Chapter Fifteen
The Rights of Older Americans

Contents

IN THE PAST, most of us viewed sixty-five as the age of retirement. Today, more people are choosing to continue working full or part-time well into their seventies or even eighties. Many even change their careers in later life. The contributions of older workers testify to their vitality.

I. Age Discrimination on the Job

The Age Discrimination in Employment Act (ADEA) ensures that older workers receive equal and fair treatment in the workplace. It protects most workers forty years of age and older from arbitrary age discrimination while on the job. It also seeks to support the employment of older persons based on their ability rather than age. See the chapter titled "Law and the Workplace" for a detailed discussion of the ADEA.

Q. Can I be forced to retire from my job when I reach a certain age?

A. Not if you are at least forty years old and work for either: a private employer with twenty or more employees, or the federal government or any local government.

If you meet these criteria, you are protected by the Age Discrimination in Employment Act cannot be (ADEA) and cannot be forced to retire. The U. S. Supreme Court has held that the ADEA cannot be applied to state governments. However most states have statutes that provide similar protections.

Q. My employer says that I do not have to stop working at age sixty-five. However, I will have to accept a job with less responsibility and less pay. Is this legal?

A. No, the ADEA also protects you in your present job situation. Your employer may not force you to take a less responsible job or accept a lower salary.

Q. Are there exceptions to the rule that employees may not be forced to retire?

A. Yes, the ADEA does not protect two categories of employees. One is government officials who are elected or appointed to a policymaking level. This exception includes the non-civil- service staff of these officials. The other is persons in bona fide executive or high policymaking positions.

Q. Must I retire if I become ill or disabled?

A. The law protects you only from being forced to retire because you have reached a certain age. If an illness or disability prevents you from doing your job satisfactorily, the ADEA does not prevent your employer from requiring you to retire, regardless of your age. However, other federal and state laws--including the 1990 Americans with Disabilities Act (ADA)--forbid discrimination against persons with disabilities or handicaps, including those associated with certain illnesses. So, if the ADEA does not cover you in these circumstances, you should consider whether you are being unfairly treated because of disability.

Q. Are there any circumstances in which age discrimination by an employer is allowed?

A. Yes. If the employer can prove that age is a bona fide occupational qualification (BFOQ), discrimination is allowed. One obvious example of age as a BFOQ is a part in a movie requiring a child actor. The possibility of age as a BFOQ is most likely to arise in jobs directly involving public safety or public transportation personnel. However, the BFOQ exception is rare, difficult to prove, and the burden of proof is on the employer. The employer must show: first, that the job qualifications are reasonably necessary to the essence of the employer's business; and second, that substantially all persons over the age limit cannot perform the job safely and efficiently, or that it is impossible or highly impractical to assess fitness on an individualized basis.

The Breadth of Age Discrimination in Employment

The ADEA does not offer a concrete definition of discrimination. Instead, the Act prohibits employers from doing anything that harms an older worker's status because of his or her age. This may range all the way from offensive age-related jokes to using age as a factor in hiring, firing, layoff, promotion, demotion, working conditions and hours, training opportunities, compensation, or benefits. Historically, most ADEA lawsuits have involved firings or layoffs of older workers.

Q. If I am part of a company division or class of employees being laid off, does the ADEA protect me?

A. Yes, if the employer considered age a factor in the layoff. Employers may make layoff decisions based on reasonable factors other than age. However, sometimes those factors merely mask age discrimination. For example, if an employer lays-off only higher paid employees, it is possible that the employer is unlawfully discriminating against older employees. Higher pay is often synonymous with higher age.

Q. Can my fringe benefits, such as employee insurance benefits, be reduced because I am older?

A. Normally no, although the law gives employers some flexibility in applying this rule. The general rule, with some exceptions, requires employers to provide all age groups the same benefit, or alternatively, provide a benefit that costs the same for all age groups. For example, if a given life insurance benefit actually costs the employer more for older workers, then the employer may provide older workers a smaller insurance benefit, as long as the cost of the benefit to the employer is the same as that offered to younger workers.

As to health insurance, employers must cover older workers and their spouses under the same conditions as younger workers. Your benefits cannot be lowered just because you become eligible for Medicare. In fact, the employer insurance must remain the primary insurer. Medicare will cover you as a secondary insurer while you continue working.

Q. Can I be denied new training that younger workers are receiving?

A. No. Older workers must be given the same privileges of employment as younger workers. These privileges include training.

Q. What are older workers' rights to promotions?

A. Under the ADEA, older workers must be given the same chance to receive promotions as all other workers. But age does not entitle a person to a promotion; an employer may have a valid reason, apart from age, for promoting a younger person rather than an older one.

Q. Can a change in job assignments be considered a form of discrimination?

A. Yes. Employers cannot use terms or conditions of employment to discriminate against older workers. If a change in job assignments is used for this purpose, it is prohibited.

Q. What if my age is only one of the reasons I was discriminated against?

A. As long as age is a determining factor for the discrimination, you are protected by the ADEA. Age does not have to be the sole factor. Other unlawful forms of discrimination, based on factors such as race or sex, are covered by other laws.

Q. If I work in a foreign country, does the ADEA protect me?

A. Yes, if you work for an American corporation or its subsidiaries and if the ADEA does not directly conflict with the law of the country you work in.

Employment Agencies and Unions

The ADEA also applies to employment agencies and labor organizations. These organizations may not discriminate on the basis of age in referrals, notices, advertisements, or membership activities.

Overqualified or Discriminated Against?

Could a prospective employer say that you are overqualified for a job? Is this legal? It depends. Sometimes it might be reasonable to deny you a job because you have too much experience or education. For example, it is reasonable to assume that someone with a Ph.D. in education is overqualified for a teacher's aide position that requires only two years of college education. In other cases, a court might decide that calling you "overqualified" is just an employer's pretext (excuse) to avoid hiring an older worker. Therefore, be wary if a potential employer says, "I'm sure that with your long experience, you wouldn't be interested in this entry level position."

Q. Can an advertisement state that only younger workers are wanted for a job?

A. Not unless age is a bona fide occupational qualification (BFOQ). Except for this rare exception, advertisements are not allowed to exclude or discourage older workers from applying. Although courts differ as to which phrases are permissible and which are not, a general rule is that ads can not imply that only certain age groups are wanted for the job.

What to Do if You Are Discriminated Against

Q. What can I do if I have been forced to retire, fired or otherwise discriminated against because of my age?

A. You should file a "charge" of age discrimination in writing with the federal Equal Employment Opportunity Commission (EEOC). If your state has an age discrimination law and enforcement agency (not every state has one), you should consider filing the charge with both the EEOC and your state agency. (The reason for hesitation is that in some states, filing a charge may prevent you from obtaining certain types of legal relief otherwise available to you. Before filing a charge, consult an attorney in your state.)

In many cases, filing a charge with either the EEOC or the state agency is automatically treated as filing with both. To be on the safe side, you should usually take the initiative and file with both.

If you file a charge, your name will be disclosed to the employer. If you wish to remain anonymous, you can file a "complaint" instead. A complaint may start an EEOC investigation; however, the government gives complaints lower priority than charges. In addition, even if EEOC intervention leads an employer to correct its discriminatory practices, your own past unfair treatment may not be remedied if you filed only a complaint.

Q. What is the EEOC?

A. This federal agency has the power to investigate, the duty to mediate, and the option to file lawsuits in order to end practices of age discrimination. See the chapter titled "Law and the Workplace" for more about the EEOC.

Finding the Closest EEOC Office

EEOC offices are listed in the telephone directory under United States Government. You may also find the location of the office nearest you by calling a nation-wide toll-free number: 1-800-669-4000 or by connecting to the EEOC Internet site at.www.eeoc.gov.

Q. Do I have to contact the EEOC with my claim, or can I file my own lawsuit?

A. You must file a charge with the EEOC first. After sixty days, if the EEOC has not filed a lawsuit, you may do so.

Q. What information should be included in my charge?

A. You should include as much relevant data as possible. Be sure to include information about how to contact you, the name and address of the discriminating party, the type of discrimination, relevant dates and witnesses, and specific facts. If pertinent, you might also include employment contracts, brochures or similar documents that demonstrate company policy. Before you file the charge, make sure you sign it.

Q. How long do I have to file a charge with the EEOC?

A. Normally, you have 180 days from the date of the violation or reasonable notice of it (whichever occurs first). It is important to understand the time limits. If you are given notice of layoff on January 1, to take effect March 1, the time limit begins to run from the earlier date and not the date of layoff.

If your state has an age discrimination law and enforcement agency, the time limit may be extended to 300 days, but every effort should be made to act within the 180 days to be on the safe side. You may file your charge with your state's agency.

Q. What happens once I file a charge with the EEOC?

A. The EEOC is required to contact the discriminating party and attempt conciliation between the parties. They also have the power to investigate charges and file a lawsuit to enforce your rights. However, the EEOC files lawsuits in only a small proportion of cases. It is important to realize that the EEOC does not make findings on your charge. Only a court can do that.

Q If the EEOC files a lawsuit on my behalf, can I still sue separately?

A. No. Once the EEOC begins a suit, private individuals are prohibited from bringing their own action.

Special Procedures for Federal Employees

Federal employees or applicants for employment who believe they have been discriminated against have these options:

- They may file a complaint with the EEOC or the federal agency they believe has discriminated against them.
- They may proceed directly to federal court by filing a "notice of intent to sue" with the EEOC within 180 days of the discriminatory action. The individual then has the right to file a lawsuit thirty days after filing the notice.

Q. If the EEOC does not file a lawsuit, is there a limit to how long I have to sue the discriminating party?

A. Yes. The statute of limitations is two years from the time you knew or should have known of the violation. If the violation was willful, you have three years to file a lawsuit.

Sometimes it is hard to determine when a person should have known of the violation. Other times, however, the exact date is easy to pinpoint. For example, suppose you receive a letter on March 12 from your labor union stating that you are expelled, and

you do not open the letter. On April 12, when your union dues are not taken out of your paycheck, you call and discover your expulsion. March 12 is the date when you should have known of the violation, and so that is when the statute of limitations began to run.

Early Retirement Incentive Programs

Early retirement incentive plans are frequently offered by employers to reduce their work force. Generally, such plans are lawful if they are voluntary and otherwise comply with federal law. They often provide substantial benefits to employees willing to retire early. However, giving up employment also has great disadvantages, economically and personally. You should be given sufficient information and plenty of time to consider an early retirement offer. Review your options with a financial advisor if possible.

Waiving Your ADEA Rights

Some companies ask employees who accept an early retirement offer or other exit incentive to sign a "waiver" of their rights under the ADEA, including the right to sue the employer. Waivers are legal only if they are "knowing and voluntary" and the employer follows specific procedures required by the Act. The required procedures involve extensive notices, disclosures of information, and time periods to ensure the employee has sufficient time to make a decision.

Q. Are state age discrimination laws identical to the ADEA?

A. Not necessarily, and not all states have such laws. It is important to check the applicable laws in your state. Some state statutes offer different protection or more protection against discrimination than the ADEA. If this is the case, you may be able to bring an action under a state law that you would not be able to bring under the ADEA.

Q. How do I know if my state has an enforcement agency?

A. f you are unsure whether your state has an enforcement agency, contact your state's department of labor or an EEOC office in your area.

Q. What should I consider in deciding whether to file a private lawsuit under the ADEA?

A. If you have suffered significant loss as a result of age discrimination and you are willing to invest substantial time and money, filing a private lawsuit may be worthwhile. The costs of such a lawsuit should be weighed realistically ahead of time. ADEA cases can involve a great deal of legal analysis, discovery, and effort. Generally, attorneys do not take ADEA cases on a contingency basis (that is, payment when and if the case is decided favorably). However, if your lawsuit is successful, the ADEA permits you to seek attorney's fees from the discriminating party.

Q. What role will the EEOC play in my lawsuit?

A. If the EEOC files a suit either on its own or on your behalf, the Commission enforces your rights and you can no longer file a private lawsuit. If the agency does not file a suit, you may do so sixty days or more after the date you file a charge with the EEOC. Unlike other areas of civil rights law, you do not have to wait for a right-to-sue notice from the EEOC. Your own lawsuit will be a private one, and you must bear the court costs and attorney fees. A big advantage of a suit filed by the EEOC on your behalf is that you would not be required to pay its costs.

Q. What if my employer retaliates against me because I file a charge?

A. The ADEA forbids such retaliation.

Q. If there is already a lawsuit against my employer for age discrimination, can I join it?

A. Yes. The ADEA allows class-action lawsuits. However, unlike many other class-action cases, you are not automatically part of the subject class. You must opt in by consenting in writing. By sending in the consent form, you can become part of the existing lawsuit against your employer.

Your Right to a Jury Trial

In most lawsuits, the type of relief you seek can affect whether or not you will receive a jury trial. The ADEA, however, grants a right to a trial by jury on any issue of fact, even if they seek only equitable (non-monetary) relief. A party wanting a jury trial must specifically ask for one. If not requested, a jury trial is automatically waived.

Q. What will happen if I win my case?

A. The court will order the employer to make up to you what you lost through discrimination. This might include:

- the awarding of back-pay for salary you did not receive while unemployed;
- the awarding of future pay or "front pay" for a period of time has been recognized by some courts;
- compensation for lost benefits, or reinstatement of lost benefits--such as seniority rights, health or insurance benefits, sick leave, savings plan benefits, expected raises, stock bonus plan benefits, and lost overtime pay;
- reinstatement in your former job, with your former salary and benefits;
- double damages in cases of willful violations of the ADEA.

If you win your case, the company that discriminated against you may have to pay for your lawyer and other expenses, as well as for court costs.

II. Pensions

Q. Is my employer or union required to set up a pension plan?

A. No. The law does not obligate an employer to have a pension plan. While many small companies do not have pension plans, most large employers and unions do. Most pensions are governed by rules of the Employee Retirement Income Security Act of 1974

(ERISA), which sets minimum standards for pension plans that already exist and new pension plans that are created. Small companies can set up simple pension plans for their employees called "SEPs." These plans require very little paperwork.

Q. Does ERISA apply to all pension plans?

A. No. It does not cover pension plans for federal, state, and local public employees, nor for church employees. Most ERISA provisions apply to plan years beginning in 1976. As a result, it does not protect workers who stopped working or retired before 1976. However, the terms of an employee's pension plan, as well as state law, do offer some protection.

Q. What are the different types of pension plans?

A. There are two major kinds, and they are quite different. One kind, called a defined-benefit plan, guarantees you a certain amount of benefits per month upon retirement. For example, a defined-benefit plan might pay you ten dollars a month per year of service. Under that plan, a person who retires after ten years of service would receive $100 per month in pension benefits.

Under the other kind of plan, called a defined-contribution plan, the employer and/or the employee contribute a certain amount per month during the years of employment. The amount of the benefit depends on the total amount accumulated in the pension fund at the time of retirement. And that amount depends not only on how much you and your employer contributed, but on how much that money earned when it was invested.

Typically, pension trustees invest the fund's money in stocks, real estate, and other generally safe investments. If those investments do well over the years, the fund grows and your monthly benefits may be relatively high. But if the investments do poorly, the fund may not grow much or may even shrink. In that case, your monthly benefits may be far smaller. (See a later section in this chapter on the requirement that plans make prudent investments.)

Even in the defined-contribution plan, your benefit will be determined by some formula that takes into account your age, how long you worked for the employer, and how much you were paid.

The choice of defined-benefit or defined-contribution plan is not yours to make. The employer decides.

Q. I am fifty-five years old and I want to retire now. Can I start collecting my pension at once?

A. Maybe. All pensions set a "normal" retirement age, often sixty-five. They usually set a minimum retirement age as well, perhaps fifty-five, sixty or sixty-two. Check with your pension plan administrator. You may be able to collect benefits now or you may have to wait until you are older. Remember that benefits are usually calculated partly on the basis of your age. The younger you are when you retire, the smaller the benefits, but presumably you will get them for a longer period.

Q. Do I get to choose how my pension will be paid to me?

A. Yes, to some extent.

The most common type of payment is called the joint and survivor annuity. It pays the full benefit to a married couple until one dies, then pays a fraction of the full benefit to the survivor as long as he or she lives. The fraction typically is half or two-thirds. The Retirement Equity Act of 1984 requires this kind of disbursement unless the worker's spouse signs a waiver. The waiver permits payment of a higher benefit, but only as long as the retired worker lives. When he or she dies, the benefits end and the surviving spouse gets no more.

The joint and survivor annuity may allow you some options. You might be able to have benefits guaranteed for a certain number of years. For example, if the guarantee is for fifteen years, benefits would be paid as long as one or both spouses are alive. But if both die before fifteen years have passed since retirement, benefits would continue to be paid to their beneficiary until the 15th year. Other guarantees might be for longer or shorter periods; the longer the guarantee, the lower the benefit.

There are some other kinds of pension disbursements as well. One pays a fixed amount for a fixed number of years, which means you could outlive your benefits and get nothing in your oldest years. Another pays all your benefits in a single lump sum when you retire, which could cost you a lot in income taxes.

Q. Will my pension benefits rise over the years?

A. Perhaps. Your union may negotiate cost-of-living increases with your employer. Or a non-union employer may increase benefits voluntarily. But generally your benefits are frozen at the level they were when you retired. You will also probably be collecting social security benefits, however, and those benefits do rise with the cost of living.

Q. What if I get sick after retiring? Will I still have health insurance?

A. Companies are not required to continue to provide health insurance after retirement. But when they have promised to do so, some courts are requiring them to keep that promise. Under a 1985 federal law known as COBRA ("Consolidated Omnibus Budget Reconciliation Act"), you must be notified when you retire that you may continue coverage, but your employer may require you to pay the premiums. Coverage generally lasts for eighteen months after you stop working, but may be extended up to twenty-nine months if you are found eligible for social security disability or Supplemental Security Income (SSI) disability benefits. You will also be eligible for Medicare at age sixty-five or possibly earlier if you qualify for disability under social security or SSI.

Q. Can my company's pension plan cover some employees but not others?

A. Yes. Some companies establish pension plans only for certain kinds of workers. A plan might cover assembly line workers, for example, and not file clerks. There might or might not be a separate plan for the clerks. But a plan cannot discriminate against employees who are not officers, shareholders, or highly compensated. For example, a supermarket's plan could not include only the company's president and top executives while excluding the managers, baggers, and cashiers. The Internal Revenue Service (IRS) determines whether a plan is complying with these complicated "nondiscrimination" rules.

Q. What rules govern when an employee can participate in a pension plan?

A. ERISA sets up two criteria for when employers must permit workers to begin earning credit toward pensions. The employer must permit the earning of credit toward a pension if the worker is at least twenty-one years old and has worked for the employer for at least one year. ERISA calculates a year of employment as 1,000 or more hours of work in twelve months. Once employees satisfy these two requirements, they must be allowed to begin accruing credits that will affect the amount of their pensions.

