating end-of-life health decision plans that are clearly written and effective. It includes a checklist for lawyers, which offers an itemized listing of what is expected throughout the entire process.

To learn about advance care planning practice principles, developed by experts convened by the Commission on Law and Aging in collaboration with the American Academy of Hospice and Palliative Medicine, the University of California at San Francisco Medical Center and the UCSF/UC Hastings Consortium on Law, Science & Health Policy, go to: https://www.americanbar.org/content/dam/aba/administrative/law_aging/acp-practice-principles-final.pdf
It’s Time to Plan for Elder Law Day

Planning for Elder Law Day is essential to help make the annual spring event a sterling success. The Commission on Law and Aging has developed a timeline to guide you as Elder Law Day approaches.

By Louraine Arkfeld, Commission Chair

Estate planning. Financial scams. Guardianship. Long-term care planning. Advance directives. These are among the topics that draw thousands of seniors and their families to Elder Law Day events happening around the country each year. For lawyers and other volunteers, this is an opportunity to reach out to your communities and provide essential information that older Americans need to help make their “golden years” safe and secure.

Now you might be saying: I thought the ABA did Law Day. We do! The ABA has been celebrating Law Day since 1958 with various themes to address and celebrate the Rule of Law in the United States. Elder Law Day is based on that idea but with a focus on issues that are critical to older adults’ health and wellbeing. The needs of the aging population, the “silver tsunami” as we know it, are many. The decisions they make to address those needs are crucial. That’s why it’s so important to help families understand something as seemingly simple as a will to more complex decisions about health care proxies and even their long-term-care rights. We must help families learn when guardianship is appropriate and when this new approach called supported decision-making is a better alternative.

The Commission on Law and Aging has been addressing these issues for years and we lead the nation in developing policy and guidance for attorneys who practice in these areas. We would like to see that expertise shared with your community.

Much like developing a local Law Day program, putting together an Elder Law Day requires planning. To help you, we’ve developed a guide and timeline for planning such an event. May 1 is Law Day, and May is also Older Americans Month, so the timeline is based on your Elder Law Day event held in May. The guide also includes a list of topics and activities. You can see by the length of the list just how many issues are up for discussion!

You are the key to the success of this program. By working with local partners, such as bar associations, courts and community organizations, you can perform a tremendous service for your community.

As you know, many seniors are preyed upon by scammers. Many of these older adults work their way through a maze of decisions with a lack of information or resources, and that leaves them feeling very vulnerable. You can provide these seniors with objective, important and necessary information to help them live and thrive.
So please honor your parents, your neighbors, and your colleagues by being part of this important event. I thank you for your participation and service to others. And they will thank you as well!

Background

Law Day is held annually on May 1. It is a national day to celebrate the rule of law and to help the public understand how laws and the legal process protect our liberty and contribute to the freedoms that all Americans share.

In 1958, President Dwight D. Eisenhower established Law Day by issuing a proclamation. In 1961, Congress passed a Joint Resolution designating May 1 as the official date for Law Day. The Joint Resolution requests that the president of the United States issue a proclamation each year and provides that Law Day “is a special day of celebration by the people of the United States ... in appreciation of their liberties and the reaffirmation of their loyalty to the United States and of their rededication to the ideals of equality and justice under law in their relations with each other and with other countries; ... for the cultivation of the respect for law that is so vital to the democratic way of life ... inviting the people of the United States to observe Law Day, U.S.A., with appropriate ceremonies and in other appropriate ways, through public entities and private organizations and in schools and other suitable places.”

Elder Law Day was derived from the American Bar Association’s annual Law Day event as an opportunity to reach out to older adults and provide important information to help them make informed decisions about their health and financial well-being. Each year events and programs are planned and carried out by bar associations, courts, community organizations and other entities. Seniors, caregivers, and family members learn about guardianship, supported decision-making, planning for adult children with disabilities, patient rights, power of attorney, long-term care rights, the role of a health care proxy, and other issues, through attorney-led seminars and other events.

In Arlington County, Virginia, for example, the Bar Association partnered with the county government and Legal Services of Northern Virginia to hold its 35th Annual Senior Law Day in May 2019. The theme was “Elder Rights: No Courts, No Justice, No Freedom.” Speakers in the county’s Central Library auditorium talked about the necessity of making a will, the importance of identifying a person you trust to make personal health and financial decisions for you in the event you became incapacitated, and the seriousness of scams perpetrated against seniors.