Of course, as with all ERISA requirements, these are the minimums allowed by law. Individual pension plans can have more generous credit-earning policies. For example, they can permit beginning employees to start earning pension credits from their first day on the job, and they can permit workers younger than twenty-one to earn pension credits also.

Q. Once I become a participant, how do I know what my rights are under the plan?

A. ERISA requires that participating employees be given detailed reports and disclosures. Within either ninety days of becoming a participant or 120 days of the plan's beginning, the employee must receive a summary plan description. This gives details of the employee's rights and obligations, gives information on the trustees and the plan's administration, sets conditions for participation and forfeiture, and outlines the procedure for making a claim and the remedies available to employees who appeal claims that are denied.

A summary of the plan's annual financial report must also be distributed. If you do not receive a summary, you should ask the plan's administrators for it. Or you can obtain one by writing the Department of Labor, PWBA, of Public Disclosure Room, Room N-5638,2000 Constitution Ave., Washington, D.C. 20210

Q. How are years of accrual determined?

A. After you meet the participation requirements, each year you work for an employer counts as a year of accrual time. A year is defined as 1,000 or more hours of work in twelve months. You can work the 1,000 hours at any time during the twelve month period; it need not be evenly distributed during the year. Days taken for sick leave or for paid vacation count toward the 1,000-hour minimum.

It is important to note that, depending on your company's policy, the first year you work for an employer does not have to count toward your years of accrual. Thus, your years of accrual will not always equal the number of years you worked for an employer.

Q. If I stop working for an employer and later return, do I get credit for my previous years of service?

A. That depends on the length of this break in service. An employer can discount the years of your previous service if two conditions are met: First, your break lasts five or more continuous years: and second, your break is longer than the years you previously worked for the employer. If, for example, after six years of work, you took a seven-year break in service, you may be out of luck. However, an employer can have more lenient rules than the ones set out by ERISA. These rules on breaks in service are complex, so you should consult an expert if you think they apply to you.

Q. Is my right to collect my pension guaranteed?

A. You always have the right to money you contributed to the pension fund. If you leave a company after only a few years, that money should be paid back to you in a lump sum. If you work for the employer long enough, you will have "a vested interest" in your pension, meaning your benefits cannot be denied even if you quit. If the total value of your pension is $3500 or less, your plan can require that you take it as a lump sum payment.

Q. When are my pension rights vested?

A. Amendments to ERISA in 1989 changed the vesting rules. Now, your pension rights must either vest completely after five years--meaning that you have a right to 100 percent of the benefits you have earned--or partially after three years of service. Complete vesting after five years is called cliff vesting. If you work less than five years under cliff vesting, you are not entitled to any pension benefits. Partial vesting is called graded vesting. Under this system, your rights become 20 percent vested after three years of service, 40 percent vested after four years, and so on up to 100 percent vested after seven years.

With graded vesting, you have the right to 20 percent of your earned benefits after three years and 100 percent after seven years. Under the other system, you have no rights to benefits until five years, and then you have rights to collect full benefits.

You do not get to choose which vesting method applies. The employer decides.

Q. I want to change jobs. May I take my pension benefits with me to my new job?

A. Generally, if you change jobs before your pension has vested, you usually lose all the benefits you built up in your old job, although your employer must refund money you put into the fund. If you change jobs after your benefits have vested, you are entitled to those benefits. You may put (or "roll over") those funds into an IRA or some other type of retirement program (to avoid taxation) or transfer the funds to the new employer's pension plan if possible. It is often not possible, though some unions have reciprocal agreements that allow you to change employers and transfer your benefits. There are also some state or nationwide pension systems that allow job changes with continued participation in a unified pension program (such as Teachers Insurance and Annuity Association, known as TIAA-CREF).

Q. What if I join an employer at age sixty-two and retire at age sixty-five?

A. ERISA assures older employees that their rights will completely vest at normal retirement age, regardless of the number of years they have worked for an employer.

Also note that since 1988, employers have been required to make contributions to the plan for workers aged sixty-five and over.

Q. If I retire and begin receiving my pension, can I still work?

A. Yes. You can retire, collect your pension, and work full- or part-time. However, if you work for the same employer that is paying your pension, you are limited to fewer than forty hours a month.

Protection Against Being Fired Right Before Your Pension Vests

ERISA prohibits an employer from firing you or otherwise treating you unfairly in order to stop the vesting of your pension rights. However, the burden is on you to show that you were not fired for legitimate reasons but because your employer did not want to guarantee you a pension.

Q. Can my employer change an existing pension plan?

A. Yes. ERISA permits an employer to change the way in which future benefits are accumulated. However, the employer may not make changes that result in a reduction of benefits that you have already accrued. In addition, ERISA specifically prohibits plan amendments that alter vesting schedules to the detriment of employees.

Q. What protection does ERISA offer when my company is sold or taken over?

A. This area of law is not entirely clear. In a growing number of cases, "successor liability" is found and the company must continue the plan. If such liability is not found, your new employer is under no obligation to continue an existing pension plan. The new employer can go without a plan, set up a new plan, or continue the existing plan. If the new employer decides to continue the plan, however, ERISA requires that previous years of service be counted.

And you still have a right to all the benefits earned under the old employer. If the new employer abandons the plan, though, you will not continue to earn benefits.

Q. Do I have a right to know how my pension plan is investing money?

A. Yes. You should receive a summary of the plan's annual financial report. Each year, a report summarizing the plan's financial operations must be made to both the Internal Revenue Service and the Secretary of Labor.

Also, ERISA requires that the people in charge of investing your plan's money use care, skill, and prudence and invest only in the interest of participants and beneficiaries. A requirement for investment diversity minimizes the risk of losses. ERISA forbids several investment practices. For example, the pension directors cannot invest more than 10 percent of the fund in the employer's stock or real property. They cannot personally buy the fund's property or lend the fund's money to their friends.

Q. What should I do if those in charge of investing my plan's money violate ERISA?

A. First, you should contact the nearest office of the U.S. Department of Labor. Then, if needed, ERISA permits you to file a lawsuit in federal court to enforce its rules.

Q**. I am worried about my pension plan going broke. Do I have any protection against such a disaster?**

A. You might have some protection. ERISA established the Pension Benefit Guaranty Corporation (PBGC). If your company has a defined-benefit plan, it must pay insurance premiums to the PBGC. If the plan goes broke, the PBGC will pay vested benefits up to a certain limit, but it may not pay all you are owed. If the pension plan is still functioning but in danger of going broke, the PBGC will step in and take control. It will use the plan's remaining money and the insurance premiums paid by other plans to keep your benefits flowing.

Certain pension benefits are not covered, particularly for highly paid people and for those who retire before being eligible for social security.

If your plan is of the defined-contribution type, the PBGC will not get involved. If that plan goes broke, you may be out of luck. You should keep an eye on how the administrators are handling the fund's money, because ERISA requires that plan trustees act in the best interests of participants. Trustees can be sued by the Secretary of Labor or plan participants if they act improperly.

Q. When must I begin to collect my pension?

A. Each plan sets a normal retirement age. However, if you choose to retire later, you must begin collecting your pension by April 1 of the year after you turn seventy and one-half years old.

Q. Does the amount of social security payments I collect affect my pension benefits? A. It might. Some pension plans allow a reduction of benefits depending on how much you receive from Social Security. You should check with your plan's administrators. Under federal law, plans subtracting social security payments from pension benefits must leave you with at least half your pension. However, the law applies only to years worked after 1988.

Claiming Your Pension

Each individual plan establishes the procedure for submitting pension claims. To find out about your plan's filing procedure, check the plan summary provided by your employer. To claim your pension, follow the procedure. You should then receive a decision about your claim.

Q. If I do not agree with the decision on my claim, how do I appeal?

A. The claims and appeal processes are regulated in ERISA. The plan summary must also contain information on the plan's appeal process. All plans must give written notice of the claim decision within ninety days of receipt of the claim. If the plan notifies you within ninety days that it needs an extension, one ninety-day extension is allowed. If you do not receive a written decision by the deadline, consider your claim denied.

If your claim is denied, the decision must give specific reasons for the denial. You then have sixty days to file a written appeal. The plan must make available important documents affecting your appeal, and you must be allowed to submit written support for your claim. The plan then has 120 days to issue a written decision on the appeal.

If you are still dissatisfied after going through this process, you have the right to sue in federal court to recover unfairly denied benefits. However, you may not get the opportunity to present additional evidence in court, so be sure to submit all relevant information and documentation in your appeal to the trustees. If you need to file a court case, the Pension Rights Center has referral lists of attorneys with expertise in this field. (See the resource list at the end of this chapter.)

Q. What if I die before retiring? What are my spouse's rights to my pension?

A. If you are vested and if you have been married for at least a year, your spouse is entitled to pension benefits. Typically, he or she will receive an immediate annuity for the rest of his or her life. However, if you and your spouse have executed a written waiver of survivor benefits, your spouse will not be entitled to survivor benefits.

Q. What are a divorced person's rights to an ex-spouse's pension benefits?

A. In order to be eligible, the divorced person must have been married to the worker for at least one year. The pension rights of divorced spouses are governed by state law. In most states, these benefits are part of the marital property divided during the divorce. If a divorced spouse is granted a share of pension benefits either through a property settlement or a court order, he or she can collect the appropriate sum when either

- the worker has stopped working and is eligible to start collecting the pension (even if he or she hasn't yet applied for it);
- or the worker has reached the earliest age for collecting benefits under the plan and is at least age fifty.

III. Social Security and Supplemental Security Income

Q. What types of social security benefits are available?

A. Qualified workers are eligible for old age and disability benefits. Benefits are also available for the spouse and dependents of a retired or disabled worker. When a worker dies, benefits can be collected by the surviving family who qualify.

Social security is the United States' most extensive program to provide income for older and disabled Americans. It is paid for by a tax on workers and their employers. The program is complicated, and the law and regulations change from time to time.

Contact your local office of the Social Security Administration (SSA) for literature about social security benefits or to ask specific questions about your own case. They are listed in the United States Government section of your telephone directory. Or, call 1-800-772-1213, or see the SSA Internet site at www.ssa.gov.

Q. Who is covered?

A. Over 95 percent of American workers, including household help, farm workers, self-employed persons, employees of state and local government and (since 1984) federal workers. Railroad workers are covered by a separate federal program, railroad retirement, that is integrated with social security.

Q. Will my social security benefits be enough for me to live on?

A. You won't get as much as when you were working, so it is important to start financial planning for retirement early. Social security was not set up to be a complete source of retirement income, but rather to provide only a floor of protection. You will probably need other sources of income, such as a pension from your employer or union, a part-time job, or income from your life savings. Social security benefits do rise with the cost of living.

Q. Who qualifies for social security?

A. Individuals must meet two fundamental qualifications to collect social security benefits. First, a worker must be "insured" under social security. The simplest rule-of-thumb is that ten years of work in covered employment will fully insure a worker for life. However, there are alternative measures of insured status that enable many workers with less than ten years of covered employment to be eligible, too. Second, you must meet the status requirement for the particular benefit (for example, age, disability, dependency on a worker, or survivorship).

Q. Just how much money will I get when I retire?

A. That depends on how much money you have earned over your lifetime, your age at the time of retirement, and other factors.

The Social Security Administration will prepare an estimate, called a Personal Earnings and Benefit Statement, even if you are some years from retirement. Simply get a Personal Earnings and Benefit Statement Form from your local Social Security Administration office or by calling the Social Security Administration, toll free, at 1-800-772-1213. It's a good idea to request this every few years, not only to see how your benefits might change but to make sure your employers have been depositing to the Social Security Administration your share and theirs of the social security tax.

Q. When can I retire?

A. The "normal" retirement age is sixty-five. But this age will be raised gradually starting in the year 2000. By 2002, you will have to be sixty-seven to retire and collect full benefits.

You can collect partial benefits as early as age sixty-two if you are fully insured. The benefits are reduced, because you potentially have more years of retirement to cover. Early retirement benefits will not be raised when you turn sixty-five, except for normal cost-of-living adjustments.

If you delay retirement until you are older than sixty-five, your benefits will be increased, because you will not have as many years of retirement in which to collect.

Of course, you can retire whenever you want or can afford to, but you will not receive social security retirement benefits until you are at least sixty-two.

Q. I want to retire, but then take a part-time job. Will this affect my benefits?

A. Yes. If you are under full retirement age (which is gradually rising from 65 to 67, see question above) and receiving benefits you may earn only a certain amount of wages before your social security benefits are cut. There are two cut-off points--one for workers age sixty-two through sixty-four, another for age sixty-five up to full retirement age. For retirees age sixty-two through sixty-four, one dollar of benefits is withheld for

every two dollars you earn above the cut-off point. For retirees sixty-five up to retirement age, one dollar of benefits is withheld for every three dollars you earn above the cut-off point. The cutoff point changes annually. Check with the Social Security Administration office to see what it is when you take your new job. If you have reached the full retirement age, you may earn an unlimited amount and still receive your full retirement benefit. Note that the cut-off point applies only to wages. Your benefits will not be affected by any money you earn from savings, investments, insurance, and the like.

Q. When the worker dies, who is eligible for benefits?

A. These family members qualify for disability benefits: a spouse who is at least sixty years old; a disabled spouse who is at least fifty; children who are under eighteen (or under nineteen if attending elementary or high school full-time) or are disabled; and parents who are sixty-two or older and who received at least half of their support from the worker at the time of his or her death.

Q. When are spouses of retirees entitled to collect benefits?

A. Depending on the situation, a husband or wife may collect benefits based on the other's work record. A husband or wife need not prove that he or she was dependent on the other. In general, spouses qualify if they are at least sixty-two years old. They also qualify if they are under sixty-two but are caring for a worker's child who is either under sixteen years old or who has been disabled since before age twenty-two. The amount the spouse receives is usually one-half of what would have been paid to the worker. However, if the spouse is entitled to benefits based on his or her own work record, the spouse will receive the higher of the two benefits.

Q. Are divorced spouses eligible?

A. Yes. As long as the divorced spouse is sixty-two or older, was married to the worker for at least ten years, and has not remarried. Divorced spouses who have been divorced for at least two years may draw benefits at age sixty-two, as long as the former spouse is eligible for retirement benefits; the former spouse does not actually have to be drawing benefits. A divorced spouse may also be eligible for survivor benefits if the worker dies while being fully insured or while receiving benefits.

Q. Which children can receive benefits?

A. A deceased or disabled worker's unmarried children under eighteen years old are eligible. Children under nineteen who attend elementary or secondary school full-time can also collect. Also, a disabled child of any age can receive payments equal to approximately one-half of the worker's benefits, as long as the child became disabled before age twenty-two.

Q. When should I file my claim to collect social security benefits?

A. If you are retiring, you should file two or three months before your retirement date. Then, normally, your first social security check will arrive soon after you quit working. It is important not to delay filing for either retirement or survivor benefits because you will get paid retroactive benefits only for the six months prior to the month you file your application, provided that you were eligible during those months. Retirement

and survivor benefit applications take two to three months to process. Disability benefit applications, however, take longer.

Q. What documents should I bring with me to apply for benefits?

A. A worker applying for retirement or disability benefits should bring his or her social security card or proof of the number; a birth certificate or other proof of age; W-2 forms from the past two years or, if you are self-employed, copies of your last two federal income tax returns; and, if applicable, proof of military service, since you may be able to receive extra credit for active military duty.

Spouses applying for benefits from the worker's account should also bring a marriage certificate. Divorced spouses should have a divorce decree.

Children or their guardians seeking benefits need a birth certificate and evidence of financial dependence.

Dependent parents who want to collect benefits must bring some evidence of financial dependence.

Finally, spouses, children or parents seeking death benefits need the worker's death certificate.

Q. If I am filing for disability benefits, what other documents should I bring with me?

A. In addition to the documents listed above, you should try to bring a list, with addresses and telephone numbers, of the doctors, hospitals, or institutions that have treated you for your disability; a summary of all the jobs you have held for the past fifteen years and the type of work you performed; and claim numbers of any checks you receive for your disability.

Q. What if I check on my benefits or file my claim and discover that the Social Security Administration has made an error in the number of quarters I worked or the amount of wages I was paid? Can I fix mistakes?

A. Yes. You have approximately three years from the year the wages were earned to fix mistakes. However, mistakes caused by an employer's failure to report your earnings have no time limit.

You can fix these mistakes any time, but you will need proof. A pay stub, written statement from the employer, or form OAR-7008 (Request for Correction of Earnings Record) are all acceptable types of proof.

What to Remember When Dealing with the Social Security Office

As with any large government office, the best way to work with the Social Security Administration is to keep a full, organized account of your communications or conversations. Make a note of when you had each conversation, who you spoke with and what was said. When you file a claim, you are automatically assigned a SSA worker. Keep this person's name and telephone number handy in case you need to contact the SSA for any reason.

Before you submit any forms or documents to the SSA, make sure you keep copies for yourself. That way if anything is lost, you have a backup copy.

Since the SSA keeps records by social security numbers, all forms or documents you submit should have your social security number on the top of each page. Then if any page becomes separated, it will still be placed in your file.

Disability

Q. What if I am under sixty-five and become disabled? Am I entitled to benefits from social security?

A. Yes. Social security protects all workers under sixty-five against loss of earnings due to disability. However, you must meet certain strict requirements for the number of years employed, the age at which you became disabled, and the severity of your disability.

Q. How does the Social Security Administration define a disability?

A. A disability is defined as the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve months. The disability must be medically certified. Some illnesses or handicaps are so serious that the Social Security Administration automatically treats them as disabilities, such as severe epilepsy or blindness; SSA has a list of such impairments. If you believe you are disabled but your impairment is not on the list, you will have to prove that it is just as severe and disabling as the ones on the list.

Q. If I become disabled, how long may I get benefits?

A. Once you qualify for disability benefits, they will continue for as long as you remain medically disabled and unable to work. Your health will be reviewed periodically to determine your ability to return to work.

Q. What about my family?

A. If you are disabled, your unmarried children under age eighteen (or nineteen, if still in high school full time) may be eligible for benefits from social security. In addition, unmarried children over eighteen who are themselves disabled will also be eligible. If your spouse is caring for a child who is either under sixteen or disabled, he or she may be eligible, as is a spouse who is sixty-two or older. In some cases the disabled widow or widower or the divorced spouse of a deceased worker may become eligible for disability benefits. Check with your local Social Security Administration for specific eligibility requirements.

Claims Decisions and Appeals

Q. How will I know the outcome of my application for benefits?

A. You should receive written notification informing you whether your claim has been approved or denied in sixty to ninety days.

If your claim is approved, you will be told how much your benefits will be and when to expect your first check. If, however, your claim is denied, your letter should list the reasons.

Q. Can my social security benefits be reduced or terminated?

A. Yes. Benefits may be terminated if: you leave the United States for more than six months; you are deported; you are convicted of certain crimes, such as treason and espionage; or, you are an alien.

Convicted felons cannot receive retirement benefits while in prison. Disability benefits can be terminated when the recipient recovers or refuses to accept rehabilitation efforts.

In any case, however, you should receive a letter notifying you of the reduction or termination before SSA takes any action.

Q. If my claim is denied, or my benefits reduced or terminated, can I appeal?

A Yes. You have sixty days from the date on the written notification of denial to appeal. Make sure the SSA gives you a written denial; you cannot appeal an oral statement.

Q. Should I bother to appeal?

A. Since a large number of claim decisions are reversed on appeal, it is probably worth your time and effort. Also, if you do not appeal, the claim decision becomes final and you give up the chance to appeal later.

Q. Do I need a lawyer to appeal?

A. A lawyer is not required for an appeal. However, you should consider the complexity of your case and the amount of money you are seeking before deciding whether to hire one or not. If your appeal goes all the way to a federal court, you probably should have a lawyer to represent your interests. Attorneys who take Social Security cases usually receive up to 25 percent of back benefits if the claim is successful. The SSA must approve the fees. An experienced advocate who is not an attorney can also represent you.

Q. If I cannot afford a lawyer but want legal representation, what should I do?

A. You may be able to obtain legal representation through an organization that provides legal services to low-income or older persons. Check with your local agency on aging or bar association to see if such an organization exists in your area.

Q. What if I just need some assistance in my appeal but do not want to hire a lawyer? A. Check with your state or local area agency on aging. They may be able to direct you to a community group that can provide help.

Q. How do I appeal?

A. The first step in the appeal process is to file a written request for reconsideration of your claim within sixty days of the notification of denial, reduction, or termination of benefits. This reconsideration is an examination of your paperwork by an

SSA employee other than the one who first decided your claim. You may add more documents to your file if you think they will help.

You should receive written notice of the reconsideration decision within thirty days. However, reconsideration of disability benefits will take longer, usually two to three months.

Q. What is the next step?

A. If you are dissatisfied with the outcome of the reconsideration, your next step is to file a written request for an administrative hearing. You have sixty days after the reconsideration decision to make such a request. Normally, however, the hearing will not take place for several months.

Q. Who acts as the judge at these administrative hearings?

A. An administrative law judge of the SSA's Office of Hearings and Appeals will preside over your case. The administrative law judge is a lawyer who works for SSA but has not been involved in your claim thus far.

Q. What should I do to prepare for an administrative hearing?

A. Before the hearing you can, and should, examine your file to make sure it contains every document you have filed. At the hearing, you can represent yourself or be represented by a lawyer or non-lawyer advocate. You should provide evidence, such as documents or witnesses, about your medical condition and why you cannot work, and your own explanation of why the decision at the reconsideration level should be reversed.

The hearing will be a new examination of your case, conducted by an impartial judge.

Q. What if witnesses refuse to appear on my behalf?

A. You can ask that witnesses be subpoenaed (ordered to appear before the judge). You must request subpoenas at least five days before the hearing.

Q. Will the SSA be represented by a lawyer at the administrative hearing?

A. No, the office does not have a lawyer presenting its side of the case.

Q. How long does it take to receive a decision from an administrative hearing?

A. You should find out within two to three months after the hearing. You will receive a written decision. If your claim is approved, you may be able to collect benefits dating back to when you filed your original claim. For disability, back benefits may date as far back as 12 months prior to the application date.

Q. Can I appeal an administrative hearing decision?

A. Yes. You have sixty days to file a written appeal with the SSA Appeals Council in Washington, D.C. The Council will review the file and issue its decision. You and your representative do not appear before the Appeals Council, but you can add additional information to your file. If you wish to appeal the decision further, you must sue the SSA in federal district court.

Q. Should I file a federal lawsuit?

A. That depends. You must take into account the expense of filing a lawsuit, the amount of benefits you are claiming, and your chances of winning. And, although you are not required to have a lawyer, it is highly recommended that you do.

Q. If I do want a lawyer, how do I find one who specializes in social security appeals?

A. You can contact your local legal services or Older Americans Act program (see page xxxx in a later section of this chapter), your local bar association or the district Social Security Administration office, or call the National Organization of Social Security Claimants' Representatives toll-free at 1-800-431-2804.

Q. What if I receive a notice from SSA that I have been overpaid?

A. If you disagree that you were overpaid, make a written request for a reconsideration of your claim. If you cannot repay the amount, first ask for a waiver within thirty days of notification of overpayment. You will be asked to fill out an "Overpayment Recovery Questionnaire." Try to show that the overpayment was not your fault, and that you are unable to repay the amount without hardship.

Getting Your Checks

Social Security checks are normally mailed on the first day of each month. However, the SSA strongly encourages you to have your check deposited directly in your bank. This is safe and convenient. The money is available a day or two earlier than if you get a check in the mail. It's handy if you have trouble getting to the bank. And it makes it impossible for a thief to take the check out of your mailbox.

Supplemental Security Income

Q. I have virtually no money. I don't qualify for regular social security or disability benefits. Can social security help me anyway?

A. The Supplemental Security Income (SSI) program pays benefits to persons who are aged (sixty-five or over), disabled, or blind and who have very limited income and personal property. The SSI program is run by the Social Security Administration. However, it is supported with income tax dollars rather than social security taxes on workers' wages.

SSI benefits are not large and the eligibility requirements are strict. You must have very little income and own very little property. If you think you qualify, check with your local Social Security Administration office. One of the benefits of getting even a dollar in SSI is that in most states you become eligible for free medical care through Medicaid.

To apply you will need your social security number, proof of age, and a wide variety of financial information. You'll want to have a record of your mortgage and

property taxes, records of your utility costs and food costs, payroll slips, income tax returns, bank books and insurance policies.

If you are applying because of disability or blindness, you will also need copies of your medical records. Be sure to have the names and addresses of physicians who have treated you and hospitals where you have been a patient. If you have worked with a social service agency, give the name of a worker who knows you.

Q. I think my elderly father is eligible for SSI, but he is much too ill and confused to visit an office or complete an application. How can he receive benefits?

A. If you know someone who should be receiving SSI benefits but can't apply for himself, you can do it for him. However, you will still need to bring all the information described above.

Q. If I am declared ineligible for SSI, are there any benefits I might be eligible for?

A. Yes. Even if you are not eligible for SSI, you may be able to have your Medicare premiums, deductible, and co-payments paid for you, depending on the amount of your income and assets.

Q If I am denied benefits, can I appeal?

A. Yes, the appeals process is essentially identical to appealing a social security claim, as described above.

IV. Your Right to Health and Long Term Care Benefits

The federal government provides a program of basic health care insurance for older and disabled individuals called Medicare. Practically everyone who has a work history and is sixty-five and older is eligible for Medicare, even those who continue working after age sixty-five.

The federal and state governments together also provide a comprehensive medical benefits program, called Medicaid, for qualified low-income people. Medicare and Medicaid are not the same, though some older people qualify for both. Medicaid coverage rules vary from state to state, but Medicare is the same all over the United States.

The questions that follow examine Medicare and Medicaid, as well as private "Medigap" insurance commonly used to supplement Medicare coverage. The section then turns to long-term care benefits under public programs and under private long-term care insurance.

Since Medicare and Medicaid came into being in 1965, they have been revised many times. More revisions are certain. Current information is available from your local Social Security Administration office. Other groups such as the American Association of Retired Persons, local legal services programs, senior centers, and area agencies on aging also provide useful information.

Medicare

Q. What is the basic structure of the Medicare program?

A. The Health Care Financing Administration, a branch of the U.S. Department of Health and Human Services, is the federal agency responsible for administering the Medicare program. Regular Medicare has two main parts. The hospital insurance part, or "Part A," covers medically necessary care in a hospital, skilled nursing facility, or psychiatric hospital, home health care, and hospice care.

"Part B," or the medical insurance benefits part, covers medically necessary physician's services, no matter where you receive them, outpatient hospital care, many diagnostic tests, and a variety of other medical services and supplies not covered by Part A.

The exact coverage rules and limitations are complex. The actual coverage determinations and payments to providers of care are handled by insurance companies under contract with Medicare. These insurance companies are referred to as "fiscal intermediaries" under Part A and "carriers" under Part B. They determine the appropriate fee for each service. That is why regular Medicare is referred to as a “fee for service” program.

Medicare beneficiaries also have the option of joining a Managed Care Organization (MCO) or care option permitted under “Medicare + Choice.” Managed care organizations provide or arrange for all Medicare covered services and generally charge a fixed monthly premium and small or no co-payments. They may also offer benefits not covered by Medicare, such as preventive care, for little or no additional cost.

Denials of Benefits

Never accept a denial of benefits without further questioning. Unfair denials of Medicare benefits occur with surprising frequency. Medicare beneficiaries who appeal unfair denials have a substantial likelihood of success on appeal. Your appeal rights are explained below

Q. What does Medicare cost me?

A. Part A coverage is provided free to all individuals sixty-five and older who are eligible for social security (even if they are still working). If you are not eligible for social security benefits, you can enroll in Part A after age sixty-five, but you will have to pay a sizable monthly premium.

Part B is available to all Part A enrollees for a monthly premium that changes yearly. The Social Security Administration office can tell you the cost of the current premium. Under both Parts A and B, beneficiaries must pay certain deductibles and co-insurance payments, depending on the type of service, unless you are enrolled in a managed care organization. "Deductibles" are payments you must make before Medicare coverage begins. "Co-insurance payments" are percentages of covered expenses that you are responsible for paying. These amounts can change from year to year.

If you meet certain income and resource tests, your state's Medicaid program will assist you in paying your share of Medicare costs. The income and resource tests are more generous than the limits for regular Medicaid eligibility, so even if you are not eligible for

Medicaid, you may still be eligible for help as a "Qualified Medicare Beneficiary" (QMB) or a "Specified Low-Income Medicare Beneficiary" (SLMB).

Q. I will turn sixty-five soon, but I do not plan to retire then. Am I still going to be able to receive Medicare benefits?

A. Yes, but you must file a written application. This can be done in two different ways. Your "initial" enrollment period begins three calendar months before your sixty-fifth birthday month, and extends three months beyond your birthday month. You can enroll at any time during this seven-month period. Your benefits will begin on the first day of the month in which you turn sixty-five.

If you do not enroll during this time, you can enroll during the "general" enrollment period, which runs from January 1 to March 31 of each year. However, you will pay a higher monthly premium if you delay enrollment beyond your initial enrollment period.

If you are working and are covered by your employer's health insurance program, or if you are covered under your spouse's plan, Medicare is the secondary payer after the other insurance pays. If you haven't enrolled in Medicare and you lose the other insurance, you may sign up for the Medicare program during a "special" seven-month enrollment period that begins the month the other program no longer covers you.

To make sure you receive maximum coverage without penalty, talk to your employer's benefits office or your local Social Security Administration office.

Q. Is Medicare only for older adults?

A. No. In addition to older social security recipients, younger persons who have received social security disability benefits for more than twenty-four months are eligible, as well as certain persons with kidney disease.

Protecting Your Rights When You Contact Public Agencies

Remember to note the name of the person with whom you speak, the date of your conversation, and the content of the conversation. This is useful if you later need to challenge the information provided.

Signing Up for Medicare

Enrolling in Medicare is no problem for most people. Everyone who is turning sixty-five and applying for social security or railroad retirement benefits is automatically enrolled in Medicare Part A. If you are receiving these benefits before turning sixty-five, you should receive a Medicare card prior to the month you turn sixty-five. The Medicare benefits normally begin on the first of the month in which you turn sixty-five.

If you are under sixty-five and receiving disability benefits, your enrollment in Medicare will begin automatically as soon as you have been receiving benefits for twenty-four months.

If you are planning to work beyond age sixty-five and are covered by your employer's health insurance program, you must still file a written application through your local Social Security Administration office.

Q. What does Medicare Part A (hospital insurance) cover?

A. Medicare Part A helps pay for medically necessary hospital care, skilled nursing care, home health care, and hospice care as described below:

1. **Hospitalization**. This includes:

- a semiprivate room and board,
- general nursing,
- the cost of special care units, such as intensive care or coronary care units,
- drugs furnished by the hospital during your stay,
- blood transfusions,
- lab tests, X-rays and other radiology services,
- medical supplies and equipment,
- operating and recovery room costs, and
- rehabilitation services.

The coverage period for hospitalization is based upon a "benefit period." A benefit period begins the first time you receive inpatient hospital care. It ends when you have been out of a hospital and have not received skilled nursing care for sixty days in a row. A subsequent hospitalization begins a new benefit period.

On the first day of hospitalization during a benefit period, the patient is responsible for a sizable inpatient hospital deductible ($776 during 2000). If you are hospitalized more than once during a benefit period, the deductible does not have to be paid for the other hospitalizations during the same benefit period. After the deductible, Part A pays for all covered services through the sixtieth day of hospitalization. From the sixty-first through ninetieth day, coverage continues but the patient is responsible for a daily co-insurance payment. After the ninetieth day, Medicare covers up to sixty extra days (called "reserve days") during the lifetime of the patient. The patient pays a sizable co-insurance payment during reserve days.

If psychiatric hospitalization is needed, Part A helps pay for a lifetime maximum of 190 days of inpatient care in a participating psychiatric hospital.

2. **Skilled Nursing Facility inpatient care following a hospitalization of at least three days.** Your condition must require on a daily basis skilled nursing or skilled rehabilitation services, which, as a practical matter, can only be provided in a skilled nursing facility. You must be admitted within a short time (usually thirty days) after you leave the hospital, and the skilled care you receive must be based on a doctor's order.

Most nursing home residents do not require the level of nursing services considered skilled by Medicare. Consequently, Medicare pays for relatively little nursing home care. In addition, not every nursing home participates in Medicare or is a skilled nursing facility. Ask the hospital discharge staff or nursing home staff if you are unsure of the facility's status.

The coverage period for skilled nursing facility services is limited to 100 days. In a benefit period, Medicare pays for all covered services for the first twenty days. For days twenty-one through 100, the patient is responsible for a sizable coinsurance payment.

Skilled Care or Custodial Care

Medicare helps pay only for "skilled" nursing home care. Medicare does not pay for "custodial" care. However, the distinction is often fuzzy, and many Medicare denials based on a finding of custodial care can be successfully appealed. Generally, care is considered custodial when it is primarily for the purpose of helping the resident with daily living needs, such as eating, bathing, walking, getting in and out of bed, and taking medicine. Skilled nursing and rehabilitation services are those that require the skills of technical or professional personnel such as registered nurses, licensed practical nurses, or therapists. Care that is generally non-skilled may nevertheless be considered skilled when, for example, medical complications require the skilled management and evaluation of a care plan, observation of a patient's changing condition, or patient education services.

3. **Home Health Care.** Medicare covers part-time or intermittent skilled nursing care; physical, occupational, and speech therapy services; medical social services; part-time care provided by a home health aide; and medical equipment for use in the home. Both Part A and Part B of Medicare cover some home health care. Medicare does not cover medications for patients living at home, nor does it cover general household services or services that are primarily custodial.

To be eligible for home health care services you must meet four conditions, presented in simplified terms here. First, you must be under the care of a physician who determines you need home health care and sets up a plan. Second, you must be homebound, although you need not be bedridden. Third, the care you need must include intermittent skilled nursing, physical therapy, or speech therapy. Finally, your care must be provided by a Medicare-participating home health care agency.

The coverage period for home health care is unlimited with no deductible or co-insurance payment (except for durable medical equipment) as long as you continue to meet all four conditions.

4. **Hospice Care** A hospice is an agency or organization that provides primarily pain relief, symptom management and supportive services to people with terminal illness. Hospice services may include physician or visiting nurse services, individual and family psychological support, inpatient care when needed, care from a home health aide, medications, medical/social services, counseling, and respite care for family care-givers

To be eligible for hospice care, a patient must have a doctor certify that he or she is terminally ill (defined as a life expectancy of six months or less); the patient must choose to receive hospice care instead of standard Medicare benefits; and the hospice must be a Medicare-participating program.

The coverage period for hospice care consists of two ninety-day periods, followed by a thirty-day period, and when necessary, an indefinite extension. There are certain co-insurance payments required under the hospice benefit, but no deductibles.

Q. What does Medicare Part B (medical insurance) cover?

A. Medicare Part B covers a wide range of outpatient and physician expenses regardless of where they are provided--at home, in a hospital or nursing home, or in a private office. Covered services include:

- doctors' services, including some services by chiropractors, dentists, podiatrists, and optometrists;
- outpatient hospital services, such as emergency room services or outpatient clinic care, radiology services, and ambulatory surgical services;
- diagnostic tests, including X-rays and other laboratory services, as well as some mammography and pap smear screenings;
- durable medical equipment, such as oxygen equipment, wheelchairs, and other medically necessary equipment that your doctor prescribes for use in your home;
- kidney dialysis;
- ambulance services to or from a hospital or skilled nursing facility;
- certain services of other practitioners who are not physicians, such as clinical psychologists or social workers;
- many other health services, supplies and prosthetic devices that are not covered by Medicare Part A (Part B also covers some home health services.)

Medicare does not cover:

- routine physical examinations;
- most routine foot care and dental care;
- examinations for prescribing or fitting eyeglasses or hearing aids;
- prescription drugs that do not require administration by a physician;
- most cosmetic surgery;
- immunizations except for certain persons at risk;
- personal comfort items and services;
- any service not considered "reasonable and necessary."

Recently, Medicare Part B began covering certain preventive services under certain circumstances. These services include:

- certain vaccinations such as those for flu, pneumonia, and hepatitis B;
- prostate cancer screenings;
- pap smear and pelvic examination;
- mammograms;
- diabetes monitoring;
- colorectal cancer screening; and
- bone mass measurements.

Q. What is my share of the cost of Medicare Part B services?

A. For Part B benefits, you must pay a $100 annual deductible. Then Medicare generally pays 80 percent of Medicare-approved amounts for covered services for the rest of the year. You pay the other 20 percent of the approved amount. There is no cap on the

patient's share of the cost. If you are a Medicaid recipient or a qualified Medicare beneficiary (QMB), then your physician must accept “assignment.”

If a physician or other provider charges you more than the Medicare-approved amount, then your liability depends on whether the provider accepts assignment. "Accepting assignment" means that the provider agrees to accept the Medicare-approved amount as payment in full. This means that your liability is limited to the annual deductible and 20 percent co-payment. If the provider does not accept assignment, generally you must pay for any excess charge over the Medicare-approved amount, but only up to certain limits. The government presently sets the limit on physician's charges at 115 percent of the Medicare-approved fee schedule. Doctors who charge more than these limits may be fined, and you should get a refund from the doctor.

Here is an example of the difference accepting assignment can make: Mrs. Jones sees Dr. Brown on June 1 for medical care. She has already paid her $100 annual deductible for covered Part B medical care this year. Dr. Brown charges $230 for the visit. The Medicare-approved amount for such services are $200. If Dr. Brown accepts assignment, Mrs. Jones must pay a

- $40 co-payment (that is, 20 percent of the $200 approved).