Planning

May 1 is dubbed by the ABA as Law Day and May is also Older Americans Month. Every year in May the Administration for Community Living (ACL) celebrates older adults, which makes May the perfect time to host an Elder Law Day event. [This year, “Make Your Mark” is the theme of Older Americans Month to celebrate the contributions older adults make to our communities]. The ACL website is also a great place to find resources that can help make the event a success.

January/February

Establish an Elder Law Day Committee and begin discussing potential themes or the kinds of programs you want to be included. Identify goals, objectives, activities, schedule of events, volunteers, speakers, and a budget. Next, it is important to recruit a variety of volunteers, attendees, and partners. Usually, lawyers and law students are eager to be involved in their community and help the public to better understand the legal system. Reach out to bar associations, National Association of Elder Law Attorneys, Agency on Aging staff, and other organizations.

When recruiting attorneys, consider using a recruitment letter that includes a realistic amount of time that the attorney would need to devote, an outline of the program, and a section to indicate activities for which they’d be available and their expertise. (If possible, a letter signed by a judge or bar official may catch an attorney’s attention and interest in participating).

This also is a good time to begin developing a publicity/media campaign. This could include flyers, websites, social media posts, press releases, or newspaper articles [more on this below]. Next, choose some potential locations for the event, such as senior centers, elderly housing projects,
retirement homes, nursing homes, libraries, religious institutions, schools, hotel conference rooms, or shopping malls. The site should be able to hold a large audience and should be in an accessible area that is well known.

**March**

With about two months remaining before the event, it is time to finalize and confirm the volunteers, speakers, and support for Elder Law Day, and begin implementing the publicity campaign to advertise the event. This includes designing and printing all materials needed for events and activities, arranging for a photographer for various events/activities, and generally making sure that the various events are ready. Some events that could be included: an “Ask a Lawyer” section, a “Mock Trial” to give folks an idea of what happens in court situations, and a free photo identification service (reach out to the local sheriff’s office). It is also a good idea to have a few speakers to give lectures in their areas of expertise. The location for the event should also be finalized and confirmed by this time.

**April**

With one month to go, the media/publicity campaign should be finalized and running. Now that all the events/activities are established and the materials printed, this is the time to handle the logistics of the volunteers. Distribute materials to the volunteers for advance preparation of the presentations and activities. Set up an orientation for the volunteers, training them briefly in speaking to older Americans. Make sure the lawyers are familiar with elder law issues and know how to refer participants to additional legal services.

About one to two weeks before the event, convene the planning committee one last time for a final review of all aspects of the Elder Law Day celebration, and follow up with any media contacts.

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**Elder Law Day**

The day is here! Enjoy the event, make sure it runs smoothly, and take notes. Be sure to collect feedback forms, or at least let attendees know that feedback is welcomed and encouraged, to improve the event for next year!

**Post-Event**

Convene the planning committee to assess the event for future years. Go through all the feedback information. Perform a final check on the budget and make sure all expenses are accounted for, then send thank you letters to all volunteers, sponsors, media, schools, and any other participating organizations. Congratulations on a successful Elder Law Day celebration!

**More on Planning Publicity**

Publicity is a necessary and extremely important part of the planning process. Types of publicity include:

- Public Service Announcements (PSAs)
  - Call or write public service directors at radio and television stations to request free air time.
  - Create a public service announcement for your program.

- Press Releases
  - Include who, what, when, where, and why specifics.
  - List a contact person’s name and number for more information.
  - Send press releases to local papers and newsletters for senior citizens as well as to city newspapers.
  - In accordance with ADA regulations, state that the program will be accessible to persons with physical disabilities.

- Posters and Pamphlets
  - Choose popular locations to maximize attendance such as grocery stores, libraries, and senior centers.
Create pamphlets and posters that are visually appealing, large print, and easy to read. State that the program is accessible to persons with physical disabilities.

- **Official proclamation**
  - Request that a governor, mayor, or other elected official issue a proclamation dedicating Law Day to older Americans.
  - Request a public signing by the elected official to increase the amount of coverage by the press of your Elder Law Day activities.