If Dr. Brown does *not* accept assignment, Mrs. Jones must pay:

- $40 plus the $30 excess charge. Her Payment = $70.

Note that Dr. Brown's actual charge ($230) is within 115 percent of the Medicare approved amount ($200) and is therefore permissible.

Finding a Doctor

Doctors and suppliers who agree to accept assignment under Medicare on all claims are called Medicare participating doctors and suppliers. You can get a directory of Medicare participating doctors and suppliers from your Medicare carrier. The directory is also available for your use in Social Security Administration offices, state and area agencies on aging, and in most hospitals.

Q. How are Medicare claims filed and paid?

A. For Part A benefits, the provider submits the claim directly to Medicare's fiscal intermediary (the insurance company). The provider will charge you for any deductible or co-insurance payment you owe. For Part B claims, doctors, suppliers and other providers are required to submit your Medicare claims to the Medicare carrier (the insurance company) in most cases, even if they do not take assignment. The provider will charge you directly for any deductible, co-insurance, or excess charge you owe. If you belong to a Medicare participating Managed Care Organization (MCO), there are usually no claim forms to be filed, nor any deductible or co-payment for any covered services, or the amount is small.

Signing Up for Medicare

Part B If you are receiving Part A coverage, you will automatically be enrolled for Part B coverage as well. If you don't want Part B coverage, you must notify the Social

Security Administration. Also, anyone sixty-five and older can buy Part B coverage. Enrollment periods are similar to those for Part A. Your Part B premium will be deducted from your monthly social security check.

Q. What if I disagree with a Medicare decision? How can I appeal?

A. You have the right to appeal all decisions regarding coverage of services or the amount Medicare will pay on a claim. If your claim has been denied in whole or in part, it is usually a good idea to appeal, especially if the basis of denial is unclear. A surprisingly high percentage of denials are reversed on appeal. In any case, the appeal will make clear the reason for the denial.

Medicare Parts A and B have different procedures for appealing and several steps in the appeal process. After the initial levels of review, Parts A and B both include the option of a hearing before an administrative law judge and even review by a federal court if sufficient amounts of money are at stake.

Key tips in appealing Medicare decisions:

- Denials by any Part A provider (hospital, nursing home, home health care agency, or hospice): Do not accept oral denials. You should be given a written notice of noncoverage from the provider explaining why the provider believes Medicare will not pay for the services. This is not an official Medicare determination. You should ask the provider to get an official Medicare determination. The provider must file a claim on your behalf to the Medicare fiscal intermediary if you ask for an official determination. If you still disagree, you may make use of several additional appeal steps if minimum threshold amounts of money are in dispute.
- Hospital coverage denials: Hospital coverage decisions are normally made by Peer Review Organizations (PROs). PROs are groups of doctors and other health care professionals under contract with the federal government to review care given to Medicare patients. When you are admitted to the hospital, you will receive a notice called An Important Message From Medicare that explains the role of PROs and describes your appeal rights. If you disagree with a PRO decision, the initial review will occur very quickly, usually within three days. You cannot be required to pay for hospital care until third day after you receive a written denial of Medicare coverage.
- Part B coverage denials: These decisions will be made by the Medicare carrier. After your doctor, supplier, or other provider sends in a Part B claim, Medicare will send you a notice called *Evaluation of Your Medicare Part B Benefits.* The notice tells you what charges were made and the amount Medicare approved and paid. It also shows the amount of any copayments, deductibles, or excess charges that you are responsible for paying. The notice gives the address and telephone number for contacting the carrier and an explanation of your appeal rights. You have six months from the date of the decision to ask the carrier to review it. If you still disagree, you may make use of several additional appeal steps if minimum threshold amounts of money are in dispute.

Always be conscious of time limits for filing appeals (normally sixty days from the date of the notice). You may lose your rights if you wait too long. You may want to get assistance with your appeal from a legal services office or a private attorney, particularly if large medical bills are involved. Nonlawyer volunteers and nonlawyer staff members of

legal service programs help a number of people with benefit appeals without charging fees.

"Medigap" Insurance

Q. Do I need any other insurance coverage besides Medicare?
A. Yes. Most older persons need to purchase a supplemental (or "Medigap") insurance policy to cover some of the costs not covered by Medicare. However, there are exceptions, explained below.

In addition, if you can afford it, you may also want to consider purchasing a long-term care insurance policies, because Medicare and Medigap policies do *not* cover long-term care. Long-term-care insurance is discussed in the next section.

Q. Who doesn't need a Medigap policy?
A. While most people need Medigap coverage, you may already have enough coverage without it if you belong to one of the four groups below:

1. If you are already covered by **Medicaid**, you do not need a Medigap policy. Medicaid covers the gaps in Medicare and more.

2. If you are not eligible for Medicaid, but your income is low, you may be eligible for help in paying Medicare costs under the **Qualified Medicare Beneficiary (QMB)** program. Under QMB the government will pay your Medicare Part B premiums and provide supplemental coverage equivalent to a Medigap policy if your income and assets fall below a qualification amount (one that is more generous than Medicaid's).
To apply contact the local office of your state Medicaid program.

3. If you get **retiree health coverage** through a former employer or union, you *may* not need Medigap insurance. But this coverage may not provide the same benefits as Medigap insurance and may not have to meet the federal and state rules that apply to Medigap. Examine the coverage, costs, and stability of your coverage to determine whether it is a better option than Medigap.

4. If you belong to an **HMO**, you probably do not need a Medigap policy, since HMO coverage is normally comprehensive. But do not be too quick to give up your Medigap coverage if you are just joining a Medicare HMO. If you can afford it, keep it long enough to be sure you are satisfied with the HMO. If you become dissatisfied with the HMO, you have the right to disenroll from it at any time. But if you have already given up you Medigap coverage, you may not be able to get it again or get the same price.

Q. How do I find a good Medigap policy?
A. Since 1992, all Medigap insurance has had to conform to standardized benefit plans. There are ten possible standardized plans, identified as Plan A through Plan J. Plan A is a core package and is available in all states. The other nine plans have different combinations of benefits. Check with your state department of insurance for additional information. Many states provide buyers guides.

Purchase only one Medigap policy. Multiple policies will almost always provide overlapping coverage for which you will pay twice but receive the benefit of only once. In evaluating policies, decide which features would best meet your health needs and financial situation. Prescription drug coverage, for example, may be right for you if you are on continuing maintenance medications, even though such coverage may be expensive. When

you compare policies of the same type (A through J), remember that benefits are identical for plans of the same type. For example, all type G plans have essentially the same benefits. However, the premiums and potential for premium increases may differ greatly.

Q. When should I get a Medigap policy?
A. Buy a Medigap policy at or near the time your Medicare coverage begins, because during the first six months that you are sixty-five or older *and* enrolled in Medicare Part B, companies must accept you regardless of any health conditions you have, and they cannot charge you more than they charge others of the same age. After this one-time period, you may be forced to pay much higher premiums for the same policy due to your health status. During this open enrollment period, companies may still exclude **pre-existing conditions** during the first six months of the policy.

Different enrollment rules apply to persons under sixty-five who are eligible for Medicare because of disability.

Q. What if I have an "old" Medigap policy and am considering a replacement? Is that a good idea?
A. If you have a Medigap policy that pre-dates the standardized plans (before 1992), you may not need to switch policies, especially if you are satisfied. Some states have special regulations allowing beneficiaries to convert older policies to a standard Medigap plan. Check with your state insurance department or health insurance counseling service for details.

Beware of illegal sales practices. Both federal and state laws govern the sale of Medigap insurance. These laws prohibit high pressure sales tactics, fraudulent or misleading statements about coverage or cost, selling a policy that is not one of the approved standard policies, or imposing new waiting periods for replacement policies. If a sales agent offers you a policy that duplicates coverage of your existing policy, the duplication must be disclosed to you in writing. If you feel you have been mislead or high pressured, contact your state insurance department, your state's health insurance counseling program, or the federal Medicare Hotline at 1-800-MEDICARE (1-800-633-4227).

EVALUATING A MEDIGAP POLICY

Obtain a free copy of the booklet Guide to Health Insurance for People with Medicare from your local Social Service Security Administration or from the Consumer Information Center, Department 70, Pueblo, CO 81009 (719) 948-3334 or at the website at www.pueblo.gsa.gov. This guide:

- explains how Medigap insurance works;
- explains the ten standardized plans;
- tells how to shop for Medigap insurance;
- lists addresses and phone numbers of state insurance departments of state insurance departments and state agencies on aging. Most states offer free insurance counseling services.

Medicaid

Q. What is Medicaid?

A. Medicaid is a medical assistance program for poor older or disabled persons whose income and assets fall below certain levels set by federal and state law. Unlike Medicare, which offers the same benefits to all enrollees regardless of income, Medicaid is managed by individual states, and the benefits and eligibility vary from state to state.

Q. Is it possible to receive both Medicare and Medicaid?

A. Yes, if you qualify for both programs. Even if you do not qualify for Medicaid, the Medicaid program may still assist you in paying for all or part of the Medicare premium, deductibles and co-insurance payments if you meet the special income and resource tests under the "Qualified Medicare Beneficiary" (QMB) program or the "Specified Low-Income Medicare Beneficiary" (SLMB) program.

Q. If I qualify for Medicaid, what sorts of services do I get?

A. Medicaid covers a broad spectrum of services. Certain benefits are mandated by federal law. They include:

- inpatient and outpatient hospital services doctors'
- nurse practitioners' services inpatient nursing home care
- home health care services
- laboratory X-ray charges.

Other services may include private duty nursing; services from podiatrists, optometrists and chiropractors; mental health services; personal care in your home; dental care; physical therapy and other rehabilitation; prescription medications; dentures; eyeglasses; and more. In all cases, you may receive these service only from a Medicaid-participating provider. As with Medicare, providers may choose whether or not to participate in Medicaid, and they must meet certain standards.

Some states have contracted with managed care organizations to provide comprehensive care to Medicaid-eligible individuals.

Qualifying for Medicaid

Medicaid programs in each state have different standards to determine whether needy individuals are eligible for assistance. All states require that older adults be at least age sixty-five, blind or disabled, and that they meet income and asset tests. In most states, persons eligible for Supplemental Security Income (SSI) or Temporary Assistance to Needy Families (TANF) are automatically covered. Most states also cover some people whose income falls below a certain level after they "spend down" their income on medical bills. Medicaid eligibility rules are so complicated that it is advisable for older persons with low incomes or with high medical expenses to talk with someone with expertise in Medicaid--such as a legal services lawyer, paralegal, or social worker, or a private attorney experienced in handling Medicaid issues.

Q. Does owning a home disqualify me from Medicaid?

A. No. All states exempt your home as an asset as long as you or your spouse lives in it. If you must leave your home in order to receive nursing home care or other long-term care, the state may still exempt it, but state asset exemption rules differ from state to state and can be complex. Besides your home, all states allow you to keep a very limited amount of cash and personal property.

Q. What does Medicaid cost me?

A. Medicaid does not require you to pay premiums or deductibles like Medicare. Providers may not charge Medicaid patients additional fees beyond the Medicaid reimbursement amount. However, states are permitted to impose a nominal deductible charge or other form of cost-sharing for certain categories of services and prescription drugs. No Medicaid recipient may be denied services by a participating provider because of the patient's inability to pay the charge.

Individuals whose income or assets exceed the state's permissible Medicaid amount may be eligible for Medicaid only after "spending down" their income or assets to a poverty level by incurring medical expenses. These "spend down" amounts can be very high, especially for nursing home residents whose income far exceeds the Medicaid eligibility level but who face enormous monthly expenses for care.

Q. How do I apply for Medicaid?

A. Contact the state or local agency that handles the Medicaid program. Its name will vary from place to place. It may be called Social Services, Public Aid, Public Welfare, Human Services, or something similar. You can also call your local agency on aging or senior center for information.

When you apply, you will have to document your financial need in detail, as well as your residency. The application form can be lengthy and complex, but the Medicaid agency can help you complete it. If you are homebound, a Medicaid worker can be sent to your home to help you apply. If you are in a hospital or other institution, a staff social worker should be made available to help you apply. Don't let inability to get to the public agency keep you from seeking assistance. Since the start of benefits is linked to your date of application, it is important to establish an application date as soon as you need Medicaid assistance. Almost any written request with your signature may be enough to establish your application date, even if you have not yet completed the full application form. The effective date can be retroactive, up to three months.

Q. How are Medicaid claims filed and paid?

A. Medicaid providers always bill Medicaid directly. The state Medicaid program reimburses providers according to the state's particular reimbursement formula. Providers cannot charge you additional amounts for covered services, but states may opt to charge you small deductibles or fees for certain items such as prescriptions.

Q. If I disagree with a decision made by my Medicaid program, what can I do?

A. You have the right to appeal all decisions that affect your Medicaid eligibility or services. When a decision about your Medicaid coverage is made, you should receive

prompt written notice of the decision. This will include an explanation of how you can appeal the decision. The appeal process includes a right to a fair hearing before a hearing officer. You may need a lawyer or public benefits specialist experienced in Medicaid law.

Long-Term Care

Q. What federal programs will pay for long-term care in a nursing home?

A. Medicare does not pay for a significant amount of nursing home care. Coverage of skilled nursing care, as described above under "Medicare," is narrowly defined and limited to twenty days of full coverage and a maximum of eighty additional days with a large co-insurance payment.

Medicaid, on the other hand, pays a substantial portion of the nation's nursing home bill (over 40 percent). Medicaid, however, pays only when most other funds have been depleted. Medicaid will cover nursing home expenses if your condition requires nursing home care, the home is certified by the state Medicaid agency, and you meet income and other eligibility requirements to receive this benefit.

Many persons who normally are not eligible for Medicaid become eligible after a period of time in a nursing home. This happens because the high cost of nursing home care forces many individuals to spend down their assets and income to a level that qualifies them for Medicaid in many states. The rules and availability of this option vary from state to state.

The Department of Veterans Affairs (VA) pays for some nursing home care for veterans in VA facilities and private facilities, but the benefit is limited to the extent that resources and facilities are available. Priority is given to veterans with medical problems related to their military service, and to very old veterans of wartime service, and very poor veterans. Contact your local VA office for more information.

Q. What if I don't want to live in a nursing home? Are home care services available under Medicare or Medicaid?

A. Yes, but to a limited extent.

The home health care benefit under Medicare focuses mainly on skilled nursing and therapeutic services needed on a part-time or intermittent basis. The benefit is described above under "Medicare."

Medicaid home health care is usually quite limited, too. But in addition to home health, several state Medicaid programs also provide "personal care" services to Medicaid-eligible individuals who need help with normal activities of daily living, such as dressing, bathing, toileting, eating, and walking. Many states also have instituted Medicaid "waiver" programs that allow the state to use Medicaid dollars for home and community based services that would not normally be covered under Medicaid. These waiver programs usually target persons who would otherwise have to live in a nursing home. Some of the services covered under Medicaid waiver programs include personal care, adult day care, housekeeping services, care coordination and management, and respite care. Respite care enables primary care-givers to take a break from their responsibilities. Check with your local office on aging or department of human services about the options available in your state.

Q. What happens if my husband needs nursing home care but I am still able to live independently? Will all our income and assets have to be used for his support before Medicaid will help pay expenses?

A. If your spouse resides in or may be entering a nursing home, Medicaid has special rules that allow the spouse remaining in the community (community spouse) to keep more income and assets than permitted under the regular eligibility rules. The specifics vary from state to state, but the general structure is as follows:

The community spouse can keep all income, no matter how much, that belongs exclusively to the community spouse. Joint income is another story. The state may require all or part of joint income to help pay nursing home expenses, depending upon the particular state's rules.

Most of the income of the nursing home spouse is considered available to pay for nursing home care. However, a portion of the nursing home spouse's income may be kept by the community spouse as a "minimum monthly maintenance needs allowance" if the community spouse's income is below a spousal allowance figure set by the state. States must establish a spousal allowance of at least 150 percent of the poverty level for a two-person household. Thus, for 2000, this calculation results in a minimum spousal allowance of $1406 per month that could be kept by the community spouse (Alaska and Hawaii have higher figures). States also permit the community spouse to keep a shelter allowance, if shelter costs (rent, mortgage, taxes, insurance and utilities) exceed a specified amount.

Assets or resources are treated quite differently. The state applies a two-step rule. First, Medicaid counts all resources owned by either spouse. This inventory will exclude a few resources. The excluded resources are: your home, household goods, personal effects, an automobile, and a burial fund of up to $1,500.

Second, from the total countable resources, Medicaid permits the community spouse to keep one-half, as long as the one-half falls between a specified floor and ceiling amount, adjusted yearly. If the one-half falls below the floor (about $16,824 in 2000), the community spouse may keep more of the couple's resources up to the floor amount. If the one-half exceeds the ceiling (about $84,120 in 2000), the excess will be considered available to pay for the cost of nursing home care. Thus, the community spouse is permitted to keep no more than the ceiling amount even if it equals far less than half of the couple's assets.

Another special rule applies to your home. Even though your home is an excluded resource, the state, in limited circumstances, can place a lien against your home equal to the amount of nursing home expenses paid. The rules are complicated and vary by state; the advice of a lawyer experienced in Medicaid law is advisable. Moreover, almost all these rules have hardship exceptions in special circumstances.

Q. If I have assets that exceed my state's Medicaid eligibility requirements, can I transfer these to my children or to a trust in order to qualify? After all, these are assets I intend to leave to my children when I die.

A. The law on transferring assets before making a Medicaid application is complex. Such transfers can result in a period of ineligibility for Medicaid benefits. Several strategies are available to shelter or preserve some of your assets, but there are a number of legal, financial, ethical, and practical consequences to any such transfer of

property. Anyone considering such transfer should seek advice from a lawyer experienced in Medicaid law.

Q. Must children pay for parents in nursing homes?

A. There is no legal obligation for children to pay for their parents' care. Only a spouse may be held legally responsible to help pay for the cost of nursing home care, and as a practical matter, the responsibility is often difficult to enforce against an unwilling spouse. If Medicaid enters the picture, the special rules for spousal responsibility described above will apply.

Children sometimes feel pressured to help pay for a parent's nursing home cost because of the shortage of nursing home beds, especially Medicaid covered beds. Some nursing homes give preference to admitting "private pay" patients over Medicaid patients because private-pay rates are often higher than the amount Medicaid pays. While admission priority for private pay patients is permissible in some states, it is illegal in others. In all states, federal law prohibits nursing homes from requiring a private payment from families, or a period of private payment, prior to applying for Medicaid coverage. Federal law also prohibits nursing homes from requiring patients to waive their rights to Medicare and/or Medicaid.

Q. What is long-term care insurance?

A. Long-term care insurance helps pay for nursing home care and usually home care services for a period of two or more years. Long-term care insurance is still a relatively new type of private insurance, so the features of this type of insurance continue to change frequently. For example, newer policies may cover assisted living facilities, adult day care, respite care, or other long - term care services.