**Press coverage:**
Contact the media and bloggers to get coverage of your event and promote community awareness.

**Programming**

Here is a list of topics and activities to consider for Elder Law Day:

- Estate planning
- Wills versus trusts
- Financial planning basics
- Balancing love/marriage against estate, tax and Medicare concerns
- Workshops in Spanish
- Brief one-on-one consultations for seniors and their families with elder law attorneys, certified financial planners, geriatric care managers, etc.
- Grandparents’ rights
- Medicare, Medicaid, and long-term care
- LGBT legal issues
- Veterans’ benefits
- Elder abuse and mistreatment
- Senior housing options
- Powers of attorney
- Health care decision-making
- Challenging a denial of health and disability insurance
- Pre-planning a funeral
- Future care planning for adult disabled children
- Managing income in retirement
- Overview on Alzheimer’s and dementia
- Fraud prevention
- Long-term care insurance
- Reverse mortgages
- Long-term care regulations and resident rights
- Family caregiver support programs
- Nutrition
- Securing benefits
- Guardianship and supported decision-making
- How to protect a beneficiary’s inheritance from divorce, lawsuits, creditors, government claims and double estate taxes
- What to do when someone dies
- Update on estate and income tax laws
- Local resources

**Evaluation**

- At the end of the program, request that participants (seniors and attorneys) fill out an evaluation form. Ask questions on program content, program length, usefulness of handouts, what they liked/disliked, suggestions for improvement, and demographic questions.

- Use the bar/aging network links created through the Elder Law Day effort as a springboard to develop other ways to meet the law-related needs of older persons.

**Conclusion**

Interested and enthusiastic people who are willing to devote time and energy to organizing will produce an effective Elder Law Day program. Community residents welcome free legal information or assistance. Public interest in legal issues will attract the media. The opportunity to fulfill public service responsibilities will attract bar groups and individual attorneys. Neighborhood and community organizations appreciate programs that are relevant and that involve their members.
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The Challenges of Caring for the Growing Elderly Population

By Joanne Lynn

Joanne Lynn, M.D., testified before the House Ways and Means Committee on the difficulties and obstacles that the growing number of elderly persons living with progressive disabilities will pose for the United States – and within just 15 years. In excerpts below from her testimony in November, she also offers options for action that meet these needs.

Most Americans will live with serious disabilities in old age for an average of two years. We should be able to count on living comfortably and meaningfully in those years, with costs and burdens that elders, their families, their communities, and the nation can manage.

I have been a physician for 45 years, mostly serving elderly persons and hospice patients in Washington, D.C. I have written hundreds of professional articles, books, and chapters; and dozens of publications with and for public bodies. I have been a tenured professor at two medical schools, a senior researcher at Rand, and an official at the Centers for Medicare and Medicaid Services (CMS) and at the Washington, D.C., public health department. I am an elected member of the National Academy of Medicine. I am now a Health & Aging Policy Fellow and am continuing to work on innovative projects at Altarum’s Program to Improve Eldercare. However, my work, like so many others, amounts to little if our country continues to drift into tolerating the effective abandonment of elderly persons in their last years.

Social Supports Inadequate

Between 2010 and 2035, the population of elders in the U.S. will double. Many are healthy when they turn 65, the traditional retirement age. But virtually all of us will have serious degenerative conditions causing progressive illness and disability in our last years. We all know this in a vague way, but mostly we remain unaware of how expensive and dysfunctional our long-term services and supports (LTSS) arrangements are until we must support an older relative or friend.

In a long life, a period of disability is expectable; yet the average retiree now often has insufficient assets and income to provide for housing and food while that person is still independent and well. Half of Americans ages 65–74 have no retirement savings at all.¹ A recent simulation of population dynamics for the next 10 years showed, stunningly, that most people who had a middle-class income during their working years would be unable to purchase housing, food, and medical care as retirees in 2029.²

Women bear the brunt of the challenges of old age, first as unpaid caregivers for parents, spouses, and/or disabled adult children, and then as disabled widows. Fewer adult children or other younger potential caregivers are available nearby to help, as families have fewer children who often move away or must work two or three jobs themselves.

Our social support arrangements are inadequate, since the Older Americans Act (OAA) has never been funded at a level that meets the needs. Thus, many cities now have more than six-month waiting lists for home-delivered food; a disabled man in Memphis waited a year for home-delivered meals.³ The waiting lists for disability-adapted and affordable housing are routinely longer than the lifespans of those in need. Federal funding for supportive services has lagged behind population growth for many years.
We could build a social system that makes it possible to count on living as comfortably and meaningfully as possible through that period of disability and illness that will eventually take our lives. But the current performance of the care system is so frustrating and hazardous to elderly people and their families that we must address those dysfunctions.

OLD AGE COULD BE REWARDING ... WITHOUT STUNTING THE ECONOMY OR ABANDONING OUR ELDERS. WE URGENTLY NEED A VIGOROUS DISCUSSION OF THE HONEST FACTS AND A SPIRIT OF INNOVATION AND LEARNING THAT MOVES US TO ACTION.

Financing Reforms

The growing ranks and the older ages of older adults will double the needs for medical and supportive services by the early 2030s. The escalating prices of medical treatments and personal care will also increase the costs. Elders eligible for Medicaid will increase dramatically, but state budgets will be unable to escalate to match the needs, so states will probably have to restrict enrollment. Ever more elders will fall into the gap between Medicaid coverage and adequate personal assets; they will be unable to afford essential supports and will have to confront homelessness, food insecurity, inability to manage personal hygiene, and being unable to pay the premiums, co-pays, and deductibles in Medicare.

Addressing these challenges requires pragmatic planning. The financing of personal care for disabled elders cannot come entirely from escalating taxes. Not only would that be politically difficult, but the numbers in need and the costs of their care are likely to exceed the capacity of the economy to generate enough revenue at the time needed. In contrast, personal savings, including buying insurance, stimulate the economy. At present, society provides few financial vehicles that make it easy, expected, or appealing to save for illness and disability in old age, even for middle class families where lifelong savings would be plausible. Rearranging certain social policies to generate private savings adequate to cover a substantial proportion of the costs of disabilities in old age is an urgently needed strategy.

The Bipartisan Policy Center contracted a simulation of an appealing strategy to finance long-term services and supports (LTSS). In short, a state or federal government would cover long durations of LTSS needs, called the “tail” of long-term care. The “front end” then might be addressed, in part, with state initiatives like the one implemented in Washington state; otherwise, the first years of covering the costs of LTSS would remain with elders, their families, and their communities. For impoverished elders, Medicaid would continue to cover services. The time that individuals would need to cover would depend upon that person’s income during their working years. A person earning low income might only need to self-fund the first year of

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Parikh, Montgomery, Lynn. NEJM 373:388 2015

Bifocal January-February 2020
needing LTSS, while a person with high income might have to fund five years.

When modeled in this way, the social insurance component could be financed with less than 1% added to the current Medicare tax. Public coverage of the “tail” of long-term care would make risks and costs predictable, thus stimulating a market for front-end coverage. At age 50 or so, people could estimate their risk of needing LTSS and their likely family situation. They could prudently save or insure to cover the predicted costs, thus avoiding incurring unexpected financial hardship on themselves and their family. An approach like this would encourage savings and investment to mitigate risk, and the model shows a 23% reduction in Medicaid costs as well. Other options should be tested, like adding some LTSS coverage to Medigap plans, as is being considered in Minnesota.

Altarum’s Program to Improve Eldercare modeled improved medical care for elders living with disabilities, showing that implementing known quality improvements and efficiencies in medical care in a geographic community would net savings of $267-$537 per beneficiary per month, which could be a substantial contribution to meeting LTSS needs, if there were a way to harvest and employ the savings.

The federal government should also undertake modest reforms such as removing the HIPAA requirement to offer 5% compound inflation with long-term care insurance (LTCI) policies, permitting penalty-free distributions from tax-privileged retirement accounts to purchase LTCI, allowing tax-advantaged long-term care savings accounts, and sponsoring substantial public education about retirement security and LTSS needs.

Reforms in Housing

Without improvements, more than half of Americans who lived their working lives in the middle class will be unable to afford housing in retirement, within 10 years. This risk of being homeless in old age hits even before these elders encounter serious disabilities and illnesses and those costs.

The housing we need for elders must be adapted to living with disabilities. Most of our housing has steps, narrow halls and doorways, and dangerous bathtubs and showers. Still, most elderly people strongly prefer to stay in their homes. The CAPABLE (Community Aging in Place—Advancing Better Living for Elders) project, a successful innovation sponsored by the Center for Medicare and Medicaid Innovation (CMMI), enabled minor housing renovations to improve safety and usefulness of existing housing and showed remarkable reductions in hospitalizations, falls, and nursing home placement. In 1985, Singapore started requiring that all new or renovated residential housing be adapted for living with disabilities. Elders now have many places to live in Singapore.

Now is the time to enact legislation to build greater capacity in housing that works for people across their lifespan through state grants. Housing stock that would be safe, affordable and accessible would prevent having to live in a nursing home when disability sets in (often paid by Medicaid) for lack of available housing.