Most individual policies are available for purchase only to persons between ages fifty and eighty-four, and a medical screening of applicants is typically required. Not every older person needs or can afford a long-term care insurance policy. Policies are appropriate for those with substantial income and assets to protect, and who desire to buy this form of protection against the potential costs of long-term care.

Most long-term care policies are structured as indemnity policies. That is, they pay up to a pre-set cap for each day of a covered service. The specific provisions of these policies should be closely examined before purchasing one, since the possible conditions and limitations on coverage can be complex.

How much health insurance do I need?

Some people covered by Medicare think they need several additional policies to cover Medicare gaps, specific diseases, and long-term care. That is probably not a good strategy. Chances are the policies would duplicate too many benefits to justify the cost. That is why insurance companies are no longer permitted to sell duplicate Medicare supplement policies. The consumer may purchase only one of the A-J policies.

The best recommendation for someone on Medicare, who is not also on Medicaid, is to purchase one good "Medigap" policy, and possibly one long-term care insurance policy if you can comfortably afford the cost of a good long-term care policy. Lower

income persons are likely to qualify for Medicaid if they need long-term care, so purchasing private long-term care insurance may be a waste of money.

Q. How are the costs of a long-term care policy determined?

A. The cost of the premium is determined in part by your age, the extent of coverage you purchase, and your health history. Age is clearly the single greatest factor because the risk of needing long-term care increases significantly with age. The premium for a seventy-five year old can be double or triple that for a sixty-five year old.

Q. How do I evaluate a long-term care policy?

A. Compare more than one policy side by side. Your state's insurance department should have names of companies offering long-term care insurance. Many states are beginning to set minimum standards and consumer protection guidelines for these policies. In addition, federal law provides favorable tax treatment of federally qualifies long-term are policies -- that is, policies that meet minimum federal standards.

Guides for evaluating long-term care insurance may be available from your state insurance department or state office on aging.

Keep in mind the following tips in evaluating policies:

- Make sure your policy will pay benefits for all levels of care in a nursing home, including custodial care.
- A good policy will pay benefits for assisted living and home care, including in-home personal care. Personal care refers generally to help with activities of daily living, such as dressing, bathing, toileting, eating, and walking.
- Consider whether the amount of daily benefits will be adequate now and in the future. Many policies give you a range of daily benefit amounts to choose from. Make sure the policy has an "inflation adjustor" under which benefits increase by a certain percentage each year to keep pace with coverage. The "right" amount depends in part on the amount of assets you have to protect inflation.
- Do not assume that more years of coverage is always better. Some policies offer benefit options of six, seven, or more years. It is possible to buy too much coverage.
- Avoid policies that exclude coverage of pre-existing conditions for a lengthy period. Six months is considered a reasonable exclusion period for pre-existing conditions.
- Policies should allow payment of nursing home or home health benefits without requiring a prior period of hospitalization as a condition of coverage.
- Most policies impose waiting periods that restrict the starting time of benefits after you begin receiving nursing home care or home care--twenty to ninety days is a common waiting period. A longer waiting period will lower the premium cost. First day coverage will increase your premium.
- Be sure your policy covers victims of Alzheimer's disease and other forms of dementia. About half the residents of nursing homes suffer some form of dementia.
- Be sure that the premium remains constant over the life of the policy and that the policy is guaranteed renewable for life.
- Buy a policy only from a company that is licensed in your state and has agents physically present in your state. Out-of-state mail order policies often leave you powerless to remedy problems if anything goes wrong.

V. Housing and Long-Term Care Options

The range of housing options for older persons is enormous--from staying in your own home or apartment, to home sharing, to moving to a senior housing facility or development. The questions and answers that follow begin by exploring an important financial option (home equity conversion) that may help you stay in your home, and then end by describing the wide variety of housing choices that combine shelter with some combination of recreational and social opportunities or supportive services and health care. In all these areas, older persons need to be aware of the personal and financial risks and benefits involved, and, above all, their legal rights.

Home Equity Conversion

Q. I own my own home, and do not want to move, but I'm having trouble making ends meet. What can I do?

A. Home equity conversion plans can help you add to your monthly income without having to leave your home. These plans fall into two broad categories: loans and sales. Loan plans permit you to borrow against the equity in your home. They include reverse mortgages and special-purpose loans on which repayment is deferred. They should not be confused with "home equity loans" and "home equity lines of credit," which require you to make monthly payments immediately or risk losing your house.

Q. How does a reverse mortgage work?

A. A reverse mortgage lets you borrow against the equity in your home, receiving a lump sum, monthly installments, or drawing on a line of credit. The amount of the loan you will receive is based on your age, the value of your home and your equity, the interest rate, the term of the loan, and some other factors. Except for some special-purpose state or local government sponsored plans, like those designed to pay for home repairs, there are no restrictions on how you use the money.

The loan usually does not have to be repaid until you sell, die or move from your home. In some new plans, you can continue to receive payments even if you move. When the loan does come due, the amount to be repaid cannot exceed the appraised value of the property.

Q. Who is eligible for a reverse mortgage?

A. A borrower must be at least sixty-two years of age, and own the property free and clear, except for liens or mortgages that can be paid off with proceeds from the loan. Unlike traditional loans or home equity lines of credit, the borrower's income is not considered. Only single family residences (including some condominiums) are eligible; mobile homes, multi-family dwellings (including duplexes) and cooperatives are not.

Q. Are reverse mortgages available in my area?

A. Reverse mortgages can be obtained in more than thirty-five states and the District of Columbia. The most common product are the federally insured Home Equity Conversion Mortgage, or HECM and the “Homekeeper Mortage” available through

Fannie Mae. Other products include state-subsidized home repair plans, lender-insured plans, and reverse annuity mortgages.

A consumer guide entitled Home Made Money and a list of reverse mortgage lenders is available from the American Association of Retired Persons, 601 E. Street, N.W., Washington, D.C. 20049, telephone, 1-800-424-3410 or visit their website at www.aarp.org. For more information, also contact the National Center for Home Equity Conversion at 651-222-6775 or their website www.reverse.org.

Getting a Reverse Mortgage

Lenders today are showing greater interest in offering reverse mortgages now that the Federal Housing Administration (FHA) is insuring reverse mortgages. Under FHA rules, the homeowner must be sixty-two or older and own a home that has a very small mortgage or no mortgage at all. The FHA limits borrowing to between $121,296 and $219,849 for the year 2000. Under FHA rules, the borrower may receive the borrowed money as a monthly income or a line of credit. This allows the borrower to use the money for emergencies, such as medical care. For more information, the toll-free number is 1-888-466-3487. Before signing on the dotted line, be sure to get professional advice about the terms and conditions of a reverse mortgage.

Q. How will a reverse mortgage affect my other benefits?

A. The income from a reverse mortgage will not affect eligibility for social security, Medicare or other retirement benefits or pensions that are not based on need. However, without careful planning, the income from a reverse mortgage could affect eligibility for Supplemental Security Income (SSI), Medicaid, food stamps and some state benefit programs.

In general, reverse mortgage payments are considered to be a loan, and will not affect benefits if the money is spent during the month in which it is received. But if the money is not spent during that month, it will be counted as a resource, and may lead to termination of benefits. Be aware that payments received under the new reverse annuity mortgage plans will be considered income, even if they are spent in the month in which they are received.

Q. What about tax consequences?

A. There are two issues here. The first is whether the income from a reverse mortgage is taxed. So far, it has not been, under the assumption that it is a loan advance. Second is whether the interest can be deducted. Generally, interest cannot be deducted until it is paid. Since the interest on a reverse mortgage is not paid until the loan comes due, it cannot be deducted until that time.

Q. What other kinds of home equity conversion are available?

A. In addition to loan plans, you can generate income from the equity that you have acquired in your home through sale plans. Sale plans include sale-leasebacks, life estates and charitable annuities.

Q. What is a sale-leaseback, and how can I find someone who is interested?

A. In a sale-leaseback, you sell the equity in your home, but retain the right to continue living there, often paying a monthly rent. The buyer usually makes a substantial down payment to you. You act as a lender by granting the buyer a mortgage. You receive the buyer's mortgage payments; the buyer receives your rent payments, which are set lower than the mortgage payments, so you gain a positive net monthly income. You remain in the home, and can use the down payment and the mortgage payments as income. The buyer can deduct the mortgage interest payment from his or her income, and will also benefit if the value of the property increases.

Be aware, however, that the IRS requires that both the sale price and the rental payments be fair market rate. Before 1986, the tax laws made sale-leasebacks good investments, especially for adult children. Today, however, there are fewer tax advantages, so finding an investor may be difficult.

Q. What if I sell my house, and keep a life estate?

A. In a life estate, or sale of a remainder interest plan, you sell your home to a buyer, but keep the right to live there during your lifetime. The buyer pays you a lump sum, or monthly payments, or both. You are usually responsible for taxes and repairs while you live in the house but you pay no rent. At your death, full ownership passes automatically to the buyer. This arrangement is most common within families, as part of an estate plan. As with a sale-leaseback, it might be difficult to find an outside investor.

Q. What about a regular home equity loan?

A. A traditional home equity loan is very different from a reverse mortgage, and can be a risk for an older person on a fixed income. As with a reverse mortgage, you borrow against the equity you have built up in your home. But in a home equity loan, you must make regular monthly payments, or you may lose your home.

There may be some tax advantages, however. Since it is no longer possible to deduct interest on consumer goods such as car loans and credit card bills, many homeowners have turned to home equity loans. With such loans, you can borrow up to $100,000 on the equity in your first and second homes, use the money for any purpose, and deduct all the interest you pay. You can even deduct the interest on a home equity loan that exceeds $100,000 if you use the money for home improvements. If you're not going to use such a large loan for home improvements and still want to deduct the interest, you must be able to prove that your home equity, plus improvements, equals the amount of the loan.

Q. Is home equity conversion the only way to increase my monthly income?

A. Not necessarily. If you find that your monthly income does not meet your expenses, you may be eligible for government benefits, such as Supplemental Security Income, food stamps, or Medicaid. (See earlier section on income security in this chapter). Some states also have property tax credit or deferral programs for which you may be eligible. To find out more about these programs, call your local agency on aging. You should consider all of the options available to you before you make your decision. If you are already receiving public benefits, you should make sure that the home equity conversion plan you choose does not affect those benefits.

Q. I am not sure that I can continue to live in my own home, but I would like to stay in my community. What other choices do I have?

A. You have several choices, depending on your current and future health needs, your financial circumstances, and your personal preferences, although not all may be available in your community. There are home-sharing programs, in which homeowners are matched with individuals seeking housing in exchange for rent or services; accessory units that provide private living units in, or next to, single family homes; or assisted living (described below), which combines a home-like setting with services designed to meet individual needs. These programs may be privately owned and operated, government supported, or sponsored by religious or other non-profit organizations. For information, contact your local agency on aging.

Retirement Communities

Q. I have heard a lot about retirement communities that offer all kinds of different services and amenities. What types of retirement community are available today?

A. In the last several years, there has been a large increase in the number of living options for the elderly as both the public and private sectors attempt to respond to the growing numbers of elders. The modern model of retirement community first sprung up in the 1950s in the sun-belt states with senior communities that offered independent living with a variety of social and recreational opportunities. Much has changed today. Between the extremes of independent living and nursing home care, a variety of alternatives now offer endless combinations of shelter plus services or amenities. Physically, facilities may range from single-family type housing, to high-rise or garden apartment buildings, to campus-like developments.

Facility definitions differ among states and sometimes even within states. For simplicity's sake, it is useful to distinguish three levels of community along a continuum of services. At one end of the continuum are *independent living communities.* These offer little or no health and supportive services, although they may have recreational and social programs. At the opposite end are *"continuing care retirement communities" (CCRCs*). These provide a fairly extensive range of housing options, care and services, including nursing home services. In between are facilities that offer a wide variety of housing and health or supportive services but not nursing home care. Today, these are commonly *assisted living communities*, but they include facilities variously called "housing with supportive services, “congregate care”, “board and care”, and “personal care homes” to list just a few.

Q. Who sponsors and who regulates retirement communities?

A. Most retirement communities are developed privately, although many are sponsored by nonprofit groups and agencies, including churches and charitable organizations. All states regulate one or more types of assisted living, and most states regulate continuing care communities, but the extent of regulation varies considerably among states.

Q. What purchase or payment arrangements do retirement communities offer?

A. Conventional independent living communities t without health services typically involve home ownership or rental arrangements that are similar to standard real estate purchases or rentals. Thus, these transactions are governed by local real estate or landlord-tenant law, and residents pay the costs of their mortgage or lease, and condominium or association fees if applicable. In facilities that promise additional services, accommodations, or health care, the payment arrangement includes some mechanism to pay for these added benefits. One may distinguish four basic types of contract, based on payment arrangement, although keep in mind that state regulations may categorize facilities differently:

1. "Turnover of assets" or "total fee in advance" contracts without monthly fees. These types of contracts are all but extinct today. They were common in the original continuing care communities, often called "life care" communities, developed by religious or fraternal organizations. Many communities using this model failed, because the assets received by the sponsors were not sufficient to keep up with rising health care expenses of residents over their lifetimes.
2. Entrance fee plus monthly fee contracts. Entrance fees, ranging from $15,000 to over $200,000, are charged by most continuing care retirement facilities today. An entrance fee may represent a partial prepayment for future services. It normally does not buy an interest in the real estate. Increasingly, CCRCs are providing greater refundability of entrance fees, even 100 percent refundability, although this usually results in higher monthly fees. Residency rights and obligations are governed by a long-term lease or occupancy agreement. Monthly fees are subject to periodic inflation adjustments, and, possibly, adjustments when the resident's level-of-care needs change.
3. "Pay-as-you-go" contracts. With no entrance fee, these contracts are essentially straight rental arrangements with a defined set of services included in the fee or available when needed for an additional charge. Most assisted living and an increasing number of continuing care facilities offer this arrangement. This type of contract involves no initial investment, but is subject to greater changes in monthly fees, since the resident assumes all or most of the financial risk for services.
4. Condominiums or cooperatives with continuing care contracts. Retirement communities that offer an ownership interest to residents under a condominium or cooperative arrangement with a service package included are relatively new to the scene. These ownership/contractual arrangements are unavoidably complex and bring with them special advantages and risks.

Q. What sorts of things do I need to consider before moving into a continuing care community?

A. This is a major financial investment, frequently using up most or all of an older person's financial resources, so consider it carefully and seek professional advice from a lawyer or financial advisor before you make a commitment. You may not be able to get your money back. Be sure to visit the facility at length and talk to both staff and residents. The following checklist highlights key questions you should ask:

Solvency and Expertise of the Provider

1. What is the provider's background and experience? The provider is the person or entity legally and financially responsible for providing continuing care. Some facilities may advertise that they are "sponsored" by non-profit groups or churches that in reality may have no legal control or financial responsibility. Be wary if such illusory sponsorship is trumpeted in sales literature.
2. Is the provider financially sound? Have the facility's financial, actuarial and operating statements reviewed by a professional. Determine whether the facility has sufficient financial reserves.
3. Are all levels of care licensed or certified under applicable state statutes regulating continuing care, assisted living, and nursing home care?
4. How does the facility ensure the quality of care and services provided? Is the facility accredited by any recognized private accrediting organization?

Fees

5. What is the entrance fee, and when can you get all or part of it back? The facility should provide a formula for a pro rata refund of the entrance fee, based on the resident's length of stay, regardless of whether the facility or the resident initiates the termination. Some facilities offer the option of fully refundable entrance fees.
6. What is the monthly fee? When and how much can it be increased? What happens if fee increases exceed my ability to pay? Some facilities have a program that grants financial assistance to residents whose income becomes inadequate to pay increasing monthly fees and personal expenses.
7. Will fees change when the resident's living arrangements or level-of-care needs change (for example, transfers from independent living, to assisted living, to nursing care)?
8. What does my living unit consist of and to what extent can I change or redecorate it?
9. What happens if I marry, divorce, become widowed, or wish to have a friend or family member move into the unit?

Services and Health Care

10. Exactly what services are included in my regular fees? Especially inquire about coverage, limitations, and costs of the following matters:

    Housing/Social/Recreational

    - meal services;
    - special diets/tray service;
    - utilities;
    - cable television;
    - furnishings;
    - unit maintenance;
    - linens/personal laundry;
    - housekeeping;

- recreational/cultural activities;
- transportation.

Health & Personal Care:

- physician services;
- nursing care
- facility services;
- nursing services outside a nursing unit (for example, assistance with medications);
- private duty nursing;
- dental and eye care;
- personal care services (that is, assistance with eating, dressing, bathing, toileting, etc.);
- homemaker/companion services;
- drugs,
- medication, and
- medical equipment/supplies

11. If the facility provides a nursing unit, what happens if a bed is not available when you need it?
12. To what extent does the facility have the right to cut back, change, or eliminate services, or change the fees?
13. Does the facility limit its responsibility for certain health conditions or pre-existing conditions? When can you become too sick or impaired to be cared for by the facility? A pre-existing health condition is one diagnosed or treated in a certain period of time before entering the facility.
14. Can you receive Medicare and Medicaid coverage in the facility?
15. Does the facility require residents to buy private insurance or participate in a special group insurance program for residents?
16. What are the criteria and procedures for determining when a resident needs to be transferred from independent living to assisted living, or to a nursing care unit, or to an entirely different facility? Who is involved in these decisions?

Residents' Rights

17. What rights do residents have to participate in facility management and decision-making? How are complaints handled?
18. On what grounds can residents' contracts or leases be terminated against their wishes?
19. What other rules and policies cover day-to-day operation of the facility?
20. Does the contract release the facility from any liability for injury to a resident resulting from negligence by the facility or third parties? Such waivers should be avoided.

Finding a Retirement Facility

- The American Association of Homes for the Aging publishes *The Consumer's Directory of Continuing Care Retirement Communities*, profiling not-for-profit retirement communities around the country and providing an overview of CCRC types, terminology, and features that consumers might want to consider. For ordering information, contact AHAA Publications, 901 E Street, N.W., Suite 500, Washington, DC 20004, telephone, 1-800-508-9442 or visit their website at www.aahsa.org.
- The American Association of Retired Persons has several brochures that can help you make housing decisions. Contact AARP at 601 E. St., N.W., Washington, DC 20049, telephone toll-free 1-800-424-3410, or visit their website at www.aarp.org.
- State or local agencies on aging frequently prepare directories or guides on housing options for older persons and persons with disabilities. Find the agency's number in your local telephone book.

Nursing Home Care

Q. What is a nursing home?

A. A nursing home is a facility that provides: skilled nursing care and related services for residents who require medical or nursing care; rehabilitation services for injured, disabled, or sick persons; and health-related care and services, above the level of room and board, that can be made available only through institutional facilities.

Often, nursing facilities make distinctions between levels of care--skilled and custodial--for purposes of Medicare, Medicaid, or private insurance coverage. The distinction between "skilled" and "custodial" care affects Medicare and is discussed under "Medicare" above.