Defeating Malnutrition

By federal standards, 7.7% of elderly persons are food-insecure for financial reasons. Some have the money but not the transportation or the ability to carry or prepare food. Food supports for elderly and disabled persons have been a mainstay of the OAA, the supportive services statute enacted with Medicare and Medicaid. While Medicare and Medicaid funding has increased more rapidly than the population, OAA funding has nearly stagnated, and it shows. Too many elders live on “tea and toast” or “rice and beans.” Waiting lists for home-delivered food (e.g., Meals on Wheels) are longer than six months in many cities and the service is not available in many rural areas. Food needs to be appealing, meeting medical and religious requirements, and nutritious, or it is worthless or harmful. Medicare Advantage (MA) plans can now pay for some social supports and are testing the effects of delivering food to high-utilizing elders. Tying food delivery to MA plans, rather than to preventing hunger and improving nutrition in the
whole community, will create inequities and inefficiencies.

What can be done? The cost of delivering food to homes generally runs around $8 per day. We could resolve to pay enough to eliminate the waiting lists. We could encourage participation of eldercare nutrition programs in local food systems to make available produce, healthy variety, and culturally appropriate food. We could have better data on nutrition of older adults living with disabilities. A July 2019 analysis found that a Medicare benefit to deliver meals to persons living with complex illness would yield $1.57 of savings for every $1 spent. Saving older adults from the pains of hunger and the exacerbating effects of malnourishment keeps these people out of hospitals.

Reforms in Medical and Nursing Care

The medical and nursing care of elderly persons needing LTSS is only rarely excellent. The most glaring problem is the near-total lack of continuity across settings and time. The growth in hospitalists, SNFists (physicians who work only in skilled nursing facilities, or SNFs), and every sort of specialty is in stark contrast to the dearth of geriatricians and primary care physicians. It is now quite rare to have a trusting relationship with a practitioner who understands your medical and functional situation, your living situation, and your priorities and preferences. Very few physicians know geriatric syndromes, the importance of function and cognition, the services available in the community, and the living situation of their elderly patients. Hospital staff rarely understand their patient’s overall situation, and hospitalization routinely disrupts the arrangements the elder has built up into an adequate routine.

Incredibly, the federal electronic medical record certification requirements still do not require a place to record the patient’s caregiver, preferences, functional status, and living situation. Very few electronic medical records include information collected from all local providers, which is necessary to guide the patient, caregiver, and providers.

Reforms in Personal Care

Personal care aides are in such short supply that elders known to need aides and be eligible for Medicaid coverage often simply cannot be served. I recently was in an Ohio city where 250 Medicaid beneficiaries living at home were known to need personal care, but the workforce was not available – so they went without, risking infections, poor nutrition, isolation, and avoidable medical care. The shortage of training and workforce numbers affects every other kind of job serving elders who are frail, ill, or disabled. For example, no geriatricians have appointments available in Washington, D.C., unless the patient is a veteran. The number of physicians training in geriatrics is declining, since the work is hard and the pay is lower than for other physician specialties.

If we were to build eldercare anew, we would emphasize continuity, team-based care, supportive services, training in behavioral issues and multiple chronic conditions, and data to guide improvement activities for geographic communities. None of these are part of our current arrangements.

Reforms in the Volunteer Workforce

Most care for frail, ill, and disabled elders is given without payment by family and friends, even though they get little recognition, support, or resources for
this disruptive and
difficult job. Nearly all
Americans have been,
will be, or are now
caregivers to a
disabled adult, and
most of us will need
caregivers. Yet, a woman who cares full-time for a
family member averages more than $250,000 lost
from her income and retirement security. Family
caregiving is becoming a task that impoverishes
families for generations. Half of volunteer caregivers
handle complex treatments that would require a
registered nurse if done in a hospital — e.g., dialysis,
intravenous medications, or wound care. Most
employers give no flexibility to family caregivers and
have substantial productivity losses from
unscheduled leave, early retirement, and employees
who are less productive due to competing concerns
about an elder they are supporting.

If one counts every adult aged 40 to 65 as a
potential caregiver, already we have one elder over
age 80 per seven working-age adults. In the next
decade, that ratio will go down to 1:4.

Reforms to Prevent Abuse and Neglect

Everyone can imagine the challenges of caring for an
erly person disabled by cognitive failure and
behaving in difficult and unpredictable ways.
Caregivers all too often become unable to provide
adequate care, but they have no options for help.
For a person at home, nursing homes are
undesirable, expensive, and often simply unavailable
— and home care aides are difficult to find or
unaffordable. For a person already in a nursing
home, staffing shortages are too often the norm,
and aides and residents have no power to force
improvements.

These situations often eventuate in neglect and
abuse, which annually harms one-tenth of America’s
seniors. In addition to the elder’s suffering, abuse
doubles the use of hospitals and emergency rooms,
quarters the use of nursing homes, and more than
doubles the risk of death within the next year. The
entity generally responsible for investigation and
intervention when needed is Adult Protective
Services, an underfunded and unempowered public
service that often cannot investigate promptly or
provide caregiver respite or qualified aides. The
Elder Justice Act has not been funded or
implemented, so it has not resolved this situation.

Public health and medical personnel could take more
active roles. A Federal Office on Elder Justice could
coordinate the required health, social, and legal
resources. The National Background Check Program,
which has provided grants for 29 states to establish
multi-source screening systems, should be extended
to all states, so that long-term care providers would
have to conduct pre-employment checks as a
condition of participation in Medicare and Medicaid.

Financial scams have become a major scourge with
elderly people being bombarded by illegitimate
phone calls and social media. Elders living alone may
be easy targets for scammers. Privately-hired aides
sometimes become unworthy trusted friends who
divert the elder’s assets to their personal gain.

Public Policy Improvements

The movement to improve eldercare has two
advantages: (1) everyone has a stake in having
reliable and efficient
arrangements for their own
old age, and (2) nearly
everyone will be a caregiver
to an adult. Eventually,
these will overcome the
current tendency to see
LTSS as a black hole of need
that has little effective
advocacy. Forward movement requires making the
current and oncoming challenges widely known.

About half of the public still thinks that Medicare
covers long-term services and supports. They learn
otherwise when a family member or neighbor
suddenly needs help and they find a chaotic array of
services that make no sense, leave huge gaps, and
are quite expensive.

Elders and caregivers are learning to demand a
better deal. This is a leadership opportunity in a
critically important but largely latent issue.

Elderly people with disabilities now face a scattered,
inefficient set of care arrangements with
incomprehensible and frequently changing eligibility for services, inadequate numbers and under-training of personal care aides, and a widespread avoidance of dealing with the situation now or as it worsens in the future. Scores of improvements are known and scores more are worth testing. We can do better. But doing better requires a mobilized citizenry and thoughtful and committed leaders. We need innovation and evaluation, along with strong commitment and vision. For eldercare to be reliable and affordable, we need to redesign our care arrangements, our housing, and food supports, our transportation arrangements, and especially our financing. We will have our new demographics for the foreseeable future, and the numbers will be overwhelming within a dozen years without action now. But with action now, we could have trustworthy and efficient arrangements. The window of opportunity for instituting preventive reforms in financing of retirement and eldercare is still open, but it is closing. Leadership is essential, though many are ready to help. The issues are classically bipartisan: we all hope to grow old, and impoverished and disabled elders will affect every family.


7 Caroline F. Pearson et al., op. cit.
9 James Ziliak and Craig Gundersen, “The State of Senior Hunger in America in 2017”

"Elderly people with disabilities now face a scattered, inefficient set of care arrangements with incomprehensible and frequently changing eligibility for services ... and a widespread avoidance of dealing with the situation now or as it worsens in the future. We can do better. "

https://doi.org/10.17226/23606.
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Call for Workshop Proposals for the 2020 National Aging and Law Conference

Please share your expertise at the 2020 National Aging and Law Conference (NALC) October 22-23 at the Hilton Crystal City in Arlington, Virginia.

This is the seventh year the ABA Commission on Law and Aging will host NALC. Much of the agenda is developed with proposals from speakers and authors who come to share their expertise.

The agenda will feature a balance of programs on retirement income security, guardianship reform, capacity and decision-making, elder abuse, Medicare/Medicaid, long term care, consumer law, and legal service delivery.

Proposals are due by February 23. Details and the proposal forms can be found at https://www.americanbar.org/content/dam/aba/administrative/law_aging/2020-nalc-rfp.docx.

Please contact David.Godfrey@Americanbar.org with any questions, or if you need help obtaining the workshop proposal form.

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There are several reasons why lawyers need to meet with a family member or friend alone for at least part of the case evaluation process. This brochure helps to explain the ethical guidelines that lawyers follow when meeting with their clients. We call it the “Four C’s” of elder law ethics—client identification, conflicts of interest, confidentiality, and competency. It helps family members understand the relationship between a lawyer and an older client.

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