Only about 5 percent of people age sixty-five and older live in nursing homes at any given time, but researchers estimate that older persons overall have about a 40 percent chance of spending at least some time in nursing homes. While some older nursing home residents stay for extended periods, the majority stay in a facility less than six months.

Q. How does living in a nursing home affect my personal rights and privileges?

A. You do not check your rights and privileges at the door when you enter a nursing home. Although institutional care, by its very nature, substantially limits one's lifestyle and scope of privacy, one should nevertheless expect high quality, compassionate, and dignified care from nursing facilities.

The federal Nursing Home Reform Amendments of 1987, and corresponding state laws, protect residents in nearly all nursing facilities. For residents who lack decision making capacity, the resident's agent under a power of attorney for health care or another legal surrogate recognized by state law (typically a family member) may exercise the resident's rights. Federal law requires that nursing homes meet strong basic standards for the quality of life of each resident and for the provision of services and activities. Specific rights guaranteed by federal and state law include the following:

Information Rights

Nursing homes must provide:

- written information about residents' rights;
- written information about the services available under the basic rate and any extra charges for extra services;
- advance notice of changes in room assignment or roommate;
- upon request, latest facility inspection results and any plan of correction submitted to state officials;
- explanation of the resident's right to make a health care advance directive--that is, power of attorney for health care or living will--and facility policies on complying with advance directives; (See discussion of advance directives on under "Right To Control Your Own Affairs" below.) information about eligibility for Medicare and Medicaid and the services covered by those programs.

Self-Determination Rights

Each resident has the right to:

- participate in an individualized assessment and care planning process that accommodates the resident's personal needs and preferences;
- choose one's personal physician;
- voice complaints without fear of reprisal, and to receive a prompt response;
- organize and participate in resident groups (such a resident council) and family groups.

Personal and Privacy Rights

Residents have the right to:

- participate in social, religious and community activities as they choose;
- privacy in medical treatment, accommodations, personal visits, written and telephone communications and meetings of resident and family groups;
- confidentiality of personal and clinical records;
- access to the long-term care ombudsman, one's physician, family members, and reasonable access to other visitors subject to the resident's consent;
- freedom from physical or mental abuse, corporal punishment, and involuntary seclusion;
- freedom from any physical restraint or psychoactive drug used for purposes of discipline or convenience, and not required to treat the resident's medical symptoms;
- protection of resident's funds held by the facility with a quarterly accounting.

Transfer and Discharge Rights

Residents may be transferred or discharged only for the following reasons:

- the health, safety, or welfare of the resident or other residents requires it;
- the non-payment of fees;
- the resident's health improves so that he or she no longer needs nursing home care;
- the facility closes. Normally residents must receive at least thirty days advance notice, with information about appealing the transfer and how to contact the

state long-term care ombudsman program. The facility must prepare and orient residents to ensure safe and orderly transfer from the facility.

Protection Against Medicaid Discrimination

Nursing homes must:

- have identical policies and practices regarding services to residents regardless of the source of payment (However, be aware that not all facilities participate in Medicaid.);
- provide information on how to apply for Medicaid;
- explain the Medicaid "bed-hold" policy--that is, how many days Medicaid will hold the resident's bed, or ensure priority re-admission, after temporary absences;
- not request, require or encourage residents to waive their rights to Medicaid;
- not require a family member to guarantee payment as a condition of a resident's admission or continued stay;
- not "charge, solicit, accept or receive gifts, money, donations or other considerations" as a precondition for admission or continued stay for persons eligible for Medicaid.

Basic Quality of Life Standard for Nursing Homes

Federal law requires each nursing facility to "care for its residents in such a manner and in such an environment as will promote maintenance of and enhancement of the quality of life of each resident. Federal law requires each nursing facility to "provide services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written plan of care that... is initially prepared, with participation to the extent practicable of the resident or the resident's family or legal representative."

Q. What can I do if I think a nursing home is not providing adequate care or respecting my rights?

A. Different problems require different responses. The following steps should help resolve most problems. The order may vary depending on the problem.

1. Keep a log of the relevant details, including dates and personnel involved.
2. Try to resolve the problem informally by talking to supervising staff.
3. Many facilities have active resident councils or family councils. Bring the problem before these groups.
4. Contact your long-term care ombudsman. (See below.)
5. Contact the state regulatory agencies that license, certify, and survey nursing homes. Usually, the state department of health has this responsibility.
6. Contact a community legal assistance program, other advocacy organization, or private attorney experienced in long-term care issues.

Q. What is the long-term care ombudsman program?

A. The federal Older Americans Act requires every state to operate a long-term care ombudsman program. The ombudsman is responsible for advocating on behalf of nursing home residents and residents of other long-term care facilities, such as "assisted living" or board and care facilities. The ombudsman provides education on long-term care options and residents' rights, and investigates and resolves complaints made by or on behalf of residents.

Most states operate local or regional programs with paid or volunteer ombudsmen. Residents and family members often find ombudsman staff to be essential partners in resolving problems. Federal law requires nursing homes to allow the ombudsman access to residents and access to resident records. In addition, the ombudsman usually has special authority under state law to inspect records and take other steps necessary to respond to complaints.

VI Rights of Persons with Disabilities

Many older people are unable to manage their daily activities as well as they once did. Others have disabilities that have worsened with age. Two major federal laws, the Americans with Disabilities Act and the Fair Housing Amendments Act, protect people with physical or mental disabilities from discrimination in virtually every aspect of their lives. In addition, these laws require employers and the providers of services to modify their rules and policies, and physical environment, to meet the needs of persons with disabilities.

Q. Who is protected by these laws?

A. Both the Americans with Disabilities Act (ADA) and the Fair Housing Amendments Act (FHAA), protect people with mental or physical impairments that limit their ability to perform one or more major life activities. These activities include walking, seeing, hearing, taking care of personal or health needs or doing everyday chores. The laws also protect people who are perceived to have a disability, or whose family members or friends are disabled.

Neither law protects people who threaten the safety or health of others, or whose behavior would result in substantial damage to the property of others. Nor do the laws protect current users of illegal drugs.

Q. What situations does the Americans with Disabilities Act cover?

A. The ADA protects people with disabilities against discrimination in employment, public transit and public accommodations (such as hotels, restaurants, banks, schools and senior centers). It generally does not cover housing (but the FHAA does, see below) although it does cover some non-housing activities that are based in a housing facility, such as meal or activity programs to which the public is invited.

Q. What situations are covered by the Fair Housing Amendments Act?

A. The FHAA applies to almost all housing transactions. Most importantly for the purposes of this chapter, the law prohibits landlords from refusing to rent to older people, or asking them to move, simply because they need assistance with certain activities. The

law does not apply to rental buildings that contain fewer than four units, and where the owner also lives in the building. Examples of prohibited discrimination include:

- refusing to rent to a family whose member has a mental illness;
- requiring applicants for senior housing to provide a doctor's letter stating that they are in good health and can live on their own;
- denying a resident who uses a wheelchair or a walker access to a communal dining room;
- evicting a tenant because he or she is receiving homemaking help or other services.

Q. What does "reasonable accommodation" mean

A. Reasonable accommodations are changes in rules or procedures that are reasonable under the circumstances, and give a disabled person equal opportunity to participate in a specific activity, program, job or housing situation. They are very individualized, and can often be worked out informally by the people involved. Examples include: providing large-print notices, leases or other written materials;

- giving a job or housing applicant more time to fill out an application;
- waiving a no-pets rule for a tenant with a mental disability who is emotionally dependent on his or her pet, or waiving a no-guest rule for a tenant who needs a live-in aide;
- assisting a customer who needs help with packages, or with opening and closing doors, or even with dialing a telephone.

Q. What are reasonable modifications?

A. Reasonable modifications are changes to the physical structure of a building or property, which are reasonable under the circumstances, and which give a person with disabilities equal access to the premises. Examples include:

- widening doorways and installing ramps;
- replacing doorknobs with lever handles;
- installing grab bars in bathrooms.

Q. Who pays for these alterations?

A. In an apartment or other housing program, the landlord pays for alterations to the common areas, such as hallways, entrances, and meeting rooms. The tenant is responsible for the costs of modifications inside the apartment. Alterations to public facilities, hotels, and other programs covered by the ADA are paid for by the owner of the facility.

Q. How do I go about getting some changes made in my apartment?

A. Although many housing providers are familiar with the FHAA, and are working to make sure that their buildings are accessible, they may not be aware of accommodations that would make life easier for individual tenants. All you need to do is request the changes; if they are reasonable, they should be honored. Remember that you are

responsible for the costs of physical alterations inside your own apartment. Also, you may be required to return the premises to their original condition when you move.

Q. What do I do if I believe I am being discriminated against?

A. These laws can be enforced through court action or by filing a complaint with an administrative agency.

If the discrimination involves housing, call the U.S. Department of Housing and Urban Development's Fair Housing Complaint Hotline at 1-800-669-9777.

If the discrimination involves employment, public accommodations, telecommunications or public transit, contact the U.S. Department of Justice, Office on the Americans with Disabilities Act, Civil Rights Division, at 1-800 514-0301 (voice), or 1-800 514-0383 (TDD).

VII. Right to Control Your Own Affairs

As we grow older, all of us face the possibility that one day we may become incapacitated mentally. The time may come when we are no longer able to make our own health care decisions, manage our own financial affairs, or act on our own behalf.

When that happens, you and your property must be protected, and people should honor your wishes wherever possible. How and where do you want to live? What decisions can you make? What decisions should you leave to someone else? Whom do you want to make decisions for you? Several alternatives will ensure that people respect your wishes whenever possible. Through planning, the decisions made on your behalf can be those you would have made yourself.

A Legal Test of Capacity

There is no universal legal test of mental capacity or incapacity. Laws vary from state to state, but some general principles apply everywhere.

Incapacity is always evaluated in connection with specific tasks. The question is always, "Incapacity to do what?" Different legal standards of capacity may apply to different tasks, such as capacity to do a will, to drive, to enter contracts, to manage money, or to make medical decisions. In a typical guardianship proceeding, most but not all states use a two-part test to determine incapacity (sometimes called incompetency). First, some type of disability must be verified, for example, mental illness, mental retardation, and/or Alzheimer's disease. Second, there must be a finding that the disability prevents the person from performing activities essential to take care of his or her personal needs or property. Most courts will also insist that all feasible alternatives to guardianship have been explored before appointing a guardian.

Financial Management Issues

Q. What may I do to make sure that people consider my wishes if I become incapacitated?

A. You should make plans now, while you have capacity, to be sure your wishes are met. Several planning tools guarantee you a voice in your future. If incapacity strikes, these tools will name the person you want to act on your behalf and/or tell other people how to care for you and your property.

There are different types of planning tools. Some--such as the durable power of attorney, joint property arrangements, and living trusts--cover your property and financial affairs. Others, known as the advance directives for health care, address your health care concerns, including decisions near the end of life.

The details of creating these documents vary from one state to another. However, some general principles apply.

Durable Power of Attorney

Q. What is a power of attorney?

A. It is a written document in which you (the "principal") grant certain authority to another person (the agent or "attorney in fact") to act on your behalf. A power of attorney may be very specific, authorizing a person only to sell a car for you, for example. Or it can be very broad, allowing the agent to do almost anything on your behalf. Traditionally, powers of attorney were used to authorize a trusted family member, friend, or attorney-at-law to act in your behalf in financial matters--the sale of real estate, the making of investments, and so on. When drafted to cover all financial matters, this authorization is called a "general power of attorney."

Q. Will a power of attorney be valid when I become mentally incapacitated or incompetent?

A. A power of attorney normally is not valid if you become incapacitated, unless you use a "durable" power of attorney. A durable power of attorney clearly states that you intend the power to continue if you become disabled or incapacitated. It generally remains in effect until you deliberately revoke it or until you die. However, in some states, your durable power of attorney is terminated if a guardian is appointed for you (although appointment of a guardian is usually unnecessary because the durable power of attorney takes care of the management of your affairs).

Q. Whom should I name as my agent under a durable power of attorney? Does the person have to be an attorney-at-law?

A. Your agent does not have to be a lawyer. In most states, it can be any adult or an institution. However, it should be someone who knows you well and whom you trust completely to manage your affairs. After all, decisions made by your agent can have tremendous consequences for you. Your agent has to carry out your wishes and always act as you would choose or with your best interests in mind. If there is no one whom you trust with this power, it may be best not to draw up a power of attorney. Other planning tools may suit you better.

You may name multiple agents who exercise all or some of the powers jointly (that is, all must agree) or separately (that is, any one may act). With multiple agents, some process for handling disagreements among agents should be considered, so that

disagreements do not undermine the usefulness of the power. In all cases, it is a good idea to name an alternate to serve as your agent in case your first choice becomes unavailable.

Q. What if I do not want a power of attorney to take effect now, but only if I become disabled or incapacitated?

A. In general, a durable power of attorney becomes effective when you sign it. However, you may tell your agent not to act until you become incapacitated or disabled. If your agent acts prematurely, you still have the right to act on your own behalf and you may revoke the durable power of attorney at any time if you still have capacity. It may be possible to write your durable power of attorney so that it becomes effective only if you become incapacitated. This is called a "springing power of attorney." Many states allow you to write this type of durable power of attorney. Consult a knowledgeable lawyer to find out what is possible in your state.

Q. Do I need a lawyer to write a durable power of attorney?

A. While not required, a lawyer is advisable for drafting your durable power of attorney for property. A lawyer should make sure that your document meets your state's requirements and that the powers you wish to give your agent are actually spelled out in language that will be legally effective.

Some powers may not be presumed to be within the scope of the power of attorney unless they are specifically spelled out--for example, the power to make gifts or loans or file tax returns. Some states require a specific format or specific wording in the document. Certain states provide a "short form durable power of attorney" that allows you to check off the powers to be granted to the agent, with state law providing an interpretation of what each power means. Even with these simplified forms, legal consultation is advisable.

Revoking a Power of Attorney

If you change your mind about whom you want as your agent under a power of attorney (durable or not), you may revoke the document. In fact, while you are capable, you may revoke a power of attorney at any time for any reason. Simply notify the person you have named to act as your agent. For your protection, it is best to do this in writing. You also should destroy all copies of the power of attorney and notify in writing any third parties with whom this person might have done business. Where substantial assets are at stake, you may also want to file a document called a "Revocation of Power of Attorney" in the public records where you live or own real state, and maybe even in the local newspaper(s) if business interests are at stake.

Q My father has Alzheimer's disease. I would like him to appoint me to act for him under a durable power of attorney, since he can no longer manage on his own. May he do this now or is it too late?

A. It is up to your father to decide if he wants to give you his power of attorney. And it may be too late. Durable powers of attorney and other planning tools must be made while a person is still capable. This is why advance planning is so important.

However, just because doctors diagnose someone as having a specific disease does not mean that the patient is necessarily incapacitated. Also, incapacity does not affect all functions in the same way. Thus, even people in the early stages of a disease such as Alzheimer's have the capacity to make some decisions. They also may have more capacity at certain times of the day than at others, or their capacity may be affected by medications.

Capacity must be assessed on a case by case basis. If your father is willing to see a lawyer about writing a durable power of attorney, the lawyer can help assess whether your father understands the purpose and consequences of the durable power.

Q. Who decides whether I'm incapacitated?

A. You can specify how you wish to have your incapacity and mental status determined if the need should arise. For example, in your durable power of attorney you can name a doctor to make this determination, or you can say that two doctors must decide whether you have capacity. Any doctor or clinical psychologist who makes evaluations of capacity should have experience in this area. If you provide no instructions, then a court might ultimately decide the issue, guided by generally accepted standards used by other courts in making these determinations.

Living Trusts

Q. What is a "living trust"?

A. A living trust (also called "inter-vivos" trust) is an arrangement under which you transfer ownership of all or part of your property to the trust during your lifetime. As the person establishing the trust, you are called the "grantor" or "settlor." You name a "trustee," who manages the property according to the terms of your written trust document. The trustee may be an individual or an institution or yourself. The trust is for the benefit of one or more persons, including yourself, called the "beneficiaries."

Frequently, a will is used to set up a trust (called a testamentary trust) that becomes effective after the death of the person establishing the trust. A living trust, however, is effective during the lifetime of the settlor, although it may be written to continue beyond the lifetime of the settlor. In a living trust, the settlor and/or members of his or her family usually are the beneficiaries of the trust. A living trust may be revocable or irrevocable.

Q. What is a living trust useful for?

A. Living trusts are one way of ensuring that someone (a trustee) has the legal authority to manage your estate properly if you become incapacitated or simply do not wish to manage your own estate anymore. They may also be used to avoid probate proceedings after the death of the person establishing the trust. They are especially useful where there is a substantial amount of property and professional management is desired. Like the durable power of attorney, a living trust may make it unnecessary to have a guardian or conservator appointed to manage your financial affairs. However, a trust is generally more expensive to create and to manage than a durable power of attorney.

Q. How may I use a living trust to plan for possible incapacity?

A. You may design a living trust so it takes effect only if you become incapacitated. In this way, you keep control over your affairs until the proper person

determines that you are incapacitated. As with a durable power of attorney, the process for such a determination should be spelled out in the document.

You may also write your living trust so that it is effective before you become incapacitated and continues even after you lose capacity. For example, you might name yourself as trustee and manage the trust's assets while you have capacity, but name a successor trustee who will take over for you if you become incapacitated. Again, you should designate in the trust document how that determination of incapacity should be made.

Q. I thought a trust simply paid an allowance to someone. If I need a trust because I cannot manage my own finances, how would this help me?

A. Some trust arrangements do just pay a sum to the beneficiary periodically. However, you may design a living trust in which the trustee handles many of the daily tasks of managing the estate, including paying bills and taxes. You may state in the trust agreement exactly what you want the trustee to do, how you want your assets managed and how much discretion you want to give your trustee.

Q. Is a living trust just for someone who is incapacitated?

A. No. While it's an excellent way for someone to plan and avoid the need for a guardian or conservator of the estate, a living trust also is useful for someone who wishes to turn over financial management of his or her affairs to another person.

Living trusts may have significant tax consequences, and may or may not reduce the amount of your estate that is subject to the probate process after your death. In addition, trusts may have an affect on your eligibility for Medicaid payment of your nursing home care. Trusts are very complicated; considerable caution is required in making them and the assistance of a lawyer is highly recommended.

To find out more about living trusts, contact an estate planning lawyer in your state. He or she will be able to give you particulars about how your state's laws affect such trusts and about the consequences of making a trust.

Q. My father has a lot of money in his estate, but he is becoming increasingly forgetful every week. May he still write a living trust?

A. Like the durable power of attorney, people must prepare living trusts while they still have the capacity to do so. First of all, your father must want to make a trust. If he does, his lawyer may determine his ability to make a trust agreement. Sometimes, this is done by having him examined by a family physician or perhaps a gerontologist. His lawyer will know what standard of capacity must be proven. If your father does not have that capacity, he cannot make and sign a living trust.

Q. May I decide that I want to change, or revoke, a living trust arrangement?

A. It depends on whether the trust is revocable or irrevocable. If your trust is revocable and you still have capacity, then you always may change or even revoke it completely. An irrevocable trust cannot be changed or revoked.

Q. How may I ensure that my trustee will manage my affairs properly after I become incapacitated?

A. Your trust instrument should contain specific instructions. You should include a precise statement of what the trustee should do on your behalf, and specify the trustee's particular duties, responsibilities, and limitations.

Q. My wife and I hold most of our assets in common. May I still draft a living trust to protect my share of the estate?

A. Yes, but take care to ensure that the trust does not violate the rights or interests of your wife in her portion of the estate. You may do this through careful drafting of the document and sound financial planning before incapacity. You and your wife may need separate counseling and planning advice, as your interests may conflict with each other.

Q. It sounds as though a living trust is a very complex type of financial planning tool. Who can help me decide if one is right for me?

A It is best to consult with a lawyer or a trust officer familiar with living trusts to determine if one is right for you. Do not rely solely on mail-order or do-it-yourself trust kits, as they may contain information that is misleading or inappropriate for your circumstances or your state's law. There is more information in the chapter, "Estate Planning."

Joint Ownership

Q. I have most of my property and bank accounts held jointly with my spouse and an adult child. Isn't this good enough to ensure management of my property if I become incapacitated?

A. No. Joint ownership, or joint tenancy with right of survivorship, is a common and simple form of ownership for property such as one's home, cars, securities, and bank accounts. It is a convenient way to allow another person access to property or money you have in a bank account or to deposit or write checks on your behalf. However, joint ownership is not a substitute for other planning tools because it has serious disadvantages. For example, an untrustworthy joint owner may withdraw all the money in a bank account and leave you with nothing. It is possible to challenge a co-owner's improper use of your money, but it may be difficult. In some states, creditors of a co-owner may be able to reach your account, even though that person is only listed on your account to help you manage your money. In addition, being listed as a co-owner of a bank account could affect the co-owner's eligibility for public benefit programs such as Medicaid. Finally, transfers of a home, a car, or securities, normally requires the signature of all owners. The loss of capacity of one owner may prevent a needed sale or transfer of the property. See the chapter on estate planning for more information on joint ownership.

Q. I'm concerned about the disadvantages of joint bank accounts. Is there another way that I can give someone access to my bank account without giving that person ownership of my money?

A. Some states have laws allowing persons to create what is referred to as an "agency bank account" or "convenience account." This works very much like a durable power of attorney. You name an agent on your bank account who then has the authority to make deposits or withdrawals and manage your account. The authority remains effective if

you become incapacitated or disabled, unless you indicate otherwise. The agent has no right of ownership in the money in the account before or after your death, unless you indicate that the agent is to receive the money when you die. This may be a useful tool for you if you do not want to give someone authority over other aspects of your financial affairs through a durable power of attorney. It also may be useful as a supplement to your durable power of attorney, because some banks are reluctant to accept a durable power of attorney and prefer their own forms and procedures. Your banker or lawyer should be able to tell you whether your state's law allows agency bank accounts and how one might benefit you.

Representative Payees

Q. I have no income other than my social security check. Would a living trust or power of attorney help me manage my money?

A. A living trust is far too costly and complicated for this kind of situation. A durable power of attorney definitely would be helpful. However, if the primary need is to take care of the social security check, a “representative payee” may be the simplest way to help you take care of your daily expenses and manage your small income.

Q. What is a representative payee?

A. A representative payee is a person or organization appointed by a government agency, such as the Social Security Administration (SSA) or the Veterans Administration (VA), to receive and manage public benefits on behalf of someone who is incapable of doing so. The payee actually receives your government benefits on your behalf and is responsible for managing those benefits and making sure that they are spent for your welfare.

Q. What types of income may a representative payee manage?

A. He or she may only manage the income paid by government programs (usually federal programs such as social security, veterans benefits, black-lung benefits, and supplemental security income programs). The representative payee has *no* authority over any other income or property that you might receive. If you have additional income from other sources, you may need other assistance (such as help from an agent under your durable power of attorney or from a money management program, discussed below) in addition to the help of a representative payee.

Q. How is a representative payee set up?

A. You, or someone on your behalf, must ask the Social Security Administration (or other program) to appoint a representative payee. Generally, you must have some sort of disability that prevents you from managing your own financial affairs, and you probably will need medical records of your disability. The government agency that provides the benefits must decide that you need help managing them. Your disability may be physical or mental. Although the decision is made by the agency and not by a court of law, you have the right to contest the appointment of a representative payee if you disagree, including the right to a hearing and all the appeals rights that apply to any claim before the agency.

Q. How can I be sure a representative will manage my money properly?

A. Supervising representative payees can be a problem. In principle, the payee must provide a detailed accounting to the agency paying the benefits. However, many exceptions exist. For example, spouses and institutions (such as nursing homes) that are acting as payees do not have to make such reports. Under some benefits programs, such as the VA, reporting requirements vary with the size of the benefit. There is not much you may do to protect yourself ahead of time in such circumstances, except to plan for incapacity through other methods that allow someone else of your choice to manage your income for you.

Q. If I regain my ability to control my own finances, may I dismiss a representative payee?

A. Yes. First you need a doctor's certification that you are now able to manage your own financial affairs. You must then notify the government agency of your wish to dismiss the representative payee, and the agency must determine that you have regained the capacity to manage your own benefits.

Money Management Services

Q. I do not have a durable power of attorney or other legal tool for managing my property, but I have heard of some organizations offering "money management" services. What are these?

A. Money management programs, also known as "daily money management" or "voluntary money management," represent a broad group of services designed to help older persons or persons with disabilities who need assistance managing their financial affairs. These services might include check depositing, check writing, checkbook balancing, bill paying, insurance claim preparation and filing, tax preparation and counseling, investment counseling, and public benefit applications and counseling.

Q. Who provides money management services?

A. This assistance may be provided by an individual or an organization. An organization may provide services on a for- profit or not-for-profit basis. Services may be provided for free, on a sliding fee scale basis (where you pay according to our income), or for a flat rate.

If you receive or are considering money management services, you should make sure that your service provider has a system of cash controls to prevent or at least lessen the risk of embezzlement of client funds. The service provider should also be bonded and insured to protect clients from theft or loss of funds.

Q. How do money management programs help me keep control of my life?

A. A money management program may be able to help by providing the financial management assistance you need in the way you want it. It may also help avoid the need for a guardianship. Money management services work on a voluntary basis, so you must be able to ask for help or accept an offer of help. Money management services may be

particularly useful if you have no family or friends who are able or whom you trust to act as your agent or trustee.

Guardianship

Q. What exactly is a guardian?

A. A guardian is someone who is appointed by a court to make personal and/or financial decisions on behalf of another person. "Guardian" is a general term for a court-appointed surrogate (substitute) decision maker. Your state may use other terms, such as “conservator,” “committee,” or “curator.” Some terms may only apply if the decision maker has authority over financial and property matters; other terms may apply if the decision maker has authority over personal decisions such as living arrangements and health care. A person who has a guardian may be called a "ward," an "incapacitated person," or some other term.

Q. When is the appointment of a guardian appropriate?

A. People need a guardian when:

(1) they can no longer manage their affairs because of serious incapacity:
(2) no other voluntary arrangements for decision making and management have been set up ahead of time, (or if they have been set up, they are not working well) and
(3) serious harm will come to the individual if no legally authorized decision maker is appointed.

A guardianship is a serious step and should relate to a serious inability to make or understand the consequences of decisions. It should not depend on stereotypical notions of old age, mental illness, or handicaps. A person has a right to make foolish or risky decisions. These decisions by themselves do not mean that the person has a decision making incapacity.

Q. Are there any disadvantages to the appointment of a guardian?

A. Yes. Although a guardianship may be necessary to protect the welfare of an incapacitated person, it also results in the loss of individual rights. The person under a guardianship may lose several civil rights: the right to marry, the right to vote, the right to hold a driver's license, the right to make a will, the right to enter into a contract, and other rights. Because of its serious consequences, guardianship should be considered the last resort for helping someone who is experiencing incapacity.

In addition, the court proceedings themselves can be costly, time-consuming, and emotionally trying for a family. Once in place, a guardian's ability to manage the estate is far less flexible than would be under advance planning legal tools such as durable powers of attorney or living trusts. Guardians must operate within strict fiduciary limitations and normally must file annual accountings with the court. On the positive side, the fiduciary rules and court accountings ensure at least some oversight and accountability of the guardian.

Q. Who appoints a guardian?

A. Procedures vary among the states, but generally a court of law appoints a guardian after hearing evidence that a person is incapable of making decisions and deciding that the person needs a surrogate decision maker.

In most states, the law requires some form of due-process rights. These rights are intended to protect a person from being inappropriately declared incapacitated. The rights include the right to be notified of the date and place of the hearing, the right to be present at the hearing, and the right to be represented by a lawyer.

Q. My elderly mother is often confused. I think she ought to have a guardian to look after her interests. What do I do?

A. First, you may want to contact your local area agency on aging to see if there are any programs or services that might help your mother manage and make it unnecessary to obtain a guardian for her. It will also help to have her examined by a doctor or psychologist experienced in geriatric evaluation. A geriatric evaluation will typically involve evaluation by more than one specialist from different disciplines, such as medicine, nursing, and social work. Often, a person's decision making may be impaired because of physical or other causes that can be corrected.

If the evaluation supports the need for a guardianship, check with a lawyer to learn the specifics of your state's guardianship law and procedures, as they vary substantially from state to state. The appointment of a guardian normally requires the filing of a petition with the court, notice to your mother and other interested parties, and a court hearing. You will probably need a lawyer to help you through it.

The court may also appoint an investigator or “visitor” to interview your mother and make a report to the court or an attorney to represent your mother. At the hearing, a judge will review the petition, the investigator's or attorney's report, and medical reports.

The judge may ask the person filing the petition why the other person needs a guardian. The judge may also ask the allegedly incapacitated person some questions. The hearings are usually fairly informal. If there is disagreement, the judge may set the case for a formal hearing with witness testimony, cross examination, and argument by counsel.

Q. What if someone thinks I need a guardian, and I do not want one?

A. Every state gives the allegedly incapacitated person a chance to fight the petition for guardianship. If you do not think you need a guardian, you must let the court know that. Usually you do this by appearing in court on the day of the hearing or asking someone to represent you at the hearing.

It is best to get your own lawyer to represent you at the hearing. If you cannot afford one, many states require that the court appoint one at the state's expense. Some free legal services programs for older persons will help you fight a guardianship. If you cannot get to court or hire a lawyer, you may write the court about your objection to the guardianship.

Who May Be a Guardian?

Laws vary from one state to another. In most states, the courts may appoint almost anyone as your guardian if the person meets legal requirements. Often the court appoints the person filing the petition. Most courts like to appoint a relative who knows the person

and is most likely to act in his or her best interests. However, the courts may appoint a friend or attorney, especially if no family members are available. The courts also may appoint multiple guardians, either with shared responsibilities or with responsibilities split between them. If there are no friends or family willing or able to serve as guardian, many states permit public or private agencies to act as the guardian and to charge fees for that service.

Q. This sounds very expensive. Who pays for a guardianship?

A. It can be expensive. There are court charges and attorney fees and fees for the doctor or other persons who examine the alleged incapacitated person to assess his or her capacity. If the court appoints a guardian, the estate usually pays the guardian's fees. Older persons who are either seeking guardianship over a family member or who are challenging a guardianship may be able to get free legal help through legal services programs or through lawyers who volunteer their services pro bono (free of charge). Contact your local area agency on aging or local bar association to find these resources in your community.

Q. If I need a guardian, may I specify whom I want and do not want to play this role?

A. Yes, the court will give due weight to your preference, and in some states must follow your preference unless there is good cause no to do so. You should nominate a guardian, this as part of your general planning for incapacity. Sometimes even the best plans for incapacity fail (for example, if your agent under your durable power of attorney passes away after you become incapacitated), so it is a good idea to name in your planning documents one or two people whom you want as your guardian if that becomes necessary.

Q. May the court remove a guardian?

A. Yes, a guardian may be removed if the incapacitated person can prove that he or she has regained the capacity to make decisions. It can be hard to have a guardian removed. Therefore, if someone's incapacity may be temporary, consider whether some other legal tool (such as money management or a representative payee) will meet the person's need for help and make it unnecessary to get a guardianship.

A court also may remove a guardian who is not properly carrying out his or her responsibilities. Usually a new guardian will replace the person who is removed.

Q. My elderly aunt needs some help with her affairs, but she is not totally incapable. May a guardianship meet her needs?

A. In most states, if a person has partial capacity his or her guardian may be given only partial power over his or her affairs. This is generally called a "limited guardianship." In your aunt's case, the court's guardianship order would identify the specific matters over which the guardian has authority. Your aunt would retain legal authority over all other areas of her life.

In all states, the courts try to ensure that a guardianship is the "least restrictive" alternative. This means that a guardianship restricts the ward as little as possible, letting the ward do whatever the disability allows.

Suppose your aunt can no longer manage her large estate, but she can handle her daily finances. A guardianship should let her keep control over everyday expenses. Or, let

us say your aunt needs placement in a nursing home by the guardian. If she can say what type of nursing home she wants to live in, the guardian should honor those wishes.

Even when a limited guardianship is not feasible, the guardian should try to involve the ward in making decisions whenever possible.

Health Care Decision Making Issues

Q. What is my right to control decisions about my health care?

A. With few exceptions, our system of law recognizes the right of capable individuals to control decisions about what happens to their bodies. This includes the right to refuse any suggested medical treatment. We normally exercise this right by talking to our doctor and other health care providers. You have a right to:

- know all the relevant facts about your medical condition;
- know the pros and cons of different treatment options;
- talk to other doctors and get their opinions, too;
- say "yes" to treatment or care that you want, and "no" to treatment or care that you do not want.

Your doctor is the expert in medicine, but you are the expert in defining and applying your personal values and preferences.

Q. What happens to my right to make medical decisions if I am too sick to decide?

A. In an emergency, the law presumes consent. In all other instances, someone else must make decisions for you. The best way to ensure that decisions are made the way you would want and by the person you want, is to do an advance directive for health care before you become incapacitated.

Q. What is an advance directive for health care?

A. An advance directive is generally a written statement, which you complete in advance of serious illness, about how you want medical decisions made. The two most common forms of advance directive are a "living will" and a "durable power of attorney for health care," although in many states you may combine these into a single advance directive document.

An advance directive allows you to state your choices for health care or to name someone to make those choices for you, if you become unable to make decisions about your medical treatment. In short, an advance directive enables you to have some control over your future medical care. You can say "yes" to treatment you want, or say "no" to treatment you don't want.

Q. What is a living will?

A. A living will is simply a written *instruction* spelling out any treatments you want or don't want in the event you are unable to speak for yourself and you are terminally ill or permanently unconscious. A living will simply says, "Whoever is deciding, please

follow these instructions." It is called a "living will" because it takes effect while you are still alive. It is also called a "medical directive" or "declaration."

Q. What is a durable power of attorney for health care?

A. A durable power of attorney for health care (sometimes called "health care proxy") is a document that appoints someone of your choice to be your authorized agent (or "attorney-in-fact" or "proxy") for purposes of health care decisions. You can give your agent as much or as little authority as you wish to make some or all health care decisions for you. And in most states, you can include the same kind of instructions that you would put in a living will.

Q. Which is better: a living will or a durable power of attorney for health care?

A. The most efficient approach is to combine the living will and durable power of attorney for health care in one document. In most states you can do this. However, some states have less flexible rules for these advance directives. In these states, having both may be the preferred approach.

On its own, a living will is a very limited document because, under most state statutes, living wills apply only to terminal illness or permanent unconsciousness. They address only life-sustaining medical treatments and not other treatment decisions, and they provide fairly general instructions that may be difficult to interpret in complicated medical situations.

The durable power of attorney for health care is a more comprehensive and flexible document. It may cover any health care decision and is not limited to terminal illness or permanent coma. More importantly, it authorizes someone of your choice to weigh all the facts at the time a decision needs to be made and to legally speak for you according to any guidelines you provide.

Q. Why can't I just tell my doctor what I want?

A. Telling your doctor and others what you want does provide important evidence of your wishes if you later become incapacitated, especially if your doctor writes your wishes down in your medical record. However, written advance directives are likely to carry more weight and to be followed.

Q. What happens if I do not have an advance directive?

A. If you have not planned ahead by executing an advance directive, many states have family consent (or health surrogate) statutes that authorize someone else, typically family members in the order of kinship, to make some or all health care decisions. Even in the absence of such statutes, most doctors and health facilities routinely rely on family consent, as long as they are close family members and no controversial decisions need to be made.

However, without an advance directive, decisions may not be made the way you would want them, or by the person you would want to make them. Making an advance directive also benefits your family members, because it spares them the agony of having to guess what you would really want.

If no close family or other surrogate is available to make decisions for you, a court-appointed guardian may be necessary. This is an option of last resort.

Q. How do I make an advance directive?

A. Requirements differ from state to state. Many states provide suggested forms, and in some cases, required language for advance directives. Most states have specific witnessing or notary requirements. Follow these requirements closely. Commonly, two witnesses are required; and often, several categories of persons are disqualified from serving as a witness, such as relatives, heirs, or health care providers.

In addition to the forms included in state law, a variety of other advance directive forms are available--some prepared by state bars or medical associations, some published by national organizations, others published in journals or local publications or do-it-yourself books.

The most important point to remember about forms is that they are supposed to aid, and not take the place of discussion and dialog. Therefore, a form ought to be a starting point, not an end point, for making your wishes known. There is no ideal form. Any form you use should be personalized to reflect your values and preferences. Before doing an advance directive, talk with your doctor, family members, and advisors. This will help you to understand the medical possibilities you may face and clarify your values and choices.

Q. What should my advance directive say?

A. No one can tell you exactly what to say in your advance directive. However, the most important task to accomplish is to name someone you trust to act as your agent for health care decisions. If there is no one whom you fully trust to act as your agent, then it is best not to name an agent, and instead, only include instructions about the kinds of treatment you would want or not want if you became seriously ill.

Also consider addressing:

(1) Alternate proxies. Whenever possible, name one or more alternate or successor agents in case your primary agent is unavailable.

(2) Life-sustaining treatments. Are there any specific types of treatment you want or don't want in any circumstances? Your personal or family medical history may make certain conditions or treatments more likely.

(3) Artificial Nutrition & Hydration. Some states will presume that you want nutrition and hydration in all circumstances unless you instruct otherwise.

(4) Organ donation. In many states, you can include instructions about donating organs in your advance directive.

Q. Can I change or terminate my advance directive?

A. Yes, you always have the right to change or revoke your advance directive while you have the mental capacity to do so. Normally, you can revoke it orally or in writing in any way that indicates your intent to revoke. Your intent should be communicated to your agent, your family, and doctor.

If you want to change the document, it is best to execute a new document. The same formalities of signing and witnessing are required for changes.

Q. Whom should I select as my agent or proxy for health decisions?

A. The choice of agent is the most important decision you may make in doing an advance directive. Your agent will have great power over your health and personal care if you become incapacitated. Name a person whom you trust fully. If no such person is available, it may be best not to name a health care agent.

Find out who can and cannot be your agent under state law. Some states prohibit health care providers or health care facility employees from acting as your agent. Speak to the person you wish to appoint beforehand to explain your intentions and to obtain his or her agreement. Preferably, do not name co-agents, because it opens up the possibility of disagreement among agents. Instead, name alternate or successor agents, in case the primary agent is unavailable. If there is anyone whom you absolutely want to keep out of playing any role in your health care decisions, you may be able to expressly disqualify that person in your advance directive.

Q. What do I do with my advance directive after completing one?

A. Make sure someone close to you knows where it is located. If you have named an agent, give your agent a copy or the original. Also give your physician a copy and ask that it be made part of your permanent medical record. You may also want to make a small card for your purse or wallet that states that you have an advance directive and provides the name, phone number, and address of your agent or person who can provide a copy of it.

Q. What if my doctor or hospital refuses to follow my advance directive?

A. First, find out ahead of time your doctor's views about advance directives and your specific wishes. If you disagree, you may wish to find a new doctor ahead of time.

Under federal law, most hospitals, nursing homes, and home health agencies must inform you of their policies about advance directives at the time of admission. Most will respect advance directives, but some may have restrictive policies. However, no facility can require you to have, or not have, an advance directive as a requirement of admission. I

If you are in a condition to which your advance directive applies and your providers will not honor your directive, state law spells out their obligations. Usually, the provider must make a reasonable effort to transfer the patient to another provider who will respect the advance directive.

Q. If I make an advance directive in one state, will it be recognized in others?

A. In many states, the law expressly honors out-of-state directives. But, in some states, the law is unclear. Realistically, providers will normally try to follow your stated wishes, regardless of the form you use or where you executed it. However, if you spend a great deal of time in more than one state (for example, summers in Wisconsin, winters in Arizona), you may want to consider executing an advance directive for each state. Or, find out whether one document meets the formal requirements of both states. As a practical matter, you may want different health care agents if the same agent is not easily available in both locations.

Getting More Information About Advance Directives

Most state or area agencies on aging have information on advance directives, as do many state bar associations and medical societies. State-specific information and forms are also available from:

Choice in Dying, 1-800-989-WILL (9455), website www.choices.org. (The organization is evolving into a new organization concerned more broadly with excellent end-of-life care. You can learn about Partnership for Caring by accessing www.partnershipforcaring.org.) If your state doesn't specify a particular form for a living will, Choice in Dying can send you a living will declaration that will keep you from being hooked up to resuscitation machine. It must be signed by two witnesses, who cannot be your relatives, heirs, or doctor

Q. Is a lawyer needed to do an advance directive?

A. No, a lawyer is not necessary, but a lawyer experienced in doing advance directives is very helpful. A lawyer can draft a personalized document that reflects your particular wishes and ensure that all legal formalities are followed. A lawyer is especially helpful if potential family conflicts or special legal or medical concerns are present.

Abuse and Exploitation

Q. What is elder abuse?

A. Elder abuse occurs when anybody neglects or abuses an older person. The abuse can be physical or mental. Definitions of elder abuse vary from state to state, but generally include:

- physical abuse, such as hitting or shoving; sexual abuse, including fondling, sexual intercourse, and forced intimate contact of almost any sort;
- verbal and psychological abuse, such as screaming at the older person, name calling, and threatening the person;
- neglect, such as withholding food, shelter, medical care, medication, and other necessities from the older person; and
- restraint, such as keeping the person locked up.

Also included in most states is financial exploitation. This can range from outright theft to misuse of the older person's money. Cashing an older person's social security check and not using the money for the person's care is one example. Many states also would consider misusing credit cards or funds held in joint bank accounts as financial exploitation.

Every state has specific elder abuse laws. You can get details on laws and programs from your area or state agency on aging or contact the National Center on Elder Abuse at 1225 I Street, N.W., Suite 725, Washington, DC 20005 or on their website at www.gwjapan.com/ncea.

Q. Is elder abuse just a problem for very frail old people who live in nursing homes?

A. Elder abuse is a real problem for many older people. Some victims are very frail and are unable to seek help on their own. However, many elder abuse victims are active older adults who feel cornered in an emotionally difficult situation.

Elder abuse can be a problem for both the rich and the poor. It does not strike only one race, social class, or economic level.

Q. My son shares my apartment with me. Sometimes, when I forget things or get confused, he loses his temper, pushes me, and threatens to put me in a nursing home. Is this abuse?

A. Yes. Many types of elder abuse occur within the home. Even if it only happens from time to time, it is still abuse. Seek help from your local social service agency on aging.

Q. My neighbor is very old and sick. She depends on her daughter for shopping, cooking, and cleaning. However, her daughter often leaves the older woman without food and clean clothes. Is there anything I can do to help?

A. Yes, you may report this neglect to your local elder abuse reporting agency. This may be your state or local agency on aging or human services department. You may even report abuse and neglect to the police.

You should not worry about being sued for making the report. Almost all states protect people who make such reports acting in good faith. You may even make an anonymous report.

Q. My son is using all my money to buy illegal drugs. He is also running up large charges on my credit cards. (His name is on my credit-card accounts and my bank accounts.) Since he is a co-owner of my home, I am afraid he will mortgage it or possibly even sell it to get more money. What can I do?

A. Even if he has the legal right to reach your funds, you may protect yourself from this type of financial exploitation. Ask your bank to help you transfer funds to new accounts that your son may not access. Write all your credit card companies and ask them to remove your son's name from your accounts. Have them issue new credit cards to you.

Contact a lawyer to see what you must do to protect your home. A free legal services program for older or poor persons may be able to help you. Your local area agency on aging can help you find those resources.

Finally, seek help for yourself and for your son from a local social service agency. Many of them have experience in dealing with family difficulties of this sort. You do not have to allow your son's problems to overtake your own well-being and financial security.

Q. My son and daughter-in-law live with me in my home. They are living rent-free and give me no money for household bills or food. I feel like they are taking advantage of me. Can someone help me?

A. Yes. The situation you describe is surprisingly common. If the help you provide them is not what you wish, you are being exploited. Over 75 percent of all abusers are family members. You can seek help from an elder abuse program operating in your area. It can provide counseling and other assistance.

Legal Services

Most of the time people prefer to resolve disputes and manage affairs on their own. Sometimes, however, they will need expert help to protect their interests. Many older people already have lawyers who have helped them with legal issues in the past. Others will need to work with a lawyer for the first time. Help from a lawyer who is an expert about social security or estate planning may be necessary.

Q. My 45-year-old son and I are co-owners of a condominium. We have had a falling-out over some lifestyle issues. Do I need a lawyer to get me out of the joint ownership? How can my son and I resolve our differences?

A. You could hire a lawyer and go to court, but some other solutions may be faster, less expensive, and produce better and more lasting solutions.

Sometimes, problems that seem to be "legal" may be solved through other means. A social worker or psychotherapist can help with family problems. Some specialize in counseling for the elderly. You also can request help from a social service agency. Your local agency on aging can provide information dispute. It may be available through your local court or through a private mediator. Your local bar association also may be able to make a referral. Another option is small claims court. Small claims court gives you the opportunity to get a legal judgment without hiring a lawyer and putting up with delays, if the dollar amount is under a certain amount, for example, $2,000. There is more information about small claims court in the chapter, "How the Legal System Works."

Spousal Abuse

Suppose your spouse sometimes hits you or pushes you around. You are both over sixty-five, and it is harder for you to run away from him or her. Is there anything you can do after all these years?

You do not have to live with abuse, no matter what your age. Physical abuse is against the law. It is no more legal for your spouse to hit you than for a stranger to hit you.

Fortunately, more and more police departments and courts are sensitive to domestic violence and are willing to help victims. If your spouse strikes you, call the police and file a complaint. You also may ask the police to help you find a domestic violence shelter. You may stay there if you wish to leave your abusive home.

If you do not want to leave your home, you may seek an order of protection through the courts. With such an order, you can have your spouse removed from the home, even though he or she may be the owner. Call the National Domestic Violence Hotline for assistance and information at 1-800-787-3224. See the chapter "Family Law" for more helpful information.

Finding Legal Help

Q. Are there any legal services that serve just older people?

A. Yes, older adults benefit from a wide variety of legal services. One small but growing area of specialization among private attorneys has become known as "elder law." Elder law attorneys focus on the legal needs of the elderly and work with a variety of legal tools and techniques to meet these needs.

An elder law practitioner typically handles general estate planning matters and counsels clients about planning for incapacity with alternative decision making documents. The attorney might assist the client in planning for possible long-term care needs, including nursing home care, locating appropriate types of care, coordinating public benefits and private resources to finance the cost of care, and working to ensure the client's right to quality care.

The National Academy of Elder Law Attorneys (NAELA) can provide more information about attorneys who specialize in elder law. In addition, NAELA can provide consumer information about what questions to ask an attorney to make sure he/she can meet your legal needs. NAELA is located at 1604 N. Country Club, Tucson, AZ 85716; 602-881-4005, or on the Internet at www.naela.org.

Publicly funded legal services are also available through programs funded under the Older Americans Act. These programs have attorneys, paralegals, and advocates who specialize in the rights of older persons. Your state or local agency on aging can refer you to these programs.

State and local bar associations may also have information about programs for older persons that provide referrals or legal services on a *pro bono* basis. (*Pro bono* programs operate for the good of the public and do not charge lawyer's fees.)

Q. I am having a problem with a local department store over some invalid credit card charges. Do I really need a lawyer to resolve this issue?

A. Before hiring a lawyer, consider other sources of help. You may be able to get help from a consumer protection agency run by your state or county. Many law schools offer legal clinics that can provide free or low-cost help. Some stores and utility companies have their own consumer complaint departments. Mediation and conciliation programs may be able to resolve your problem without requiring you to go to court or hire a lawyer. Check with the district attorney's office, city hall or the area agency on aging.

Q. My insurance company won't pay a claim. Is there anything I can do short of suing?

A. Many insurance programs provide an opportunity to provide additional information about the claim and may provide for impartial hearings. These may be done in writing or in person. Check with the Insurance Commissioner's Office in your state about how such disagreements might be resolved. Make sure your personal insurance agent is aware of the problem. He or she wants to retain your business and may provide extra help.

For problems in specific fields, bankers, accountants, real estate brokers, and stockbrokers may be able to help. But don't rely entirely on these individuals. If they can't resolve your problems, see a lawyer. A lawyer can discuss possible actions other than lawsuits.

Q. Do I need to be poor to get any of these legal services?

A. Some bar-sponsored programs may be limited to people with low incomes. Services offered through the Older Americans Act do not have income requirement.

You can find out more by contacting your local agency on aging or bar association.

Before You Hire a Lawyer

If you need a lawyer, you should ask some questions before hiring one. Ask about the lawyer's experience and the kinds of law he or she specializes in. Ask who will be working on your case. Ask how fees are computed and what the lawyer's estimate is for the total time and cost of handling your case. Ask about what the attorney thinks is necessary to complete what you need and whether there are alternatives. Ask how you can participate (you can save money by doing some leg work yourself, such as providing complete documents and other information).

Legal Help for the Homebound

If you are homebound and want to speak to a lawyer, call your local agency on aging. Request their help in contacting a lawyer who may be able to come to your home. If you live in a nursing home, you should speak with the nursing home ombudsman.

Many special programs and services are designed to meet the needs and enrich the lives of older adults. Some are funded with tax dollars, especially under the Older Americans Act. Others have been developed through agencies or private enterprise.

The Older Americans Act and Services

Q. What kinds of services does the Older Americans Act provide?

A. The Act provides funding for a wide variety of services. These include education, social services, recreation, personal assistance, and counseling. It also makes available transportation, legal and financial assistance, career and retirement counseling, advocacy, long-term-care ombudsman services, services for the disabled, crime prevention, elder abuse prevention and volunteer services. In addition, your local area agency on aging can provide information and guide you to services in your community. These might include home helpers, money management agencies or special discounts available to seniors. The specific services offered in each category vary with locale.

Q. How can I find out about programs that might help me?

A. Start at your local or state agency on aging, or call the "Eldercare Locator" at 1-800-677-1116. The toll-free assistance helps to identify community resources nationwide. Also, view the internet site of the Administration on Aging at www.aoa.dhhs.gov/

Your local area agency on aging (AAA) can tell you about the programs in your community that provide services to seniors. Most AAAs have written materials that describe resources in the community. Some have brochures that identify common problems that the elderly might face with resources and ways to solve the particular problem. The AAA may have additional resource materials published by community, state

and national organizations. The AAA in your community is a beginning resource for many questions by the elderly.

Your Area Agency on Aging (AAA)

One important product of the Older Americans Act is the nationwide network of area agencies on aging (AAA). Today, every area of the country is served by either an AAA or a state unit on aging. These agencies help local communities develop services specifically for older residents. The AAAs channel funds from the Older Americans Act to local communities.

Each AAA operates autonomously. All of them offer information and referral services to older adults. A few provide services directly, but most only coordinate services and provide assistance to designated service agencies in the local communities.

AAAs provide funding and programming for local senior citizen centers, too. Programs include recreation, socialization, meals, and educational programs. Many service organizations offer programs at the senior centers as well as at other sites in the community. Additional funds are generally provided by local and state governments, as well as by such organizations as the United Way, private foundations, corporations, and individual donors.

You can feel confident in calling your AAA with almost any question about services in your neighborhood for older people. You can also go directly to a senior citizen center near you and ask for help. If staff there cannot provide it, ask them to put you in touch with someone in the AAA who can help.

Q. My Aunt Minnie is in a nursing home. I fear they do not treat her well. They may even tie her in a chair part of the day. Her husband is in a board care home, and they won't let him visit Aunt Minnie. Her younger sister lives in her own home. She had an aide and nurse to help her when she left the hospital, but they just stopped visiting her. How can I be certain that all three receive quality care?

A. You should call the local long-term care ombudsman, an advocate who works to ensure that older Americans receive appropriate quality care.

Q. A. I have an elderly neighbor who is finding it hard to manage on her own, especially with shopping and preparing meals. Are there services that could help her?

A. Yes. Under the Older Americans Act, several types of nutrition programs and chore services are available to aid older adults. These include home-delivered hot meals, as well as meals served at a "congregate" dining site. There may be limitations placed on home-delivered services because of the great need and the limited amount of funding. The AAA or someone designated will do an assessment of need. The result of such an assessment may lead to the identification of more services that may be arranged for your neighbor.

Q. I would like to use some of the services described here, but I really can't afford to pay for helpers or home-delivered meals. How can I use these programs?

A. The Older Americans Act targets services to low-income and minority elderly, as well as to those who are frail or disabled. Many of the programs funded by the Act are provided without charge, although donations may be requested. Other programs offered by, arranged for, or provided through area agencies on aging may have a small fee or use a "sliding scale," where the fee is assessed on the basis of your ability to pay. Some programs are reimbursed by other governmental programs such as Medicaid. Do not let financial concerns keep you from benefiting from the variety of programs available.

Q. My elderly mother has been diagnosed as having Alzheimer's disease. I would like to have her live with me. Are there services available to help me provide for her needs in my own home?

A. Maybe. Although the Older Americans Act authorizes grants to be made to provide such services, they may or may not be available in your community. These may include in-home supportive services for victims of Alzheimer's disease or related condition, and for the families of these victims.

The services and the extent of services vary from place to place. They might include counseling and training for family care-givers, a needs assessment and assistance in locating and securing services, and case management. A case manager acts as an advisor, broker, and services might also include homemaker and home health aides, in-home respite service so family care-givers can get away for short periods, assistance in adapting a home to meet the needs of an impaired older person, and chore maintenance.

A second very important resource is the state or local Alzheimer's Association. Local chapters can be found through the Alzheimer's Disease Education and Referral Center, P.O. Box 8250, Silver Spring , MD 20907, telephone: 1-800-438-4380, website www.alzheimers.org. The Alzheimer's Association's local chapters provide extensive knowledge of resources for families of Alzheimer's victims in your specific community. Chapters also offer support from others whose loved ones are victims.

Q.I would like help in getting a job, since I feel able to continue working even though I have retired. Can I get help under the Older Americans Act?

A. Yes. Through the Community Service Employment for Older Americans program you may be able to get help in finding a job or training opportunity. These may be part-time positions, at minimum wage. In general, this program is designed for lower-income seniors, so income and resource eligibility requirements may apply.

Q. I'm retired and I'm looking for new experiences, but I don't really want to enroll in a school. Is there anything for me?

A. Many universities, local junior colleges, and museum education programs provide special programs, reduced fees, and auditing of classes. A call to the one closest to you can provide information about such programs. The Elderhostel program meets the needs of people like you. Elderhostel is a not-for-profit agency offering educational programs for adults aged sixty years and older. Through an international network of colleges and universities, Elderhostel is able to offer low-cost residential academic programs both in America and abroad. Courses offered have included "The Literary Heritage of Oxford," offered in Oxford, England; "Political Controversies, Judicial Politics and You"; and lectures on Greek Island society, in conjunction with a cruise of the

Greek Isles. The courses are usually taught by university faculty, and run from one to three weeks. Most of the time, participants are housed in dormitories. On special trips, other arrangements may be made. Students may expect to spend approximately three hours a day in class, with many field trips and opportunities for sightseeing.

For more information, contact your local agency on aging or write to Elderhostel at 75 Federal St., Boston, MA 02110-1941, or call 617-426-8056. web: www.elderhostel.org

Where to Get More Information

General Resources

For most older people, their main resource is their area agency on aging (AAA). It can supply details and referrals on many topics. To find your local area agency on aging or the one serving someone you are trying to help, call the toll-free Eldercare Locator 1-800-677-1116 or visit the web page of the Federal Administration on Aging at www.aoa.gov.

Many associations promote the interests of older adults. The best known--and the largest--is the American Association of Retired Persons (AARP). You can join if you are over age 50. AARP has regional and local groups nationwide, and it provides booklets and other resources on virtually any topic of interest to older persons. Look in the telephone directory for the nearest group. Or contact: American Association of Retired Persons, 601 E Street, NW Washington, DC 20049 (202) 434-2277 or 1-800-424-3410 web: www.aarp.org

Other associations also promote the interests of older persons. They also provide information and education to senior citizens. These include:

- National Council on the Aging 409 Third Street, SW, Washington, DC 20024 (202) 479-1200 web: www.ncoa.org
- Older Women's League 666 11th Street, NW, Suite 700, Washington, DC 20001 1-800-825-3695 web: www.owl-national.org
- National Council of Senior Citizens 83301 Colesville Rd., Suite 1200, Silver Spring MD 20910, 1-888-SENIOR. web: www.ncscinc.org

Click here to go to Chapter 16